**DEPARTMENT OF HEALTH CARE SERVICES**
**Behavioral Health Stakeholder Advisory Committee (BH-SAC)**
**February 11, 2021**
**1:30 p.m. – 4:30 p.m.**

# MEETING SUMMARY

**Behavioral Health Stakeholder Advisory Members (BH-SAC) Attending):** Barbara Aday-Garcia, California Association of DUI Treatment Programs; Sarah Arnquist, Beacon Health Options; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI; MJ Diaz, SEIU; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Robert McCarron, California Psychiatric Association; Farrah McDaid Ting, California State Association of Counties; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association of California; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program; Catherine Teare, California HealthCare Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Jevon Wilkes, California Coalition for Youth.

**BH-SAC Members Not Attending:** Jei Africa, Marin County Health Services Agency; Britta Guerrero, Sacramento Native American Health Center; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Jonathan Sherin, Los Angeles County Department of Mental Health.

**DHCS Attending**: Will Lightbourne, Jacey Cooper, Kelly Pfeifer, Jim Kooler, Jeffrey Callison, Norman Williams, Morgan Clair.

**CHHS Attending**: Stephanie Welch

**Public Attending**: There were 158 members of the public attending.

## Director's Update
***Will Lightbourne and Jacey Cooper, DHCS***
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentations-021121.pdf

Director Lightbourne provided a review of the DHCS proposed budget for Fiscal Year (FY) 2021-22. He commented that the budget was prepared with the assumption that the public health emergency (PHE) would continue through the calendar year. The Centers for Medicare & Medicaid Services (CMS) has confirmed the PHE with its enhanced federal match and continued eligibility for all current Medi-Cal enrollees through December 2021. In addition, with state revenue better than expected, the suspension of Prop 56 payments planned for June 30, 2021, has now been delayed by one year. Other items, including HIV/AIDS waiver providers, home health providers, and pediatric day health care facilities services have been removed from the suspension. The budget includes the creation of a DHCS Office of Medicare Innovation and Integration, a component of the Master Plan for Aging that aims to lead innovative models for dual eligibles and Medicare-only individuals.

There are exciting new budget proposals, especially for behavioral health. Director Lightbourne highlighted these items, including $750 million in one-time funding to be spent over three years to build out the residential infrastructure and develop a continuum-ofcare of resources in the community. These will be grants to counties with a matching requirement and flexibility on how the match is met and which could add up to 5,000 beds. Also, there is $400 million in one-time funding over three years for incentive payments to Medi-Cal managed care plans (MCP) to develop strong interfaces with schools and counties to increase the level of services to students. This is infrastructure funding not intended for services which are already budgeted within the MCPs. Finally, we are excited that the budget includes the relaunch of California Advancing and Innovating Medi-Cal (CalAIM).

Jacey Cooper reviewed the history of CalAIM prior to the relaunch. It was proposed in 2019, and DHCS conducted workgroup engagement as well as written and in-person public comment to gather input. With the COVID-19 public health emergency (PHE), CalAIM was put on hold. The relaunch of CalAIM includes an updated proposal that is based on extensive feedback. Ms. Cooper reviewed the updated proposal, timeline, and milestones presented recently in a January 2021 webinar attended by 2,800 participants. DHCS will post a full package for Enhanced Care Management (ECM) and In Lieu of Services ILOS) with contract language, a model of care, and requirements for MCPs. DHCS will be vetting systems and engaging stakeholders in many conversations going forward.

Ms. Cooper reported on the status of current waivers and CMS approvals. On December 29, 2020, CMS approved DHCS' request to extend the Medi-Cal 2020 Section 1115 demonstration through December 31, 2021, with most Special Terms and Conditions (STCs) carrying forward "as-is". DHCS and CMS remain in discussions regarding the Global Payment Program, Whole Person Care (WPC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Dental Transformation Initiative (DTI). As expected, the Designated State Health Programs (DSHP) was not extended. The tribal health request will likely be pushed to the renewal approval process.

In December 2020, CMS also approved an extension of Medi-Cal's Specialty Mental Health Services (SMHS) 1915(b) waiver for three months through March 31, 2021. CMS has verbally committed to extending the waiver through 2021, but extension approvals will

be handled through incremental three-to-six month extensions. DHCS is working with CMS on a new 1115 waiver and consolidated 1915(b) waiver for approval in January 2022. DHCS will start a public stakeholder process for both waivers in spring 2021 prior to submission to CMS.

Jim Kooler reported on the work of the Foster Care Workgroup, acknowledging several members who also serve on BH-SAC. There have been five meetings since June 2020. The workgroup established its charter and guiding principles and has explored approaches from other states and proposals from county, provider, health plan, and advocacy associations. The group will meet again in February 2021 and aims to finalize recommendations in June 2021.

Director Lightbourne thanked members for a rich discussion on race equity during the last BH-SAC meeting. In the interim, DHCS has held internal conversations, and equity is becoming rooted in every part of DHCS work. The state budget is framed with an equity perspective and provides resources, especially in health and human services, to develop externally facing data dashboards and measures to close disparities. DHCS is restructuring its quality management systems into a single operation to be led by a to-be-named Chief Quality Officer. With the support of CHCF, consultants are examining existing data and identifying gaps. The next step will be the development of recommendations on metrics across the whole system for implementation in the coming months and years to identify, and start to close, disparities through contracting, purchasing, planning, and evaluating systems. By the next BH-SAC meeting, DHCS will have draft goals and metrics to reflect upon and gather input.

**Questions and Comments**

*Andy Imparato, Disability Rights California*: I want to commend the work of the Biden administration to build a more inclusive economy post-pandemic through its proposal *Building Back Better* and by elevating racial equity. Proposals on mental health, criminal justice reform, and employment moving forward may be interesting for California to consider.

*Will Lightbourne, DHCS*: There is optimism in the new administration. The President issued executive orders to undo anti-immigrant measures implemented over the past four years that had a chilling effect on health and human service systems.

*Hector Ramirez, Consumer Los Angeles County*: I am a person with autism, a psychiatric disability and I am hard of hearing. I am a consumer of mental health services. I thank the Department for the investment in the stakeholder process that went into creating CalAIM, which will be important to our community. We are now dealing with so many pandemics we don't know where to start. Moving forward in the conversation of racism and equity, it is important to note that for heavily impacted communities like Latino, Native American, and Black communities, terms like "justice" are up for determination. And, for Black, Indigenous and People of Color (BIPOC) and the disability community, terms like "justice" and "health" mean different things to different groups. There is a need to have conversation about the word "equity". The pandemic has changed this. It is a privilege of wealth and opportunity to be able to engage here and I am very aware that so many don't have a place to sleep or

food. The work the state is doing is fantastic, but don't leave us behind. We are used to getting information in clinics but that no longer happens. I am requesting that you consider how access to the stakeholder process has equity, and how to take into consideration someone who is not part of an agency.

*Kim Lewis, National Health Law Program*: Thank you for the investment in quality of services in Medi-Cal. I hope this becomes a perspective throughout all the work of DHCS as you indicated is your intention. How does the investment in schools and infrastructure relate and connect to ECM and building coordination across systems in CalAIM?

*Jacey Cooper, DHCS*: The $400 million for increasing behavioral health in schools is a one-time appropriation, but over three years. We plan to work on connecting the dots. For example, through CalAIM the intention is to work across delivery systems like schools to ensure children are getting services. This proposal will bring together MCPs, schools, and behavioral health plans to build local partnerships and increase infrastructure and capacity for health services in schools. It is complementary to CalAIM and can happen over time. We hope to engage stakeholders in 2021 to work on what incentives look like, build data-sharing systems, and develop the relationships.

*Linnea Koopmans, Local Health Plans of California*: Can you speak to how the DHCS proposal on beneficiary context and demographic data fits into the equity conversation? We hope the data piece will be a priority and not wait until 2022. Local plans see a connection between these two things and see data as foundational to race equity.

*Jacey Cooper, DHCS*: We agree. It is a core piece of equity to improve the Medi-Cal application, and we are working now to make improvements on how contact and demographic information are updated. The timeline is challenging, as county partners are key to this effort. We will take this back to discuss.

*Linnea Koopmans, Local Health Plans of California*: It is reassuring that the PHE will be extended. Do you expect any more formal communication from CMS beyond the letter to the Governor?

*Jacey Cooper, DHCS*: There are federal rules about regulatory process, but having in writing from the administration indicating the PHE will be extended through 2021, plus the fact that they will give us six months' notice before ending the PHE, is welcome. At this point, we feel comfortable.

*Michelle Doty Cabrera, County Behavioral Health Directors Association of California*: Thank you for the investment of $750 million for the behavioral health continuum. County behavioral health is restricted to cost-based reimbursement with very few other resources for infrastructure. It is so important to make sure we can meet the overwhelming behavioral health needs right now. On the schools proposal, there is great need. In a survey of members, 88% of counties provide services in schools, and about half cover a significant portion of schools in their counties. It would be important to have an opportunity for county behavioral health plans to be the lead entity in addition to MCPs. I commend DHCS for taking significant action to elevate equity and creating a quality position with an emphasis on equity. County behavioral health has had required ethnic services managers and

competency plans. There is significant White supremacy embedded in how we think about health quality, data collection, and valid measures. I sit on the National Quality Forum Committee on Disparities, and determining acceptable measures is still in the early stage.

*Veronica Kelley, San Bernardino County*: Will there be a conversation about county behavioral health and the competency plan we send to the CDPH Office of Equity. Perhaps there is room with the new position to bring that effort back into DHCS?

*Will Lightbourne, DHCS*: Let's explore that; all tools need to be employed.

*Kiran Savage-Sangwan, California Pan-Ethnic Health Network*: While we see the word "equity" throughout the budget, we don't see resources in the way we would like. This is not specific to DHCS. If we are serious about addressing structural racism, we need to put resources there, and I don't see resources tied to equity in the budget. I sincerely appreciate the leadership and want to push us to be bolder. In the measurement and equity metrics, how will mental health metrics come into this given the challenges health plans have in providing data? How do you think about the intersection of behavioral health measures and equity?

*Will Lightbourne, DHCS*: We are looking at the whole system, not solely managed care, but also specialty care and behavioral health. We want to see if we have the tools we need. We welcome the challenge. DHCS spends $115 billion, and we want it all devoted to equity not in siloes.

*Jacey Cooper, DHCS*: We also have positions in the budget dedicated to equity beyond the Chief Equity Officer. There is an entire section we requested resources for as well.

*Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program*: I applaud the previous comments on equity measurements. On the new quality position and staffing, what we see in the LGBTQ community is that even when positions are created intended to support our community, oftentimes the state hiring process upholds White supremacy and makes it impossible for the communities you are trying to serve and reflect to be hired. I would like to see a plan for how to change this outcome.

*Steve Fields, Progress Foundation*: The $750 million is a major investment in building capacity in community programs to avoid institutionalizing people, if there is a community program that can serve them better with a recovery process. The key is infrastructure; the service money exists. Some of us have experience from a modest early version of this to promote crisis residential and community stabilization programs. We ran into a long and complex process to stand up the programs between the passage of legislation and implementation. As this rolls out, we need to look at the experience of SB 82 for lessons to get ahead of those challenges.

**COVID-19 and Behavioral Health Services; COVID-19 Dashboard**
**Jacey Cooper and Kelly Pfeifer, MD, DHCS**
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentations-021121.pdf

Jacey Cooper presented an update of DHCS activities related to COVID-19. She noted that there is a weekly update and COVID-19 website with current guidance, links, and information. She reviewed DHCS requests for federal flexibilities, including pending approval for COVID-19 testing for Medi-Cal children in schools, delivering vaccines through Medi-Cal fee-for-service (FFS), and extending coverage of vaccines to Medi-Cal limited-scope benefit populations.

Jim Kooler provided an update on CalHOPE and provided links to online resources related to COVID-19. In recent weeks, the media campaign placed 13,000 spots with 110 million impressions to share CalHOPE resources and normalize the experience of stress during this time. Coming soon is an Employee Assistance Program-style program with multiple counselling sessions provided through 35 contractors, representing California's diverse language and cultures, who will be hiring almost 500 peer level crisis counsellors.

Kelly Pfeifer offered a report on COVID-19 behavioral health services in response to the public health emergency. One of the significant issues during the recent surge of COVID-19 cases is the lack of psychiatric bed capacity, leading to more people waiting in emergency departments for placement. DHCS is in frequent communication with behavioral health directors to problem-solve how to open beds quickly and safely. DHCS launched a weekly all-facility call so counties and behavioral health providers receive timely information from public health, social services and health services. DHCS facilitated statewide and local problem-solving conversations, to help ensure local health departments, counties and providers worked together to balance capacity and safety. We worked with the hospital association on the need for regional hubs, and five psychiatric facilities are now taking COVID-positive psychiatric patients. We worked with public health to prioritize providers for vaccine. The COVID surge may be slowing, but the impact of the pandemic on mental health and substance use needs will be with us for quite some time.

Jacey Cooper reported on the analysis and dashboards DHCS is developing to monitor the impact of COVID-19, with a focus on cases, hospitalizations, and testing and utilization of services prior to and during the pandemic. The data are preliminary, and encounter data will continue to arrive. In particular, testing data only show tests that were billed, and there is lots of free testing not included here. Finally, the substance use disorder data is not separated out here due to coding issues. We hope to have that for a future presentation.

The data will be updated regularly as claims are received and posted on the DHCS website.

**Questions and Comments**

*Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program*: In particular, I am excited that contracts with local providers who have community connections are going out to build relationships that will center care locally and offer people trusted relationships when the crisis is over. Thank you for the dashboard. Can you share more about efforts to collect data on sexual orientation and gender identity during COVID and in general for the dashboard?

*Jacey Cooper, DHCS*: I will get back to you.

*Kiran Savage-Sangwan, California Pan-Ethnic Health Network*: Have you looked at the comparison in race and ethnicity between 2019 and 2020? Were there trends in that data? If we have an uptick in mild-to-moderate, is that contributing to closing racial disparities?

*Jacey Cooper, DHCS*: We will get back to you.

*Catherine Teare, California HealthCare Foundation*: The rate of 8 to 9 percent for adult specialty mental health via telehealth is striking. Do you have thoughts on why?

*Jacey Cooper, DHCS*: We are looking at the data to make sure the modifier is not the issue, meaning it was data quality as opposed to a service difference.

*Jevon Wilkes, California Coalition for Youth*: I want to highlight that the substance use disorders information is pivotal because there is Proposition 64 funding going out, and we need to have data to support the funding stream. I want to request that youth are taken out of 18-64 age band and suggest it follow the Medi-Cal eligibility of up to age 21. This may highlight those who have access and those who have limited access. I believe telehealth services are here to stay, so it will be important to have all opportunities to serve under that modality.

*Rosemary Veniegas, California Community Foundation*: In reviewing the data on utilization and emergency department visits, I am thinking about the long-term consequences of having COVID. The beneficiaries of 2020 will continue in 2021. Are there plans to understand the implications for patients in the first year when there were fewer medical interventions versus this year with more options available? I imagine there may be long-term cost implications as we look ahead to value-based payment approaches.

*Jacey Cooper, DHCS*: That is a great reflection on the data. We will take that back and think about it. Teams are doing a lot of thinking about the impact of COVID on the health care delivery system and what it will mean for the future for those who were COVID positive. You raise a good point about the difference for those who tested positive early in the pandemic. I imagine there will be many research projects we can learn from. And, absolutely as those members age, we may see co-morbidities early and we do often see co-morbidities at younger ages in Medi-Cal than other populations.

*Michelle Doty Cabrera, County Behavioral Health Directors Association of California*: I want to caution us on uptick in specialty versus non-specialty mental health for children. Counties serve a broader set of needs for children that may explain the data. Also, I hear some concerns about efficacy over the long-term of telehealth for specialty mental health care versus in-person care.

*Jacey Cooper, DHCS*: That is a good point. We are looking forward to more discussion on the data.

*Veronica Kelley, San Bernardino County*: There is a need for telehealth infrastructure, even some basics like satellite coverage. Many clients don’t have data plans, and we triage how

to serve them. Sometimes that involves sending a client to one clinic and serving them from another site. How we utilize telehealth also is a clinical decision because if someone is psychotic, it is not appropriate. It is important to build on the momentum from COVID and build infrastructure.

*Hector Ramirez, Consumer Los Angeles County*: These data allow me to conduct better advocacy. I see that intersectionality is missing and there is not much on co-morbidities in populations, which is important to me as a stakeholder. Is there data on co-morbidities, and can you speak to the benefits of integrating this into the dashboards as we advance principles of equity?

*Jacey Cooper, DHCS*: Thanks. We will take that back to the data team to see what we can produce in the future.

*Linnea Koopmans, Local Health Plans of California*: My observation on the data is that absolutely race and ethnicity needs to be included to see who is utilizing services. There is also a limitation to flag in that it is a beneficiary choice to provide the data. In the data on mild-to-moderate services for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), the biggest bar is "unknown" and this is a significant challenge in understanding the data.

*Jacey Cooper, DHCS*: We agree the "other" category is large and we have seen it grow in the era of public charge. It is optional and cannot be required. We have received best practices from other states and shared it out to the groups working on application changes. So we agree and are continuing to work on improving this reporting.

**CalAIM: Medical Necessity Definition and Related Process Changes**
**Kelly Pfeifer, MD, DHCS**
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentations-021121.pdf

Dr. Pfeifer reminded members that almost one year ago, the group discussed medical necessity and concluded there was a suite of changes necessary to improve behavioral health services for children and adults. She then walked through the suite of changes described in the slide deck, including clarifying who can receive specialty mental health services and how access to services is streamlined, even before a diagnosis, especially for children with high levels of trauma, children in foster care, and those experiencing homelessness. DHCS is creating a statewide standardized screening tool to identify which beneficiaries would benefit from specialty mental health services from counties or nonspecialty mental health services from managed care plans. DHCS will also develop a standardized transition tool so care is coordinated across delivery systems.

**Questions and comments**

*Cathy Senderling, County Welfare Directors Association (CWDA) of California*: Thank you for the changes in medical necessity. CWDA took particular interest in trying to get services pre-diagnosis as well as for those at risk and in foster care to get care with the county

health plans. We hope there will be further refinements ahead, but are pleased to see this included in CalAIM.

*Kelly Pfeifer, DHCS*: Yes, CWDA and the behavioral health directors highlighted this need early.

*Kim Lewis, National Health Law Program*: Thank you for working to align this with EPSDT. I want to flag that since there is no medical necessity for EPSDT, using this terminology can be confusing. I appreciate the second criteria listed for children under age 21 being able to access services in addition to getting it from the health plan. That has been very confusing for people, and we agree it does need to be access to both services and systems, given that the same services are not covered by both. I hope there is additional guidance that a diagnosis is not needed to get into either system and that people can get services from both systems at the same time. Also, on criteria one, I wonder if there will be questions from CMS. I am supportive of youth in foster care or the homeless being able to access services and am concerned that not specifying a condition will raise questions from CMS on the clinical need.

*Kelly Pfeifer, DHCS*: Thank you. Precise and clear language is important as this rolls out.

*Gary Tsai, MD, Los Angeles County*: Thank you for adding the ASAM criteria 0.5 for early intervention in the waiver. I think the criteria would also apply to substance use disorders. Unless I misunderstand, it seems that we are making a distinction between specialty mental health and substance systems when there should be greater alignment.

*Kelly Pfeifer, DHCS*: The language changes for mental health are needed because there are two delivery systems – managed care and specialty mental health. It is our intention to align mental health and substance use disorders.

*Aimee Moulin, UC Davis/Co-Director*: It is huge to be able to access services prior to diagnosis. Stimulant use is a growing problem and we are looking at contingency management; however, many people feel the limitation of $75/year is too low to maintain a patient in treatment. Is there any way to address the kickback laws?

*Kelly Pfeifer, DHCS*: The science is clear that it needs to be higher, and we are looking into that.

*Chris Stoner-Mertz, California Alliance of Child and Family Services*: We are thrilled to open up screening and services to intervene early. And, we applaud DHCS for addressing documentation so providers spend closer to 80 to 90 percent of their time on direct services. I agree with the issue raised about including an early focus on substance use issues as well. I know there will be additional discussion on screening tools and hope we can take the same value to that topic to make it simple to do and inclusive.

*Ken Berrick, Seneca Family of Agencies*: I agree with the comments by Kim Lewis that there may be questions about how to quantify this approach to service, and I think there are simple ways to document need and approach to service. I hope we can look at best practices that everyone should be doing anyway to document risk to incorporate that into a plan that demonstrates there is risk.

*Steve Fields, Progress Foundation*: Within the waiver language, can you speak to the role and skills of a licensed person in developing and overseeing a treatment plan and moving it forward?

*Kelly Pfeifer, DHCS*: We are focused on the role of the licensed person in making the diagnosis and determining medical necessity. A non-licensed counselor can do components of assessment and history as long as a licensed person makes the diagnosis.

*Rosemary Veniegas, California Community Foundation*: Thank you for integrating contingency management into the proposal. That step itself is an equity move. As counties implement, I recommend that the telehealth capacity expansion be allowed as a fixed part of services. California Community Foundation made grants early in the PHE to support substance use disorder providers in making the transition as schools shut down and in-person services were not available. Looking forward, how might the beneficiary experience be integrated into the measure of effectiveness? Asking youth about challenges navigating systems and whether they have been addressed?

*Kelly Pfeifer, DHCS*: Contingency management is new, and we will have things to work out. We are committed to doing everything we can to move that forward. We agree on the importance of beneficiary experience. We have patient experience surveys that we take very seriously and want to make sure we're seeing improvements across the board.

*Michelle Doty Cabrera, County Behavioral Health Directors Association of California*: On criteria for foster youth, we see this as hand in glove with the CWDA process with foster youth that was referenced. Not that every child in foster care needs the highest level of intervention, but that foster youth could be served right away and services could be reimbursed.

**Public Comment**

*Yvette Willock, Los Angeles Department of Mental Health*: My comment is related to the telehealth infrastructure comment shared by Veronica Kelly that certain communities we serve don’t have access to data plans, and there is not the infrastructure in place to serve them. We know that the digital divide in communities of color is glaringly evident during COVID. As you are working on telehealth recommendations and policy post-public health crisis, my concern is around the payment equity for telephone-audio only. I know the document indicates there will be a different payment schedule. I want to highlight that some of our communities of color potentially may suffer and not be able to access care because they don't have the ability to travel and are uncomfortable going back to the clinics

immediately. If the audio visit does not have the same level of payment, providers may make a decision to offer only in-person services and not do a lot of telehealth. I wanted to highlight that for consideration.

*Jeff Farber, Executive Director of Helpline Youth Counseling and Chair of the Los Angeles County Youth Services Policy Group*: I commend DHCS and the behavioral health stakeholder advisory committee for working to promote greater access to behavioral health services for youth through the changes in the CalAIM proposal. It is inspiring to see a no wrong door approach for children and greater coordination of primary health, mental health, and substance use disorders treatment services. It's really exciting for us to hear that SMHS are clarified regarding EPSDT criteria for beneficiaries under age 21 and criteria developed for access to SMHS based on experience of trauma and risk of developing conditions, such as involvement in child welfare and homelessness. Contingency management is an evidence-based approach, as noted earlier. Adding the ASAM 0.5 as a benefit is amazing and will bring greater access to service without barriers as stated earlier. Thank you for clarifying the difference between SMHS and DMC regarding the ESDPT benefit. As we move forward with an integrated model of care, the creation and implementation of a no wrong door approach must be inclusive of access to substance use prevention and treatment services at the same level of those in need of SMHS for youth under age 21.

*Angela Vazquez, The Children's Partnership Mental Health Policy Director*: We absolutely applaud the $400 million proposed investment in infrastructure building between MCPs and schools. We all saw today an incredible amount of data that shows we still have a ways to go ensuring our young people have the services they need to be well and heal from the incredible amounts of trauma and grief they're experiencing from the pandemic. We believe the investment can only be met if school leaders and staff and youth are engaged in the model of care. In the era of local control funding, there is an unprecedented level of flexibility to create partnerships that benefit students, and the Department of Education is a critical partner. The real work will come in partnerships not just between county offices of education, but also individual school districts that have the political will and the supportive partnerships in the community to implement this work. We look forward to partnering with DHCS.

*Steve McNally*: I have a family member with mental illness who uses the services in the system, so thank you very much. My intention for being here is trying to figure out who are the like-minded people in the state open and willing for change. My request would be for each of you who sits on different commissions to think of bringing this information back and linking the state and local community mental health boards and commissions so that we can get the 900 community members that belong to those boards to be a research panel for you. I think that's a missing opportunity. And, I'm happy to see the data. One thing we struggle with is that we don't know what data are submitted from the counties to the state. I'm also very interested in the federal funding participation rates because they vary dramatically across counties and the dollars are big. I appreciate what you are doing to make a better system and to make it easier for people to access direct services. To me, the need is communication and linking the system users back to the providers, and getting the providers to really own the mental health system – and that we all own it for the most vulnerable.

*Deb Werner*: I fully support the value of contingency management in addressing stimulant and other substance use disorders, but contingency management should not be considered a stand-alone service. Contingency management studies all combine it with other behavioral therapies. I worry that people who are unfamiliar with behavioral therapies may see it as the alternative to MAT for stimulants and, in general, it does not stand alone.

**Thanks, Next Steps and Final Comments; Adjourn**
***Will Lightbourne, DHCS***

Director Lightbourne said we are making headway in many areas and appreciate the encouragement and input from stakeholders. Director Lightbourne reminded members of the quarterly meeting dates for 2021:

**2021 DHCS BH-SAC Meeting Dates**

- April 29, 2021 – 9:30 a.m. – 12:30 p.m.
- July 29, 2021 – 1:30 p.m. – 4:30 p.m.
- October 21, 2021 – 9:30 a.m. – 12:30 p.m.