DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

Hybrid Meeting

July 20, 2023

1:00 to 3:30 p.m.

BH-SAC MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Ken Berrick, Seneca Family of Agencies; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, Service Employees Service Union; Samuel Jain, Disability Rights California; Meshanette Johnson-Sims, Carelon Behavioral Health; Veronica Kelley, Orange County; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner- Mertz, California Alliance of Child and Family Services; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services.

BH-SAC Members Not Attending: Jei Africa, Marin County Health Services Agency; Kirsten Barlow, California Hospital Association; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Dannie Cesena, California LGBT Health And Human Services Network; Sarah- Michael Gaston, Youth Forward; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Karen Larsen, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jolie Onodera, California State Association of Counties; Jonathan Porteus, WellSpace Health; Cathy Senderling, County Welfare Directors Association of California; Angela Vasquez, The Children's Partnership; Jevon Wilkes, California Coalition for Youth.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, David Omarov, Ilana Rub, Holly Clifton, Tyler Sadwith, Lindy Harrington, Paula Wilheim, Ivan Bhardwaj, Morgan Clair.

Public Attending: There were 285 members of the public attending in person and virtually.

Welcome, Roll Call, and Today's Agenda
Michelle Baass, DHCS Director

Baass welcomed BH-SAC members.

Contingency Management
Ivan Bhardwaj, DHCS

Bhardwaj provided background on Contingency Management, referred to as Recovery Incentives Programs, and noted that California is the first in the country to receive approval to cover contingency management services for substance use disorders as part of CalAIM. Contingency management is an evidence based, cost effective treatment for substance use disorders, and the only approach with demonstrated outcomes for individuals living with stimulant use disorder. To date, 24 counties have opted into the benefit, covering 88% of the Medi-Cal population. Bhardwaj outlined the specific elements of the program and reported on the training, evaluation, and oversight elements. Bhardwaj reviewed the counties implementing the services and offered early data on enrollment.

BH SAC member Al Senella offered a perspective on the experience from Tarzana Treatment Center and other providers in the field. He commented there were early challenges in the approval and implementation of the program. Tarzana has six sites approved and close to 50 patients identified or enrolled. The program is well received by patients. This is an opportunity to save lives and the field is committed to the success of this important program.

Questions and Comments

Teare: This is path-breaking work that providers, counties, and DHCS are doing. Given the slower start and the timing of the evaluation, what information will counties have about whether to continue funding the program from their own resources by the deadline of March 2024?

Bhardwaj: We are working closely with the evaluators to provide meaningful information to expand the pilot. Realistically, it will be one year or so of data.

Baass: We are able to extend contingency management through the time period of the CalAIM Waiver through December 2026.

Bhardwaj: The non-federal share is covered through the Home and Community Based Services (HCBS) spending plan which ends in March 2024.

Savage-Sangwan: Will the evaluation look at racial disparities, who is offered the program, who enrolls and who successfully completes it? Also, the number of participants seems small so how does the current enrollment of 188 participants compare to expectations?

Bhardwaj: Yes, the evaluation will include demographic and other information as you outlined. On beneficiary numbers, the initial implementation included a series of steps such as training and readiness assessment and the program only began in March 2023. Once sites are onboarded, we anticipate rapid expansion.

Lewis: Can you say more about how the end of HCBS financing for the non-federal share will impact the planning and service delivery by counties and vendors after that date?

Bhardwaj: We are pleased that the services can continue through 2026 and will be working with counties and providers during this next period of time to determine what that period following March 2024 really looks like.

Veniegas: Have there been some implementations of recovery incentives that pair relapse prevention and culturally specific cognitive behavioral therapy? Is there a plan in the evaluation to parse out or segment some of the communities served? For example, gay cognitive behavioral therapy, a culturally tailored approach blended with recovery incentives that has shown positive outcomes in past research trials?

Behavioral Health Bridge Housing
Ilana Rub, DHCS

Rub provided background on the need for the Behavioral Health Bridge Housing Program (BHBH) and explained the purpose, components, and priorities of the program. She reported that the primary focus of the BHBH Program is to help people experiencing homelessness who have serious behavioral health conditions that prevent them from accessing help and moving out of homelessness. Program implementation is aligned with the CARE Act. She noted that the proposed reform to the Mental Health Services Act will provide sustainable funding for BH housing. Rub outlined the initial funding opportunity of $900 million for county behavioral health agencies for BHBH and provided information on the types of shelter and interim housing funded through the program, such as tiny homes, emergency shelter, motels, and other options. Rub also outlined funding available to tribal entities ($50 million total) and a competitive funding opportunity to be released in Fall 2023 ($500 million total). She stated that DHCS released an application for the persons with lived experience panel that will inform the funding process.

Questions and Comments

Lewis: It can be challenging to understand where BHBH fits in the continuum and how programs are being paid for with future legislation and propositions. For example, how does the role for MCPs providing Enhanced Care Management (ECM) to homeless populations fit with this supportive services and housing navigation. Is the expectation that this will complement the role of MCPs, given this is only available to county behavioral health agencies?

Rub: It is a complicated area of implementation with multiple pieces related to housing and housing services, Community Supports, upcoming 1115 Waivers, etc. We are designing TA to counties on this area to coordinate ECM and other efforts. As we dive into the implementation, we are finding that each county is a unique situation as to what is in place and what other funding sources they are combining into the BHBH program.

Baass: The long-term vision for funding for these interventions is expected to be under the

Behavioral Health Services Act (BHSA). This is one time funding.

Savage-Sangwan: My question is about the interaction with the CARE Act. I understand BHBH is prioritizing beds for CARE participants. However, BHBH has 8,000 beds and I thought there were more CARE participants. Are there beds for other priorities? If the long-term vision is funding this through BHSA, does that mean BHSA is also prioritizing CARE participants?

Rub: In practice, each county identified this priority population within their plan and we are coordinating TA as the CARE Program is implemented to build the connections across programs. We don't have a concern related to capacities. CARE program participants are the priority population under the funding.

Baass: BHSA priorities are happening at the local level, and we are not telling counties what specifics to fund. The priority populations are identified in the statute, but CARE is not specifically listed.

Eisen: I hope there are guidelines. For example, rather than stretch the dollars for too short of a length of stay, there should be consideration of keeping people safely housed until they can move into a better situation. We have seen on the substance use side with Recovery Bridge Housing that in some counties, it's not enough to bridge them over into housing. Is there a way, particularly on recovery housing, to ensure that the housing does not discriminate against people who are on opioid agonist therapies for their opioid use disorder; that there's no discrimination against people who are on methadone or buprenorphine?

Rub: Housing First principles are a requirement of the program, and we are monitoring that component.

Ramirez: LA is deploying bridge housing and it is having a positive impact. Board and care were not listed, and that is a significant element of the discussion in LA. LGBTQ, homeless youth and other special populations experience bilateral trauma in many bridge housing settings and need safer options. In addition, many of the settings are not designed for people with disabilities. Folks end up back on the streets because they can not safely access the bridge housing options.

Rub: We are seeing board and care options being incorporated into county plans in many places. On your concerns about special populations, we would like to hear more input and recommendations, especially for the competitive funding so that it fills gaps and reaches populations not served through traditional approaches.

Ramirez: There were listening sessions but it was primarily providers, not actual residents who were included in previous stakeholder discussions. Board and Care providers recommend more board and care, but no one asked if people want to continue living there. As this moves forward, I hope you consider engaging primary stakeholders.

Fields: There is a long list of overlapping definitional options and I hope someone can

provide a glossary of what is meant by supportive housing, treatment-based housing, wrap around housing. all the housing supports across programs. Is this one-time funding for services not covered by Medi-Cal and other reimbursement? For example, housing navigation centers are on the list and that isn't new in many places. What is the exact meaning of new models?

Rub: We are looking at the range of options and targeting funding directly to housing, ensuring behavioral health supports are in place. As you say, there is other funding for services. We are reviewing each budget and plan for each county to identify the needs not met with other resources. Understanding the context does make it more complex to ensure each county is maximizing funding under behavioral health. There is also the challenge of urgency to get shelters established as quickly as possible.

Fields: So, if a county wanted to expand an existing service, that would be eligible?

Rub: Yes, as long as it did not supplant existing funding of services.

Harris: You mentioned the priority for individuals in the CARE Act and the slides indicate 39,000 people with mental health issues and 36,000 people with SUD issues who are homeless. How are counties dividing the funding by homelessness and the issues they experience? How much money did each of those departments get?

Rub: The specific information for each county electing to participate is on the Bridge Housing website. For LA County, they received one funding level as a county and then opted to divide it between the two departments. We also had Sutter and Yuba County opt to submit a joint application, so there were a few different configurations.

Teare: As one-time funding that we hope will be supported by ongoing funding, this is a great opportunity for monitoring and tracking whether these options are sustained through ongoing sources such as the BHSA. Also, in response to Steve's question, CHCF is working on a glossary on the housing options for individuals with BH needs that will be available in a couple of months.

Graelish: I want to raise awareness about the justice involved population who experience housing insecurity. The most recent count is just under 4,000 unhoused individuals on parole, and about 75% of them have a behavioral health need at the time of release - and that is just the parole population. There is no statewide number for the unhoused probation population. The justice involved population, particularly people transitioning out of incarceration experience barriers gaining access to housing, like criminal background checks and stigma associated with both the behavioral health condition and the justice system involvement. I hope folks are sensitive to that as they're doing this work so that the justice involved population benefits from this opportunity.

Behavioral Health Continuum Infrastructure Program
Holly Clifton, DHCS

Clifton offered background on the Behavioral Health Continuum Infrastructure Program

(BHCIP) and noted that this funding is specific to new and expansion of BH infrastructure and not targeted for BH services. AB 133 provided $2.2 billion to construct, acquire, and expand properties, and invest in mobile crisis infrastructure through June 2027. DHCS is releasing the funds through six competitive grant rounds to counties, cities, tribal entities, nonprofit, and for-profit organizations. Clifton provided a list of the types of entities that received awards and a map of funding awards for rounds 1-5.

- Round One: Crisis Care Mobile Units.
- Round Two: County and Tribal Planning Grants.
- Round Three: Launch Ready Projects.
- Round Four: Children and Youth.
- Round Five: Crisis and BH Continuum.
- Round Six: Unmet Needs.

Questions and Comments

Fields: Are the actual awards listed on the website? Can we see the freestanding programs vs beds and the entities receiving funding?

Clifton: Yes, there is a dashboard that offers details on the awards. The awards are for new and expanding BH infrastructure.

Berrick: Can you review the number of existing youth crisis and expansion beds and the timeline for new beds to open? What licensing category will they fall into?

Clifton: There is detailed information on the website. For Psychiatric Residential Treatment Facilities (PRTF), we are expecting about two. The dates for construction completion are partially available and information will be updated over time.

Lewis: My question is what is eligible for funding? Are there limitations on the type of program or treatment? Is there guidance about how to prioritize the continuum available?

Clifton: The goal is to expand BH infrastructure, and not treatment services. Round 3-5 does include restrictions on locked units. Round six will focus on filling gaps and remaining unmet needs not covered by other funding.

Lewis: Is there DHCS guidance about the values underlying how gaps are assessed, what alternatives are available to people?

Baass: An overall guiding principle of the funding is to serve people in the least restrictive, most community and integrated setting possible.

Senella: This is a wonderful program, and it is providing badly needed resources to expand capacity. In the spirit of administrative efficiencies, have we looked at streamlining the process? Following the funding award, this is more complicated than any program I have participated in over the years. I'm wondering if there could be a hard look

at how to improve the process, so it is less time consuming and complicated?

Clifton: We appreciate that feedback. There were many complexities related to federal funding in round three. We are taking the need for streamlining into account in future rounds of funding.

Senella: I have not observed any improvement in rounds 4-5.

Clifton: I will take that back.

Johnson-Sims: What process will you use to identify the gaps for round six priorities?

Clifton: We are reviewing the statewide assessment report created in 2022, incorporating RAND studies, doing surveys, gathering information from stakeholders, and conducting gap analysis based on what has been awarded.

Savage: I understand these are funds for infrastructure, but long term, is there any accountability for how those facilities are used and who benefits from them? Will we ensure funding is used long term primarily for Medi-Cal members?

Clifton: They are required to fulfill a 30-year requirement for behavioral health services.

Savage: Is there no specific obligation that they primarily provide services to Medi-Cal members? The data dashboard is great. From a racial justice point of view, I was surprised and concerned to see mobile crisis unit funding to law enforcement.

Documentation Redesign
Paula Wilhelm, Assistant Deputy Director, Behavioral Health

Wilhelm reported on the DHCS policy priority to ensure that documentation requirements support care and are not a barrier to providers or consumers. She recapped the background of stakeholder input and legislation that guided the Behavioral Health Information Notice in 2022.
New guidance will be updated in Fall 2023 for implementation in January 2024 to clarify, streamline, and respond to stakeholder input. Wilhelm offered details on the topics that are being redesigned, such as treatment plans and progress notes. She outlined the issue and solution for each area that will be included in the revised BHIN. She reiterated that quality and program integrity are the foundations for this process. Wilhelm noted that discussions with CMS and SAMHSA have been positive on the proposed approach.

Questions and Comments

Gavin: I appreciate the attention to this as we face a workforce shortage. On the ground, we are not seeing improvements in documentation requirements. In many cases, when funding includes federal sources, counties are retaining documentation complexity. Providers are feeling burned out by this. I wanted to share our experience, and that I still feel excited about the possibility.

Wilhelm: Thank you. We want to work toward the goals over time. We received a thumbs up from SAMHSA and will issue guidance that we hope will help with the issues you mention.

Lewis: The process itself has been good and responsive to provider concerns. The goal, whether it's yet to be realized, is that counties should not be adding on top of these requirements and there should be more flexibility, especially with CMS lending verbal cooperation.
It's important to be consistent across the system, and I want to make sure DHCS is tracking whether counties impose certain assessment tools that undermine EPSDT obligations. Relatedly, prior authorization is a big concern, especially with intensive home and community-based services that we think are impairing timely access.

Wilhelm: That is really helpful feedback and thank you for the ongoing collaboration. On the assessment tools, we have proposed guidance on the SUD side, and we can do more thinking about the mental health side.

Pitts: There are many questions from counties about how fraud, waste, and abuse will be defined and some concern about disallowances based on different auditors' interpretation of guidelines. LA County providers do report successful reductions in the complexity of documentation that represent early success.

Wilhelm: As we are working on documentation guidance, we are rolling out an updated process for monitoring and reviews. This question of how we define fraud, waste, and abuse has been a core questions from counties. What will these reviews look like? Can DHCS clarify what findings to expect? What would be a potential recoupment? We are looking at TA because publishing the policy is just step one and we want to support continued clarification on the issues.

Eisen: Is there anywhere that specifies that progress notes be in a narrative form? What would prevent it from being a dropdown menu? We want to align to the way medical notes are documented and there is little narrative there. Particularly for groups, narrative notes are a disincentive, and SUD treatments typically have more group interventions than mental health.

Wilhelm: We need to see enough detail and individuality to support good care and to justify the service being claimed and the medical necessity of the service. We did provide guidance on required elements for the note that requires some individual client reference or notation, but some of it could come from drop-down options in the electronic system. We welcome additional feedback on where we could clarify and improve related to the guidance on notes.

Stoner-Mertz: I endorse the points made here and underscore the need for training and TA to manage the concern that audits drive the process. Continuing to look at where we can remove the need for narrative, similar to physicians, is important. The issue of prior authorization is limiting the

timeliness of services for youth.

Veniegas: This work really advances the implementation of the waivers. A complementary perspective to the one already shared is that insufficient documentation can lead to not receiving timely reimbursement and diminish an organization's capacity to serve. There have been instances in the past of organizations sharing information about what is most likely to result in disallowances and thereby reduce the likelihood of findings in audits. I hope in the future, the team can provide information on areas most costly in terms of these disallowances.

Public Comment

Aaron Bailey, VP of Corporate Development and General Counsel: I am General Counsel for outpatient treatment centers and mental health providers in Orange County, most notably the Edge Treatment Center in Santa Ana. I hear wonderful reports about programs and pilots to improve the behavioral health system, provide better care, get better outcomes. I hear all the buzzwords, addressing social determinants of health and housing security, and providing comprehensive wraparound services. And, it's continually frustrating to me how many times the barrier to my treatment centers providing better care is DHCS rules, or more often than not, unwritten rules. One example is that the only reason I have a separate mental health center, is that DHCS representatives agree is that I can't treat primary mental health diagnoses with secondary substance use disorder diagnoses. I can't find that in the AOD standards, but they all agree I can't do it. I don't get the impression that your intent is to stop people like me from doing that, but that's the effect. And I'll just throw out there, when we had this conversation with the representative from SAMHSA at the Behavioral Health Planning Council, about half that table started nodding their heads when I brought this up because it matched their experience.

Richard Gallup, Santa Cruz, California: I want to know whether bridge housing programs, such as respite navigation centers, transitional housing, supportive housing, include peer workers and it needs to. The Mental Health Services Act funding was not meant for CARE Court and that is not in the spirit of the Act. The community planning process needs to be part of the system and it needs to be consumer and family driven, not county driven. Counties want the old ways. They want to do whatever they want, instead of meeting the needs in their county. Right now, there are 818 seriously mentally ill unhoused individuals in Santa Cruz County, with only 16 psychiatric beds and all step-down programs are short term. There is no long-term supportive housing.
Where are they going to go? People with disabilities and seniors can't find affordable housing and they end up in nursing homes where they don't want to be. This is a violation of the Olmstead Act. I heard nothing about the peer support Medi-Cal certification training and the policies and programs related to that in this meeting. I am Secretary of the California Association of Peer Professionals, and I am truly disappointed that DHCS has not mentioned the importance of peer support.

Chynell Clark: I'm a person with lived experience and the policy director of Cal Voices. It has been extremely frustrating for the public to be barraged with hundreds of pages of amendments and changes to laws that currently save lives. This was done in spot bills

and there's a total lack of transparency. They are amending it again and again and again and the community can't keep up. As a person whose life was saved by an MHSA program, to watch a billion dollars get cut for the sake of leveraging a federal dollar, with absolutely no attempt to take stock of the human cost, is ridiculous. These are people's lives. These are services that people need. And the insurance model, medical model, notions of medical necessity, those aren't sufficient to serve us. What's going to happen is that people are going to suffer and end up in the acute system as a result of this. You ought to include us; you ought to slow down. The cost of this is that the community couldcome together and say, we are against this; don't vote for it. I think that's a real possibility if this process continues to unfold the way it has.

J*ohn Drebinger, California Council of Community Behavioral Health Agencies*: I thank the advisory committee members, and all of the presenters today for the great updates. Our members share some of the concerns mentioned around preserving the programs that are funded by the MHSA. We look forward to continued conversations with the administration and the agency to ensure those programs are preserved as we update the Act. Thanks for a great meeting today.

Next Steps and Adjourn

Lindy Harrington, DHCS

Harrington thanked everyone for a productive meeting and commented that hybrid meetings will continue. Once agenda topics are decided for each meeting, we will announce the timing of the BH SAC meeting. Please hold 9:30 AM to 1:30 PM for each upcoming joint SAC – BH SAC meeting and 2:00 to 3:30 PM for the BH SAC only meeting. The next meeting will be on Thursday, October 19th, 2024.