Behavioral Health Workgroup
12.20.19 Meeting Summary

The Department of Health Care Services (DHCS) held the first of two Behavioral Health (BH) workgroup meetings focused on medical necessity on December 20. The second Behavioral Health workgroup meeting focused on medical necessity will take place on January 30, 2020.

The meeting was attended by DHCS staff, workgroup members and members of the public. Molly Brassil from Harbage Consulting facilitated the meeting and Autumn Boylan, Brenda Grealish, and Kelly Pfeifer were the DHCS lead presenters.

This meeting focused on the following topics. A full agenda can be found here.

- An overview of the goals of the medical necessity proposal;
- An overview of proposed changes to medical necessity criteria for outpatient Specialty Mental Health and Substance Use Disorder services;
- An overview of the level of care assessment tools and case study examples;
- Workgroup discussion on the above topics; and
- Public comment on the above topics.

Discussion Summary

- The meeting began with a presentation from DHCS providing an overview of the goals of the medical necessity proposal. See slides here (4-11). Below are additional comments from workgroup members:
    - Add explicit language relevant to developmental considerations. It is critical for kids that they are supported for normal development trajectory.
    - Ensure consistent access for children including those in the foster care system. The goal is to ensure children receive the services they need.
    - Several workgroup members called for separating adult and children medical necessity criteria and meeting on these topics separately.
    - Multiple workgroup members called to incorporate concept of trauma into the criteria.

- Next DHCS presented an overview of proposed changes to medical necessity criteria for outpatient substance use disorder services. See slides here (12-17). Below is a summary of the key themes from the workgroup discussion:

    - Multiple workgroup members urged the Department to consider unique medical necessity criteria for people coming out of the criminal justice system.
    - Multiple workgroup members urged the Department to consider homelessness a risk factor.
    - Substance use disorder needs to be considered a chronic disease and have criteria that take into consideration the chronic nature of substance use disorder.
    - Counties struggle with interpreting ASAM. It wasn't designed to be tied to payment.
    - Multiple calls cautioning against imposing ASAM for youth.
    - Call to address the issue of voluntary detox. People seeking inpatient detox can't access the benefit until they exhibit symptoms.

- Next, DHCS presented on outpatient specialty mental health services for adults. See slides here (18-27). Below is a summary of the key themes from the workgroup discussion:
    - Multiple calls to make documentation as streamlined as possible for providers and counties. Providers should have minimal documentation barriers to justify treatment and services as this often creates challenges for small providers that may not have as much administrative capacity.
    - Call to use this as an opportunity to increase interagency coordination.
    - Multiple stakeholders called for a universal assessment tool but have questions about the timing and implementation process.
    - Important to consider older adults and conserved individuals in revising medical necessity criteria.
    - Caution against using the DSM as using diagnostic tool, particularly regarding kids.

- Next, DHCS presented on the no wrong door approach for children and youth and offered a case study to illustrate the approach. See slides here (25-29). Below is a summary of the key themes from workgroup members:
    - Multiple workgroup members agreed that the case study is a good example of how the system should work.
    - School-based mental health providers should be folded into this conversation.
    - Some of the problems with a no wrong door approach have to do with interoperability. There are many challenges around data sharing and providers can't always share as much as they would like.

- Next, DHCS presented on the level of care assessment tools. See slides here (30-33).

- Next, Kristen Slater and Sarah Arnquist from Beacon Health Options presented on their mental health screening process. See slides here. Below is a summary of the presentation made by Slater and Arnquist:
    - Beacon contracts with 8 Medi-Cal managed care plans across 26 counties. Beacon has experience working with both counties and managed care plans. We use 8 different adult screening tools and 10 child screening tools. Most people get screened into the mild/moderate level of care. Very few require a referral to county services. Of those that go mild/moderate, very few (8%) are high utilizing (have more than 15 units of service). Also walked through the call center screening workflow, the county step-up process, and the county step-down process.

- After the presentation from DHCS and Beacon, workgroup members were invited to comment. Below is a summary of the key themes from workgroup members:
    - Multiple workgroup members called to better define what is mild/moderate vs. severe so the system is easier to navigate from a beneficiary perspective and there is less confusion between systems of care around roles and responsibilities.
    - Transitional care is critical to make sure we don't lose people as they move between levels of care.
    - Multiple calls to ensure that the right tool is used for the right purpose. The tool must be reliable and valid. Sometimes the most popular tool is not the most reliable and valid.
    - Call to move toward using feedback informed care and the importance of putting the client first.
    - Calls for standardization in selecting a tool. Without a common framework and tool, we can't ensure consistency across the managed care and specialty mental health delivery systems throughout the state.
    - Distinguish between screening and assessment as they are two different processes with two different purposes.

- Next, DHCS presented on case study examples and ASAM criteria. See slides here (35-39). Below is a summary of the key themes from workgroup members:
    - Consider using Reaching Recovery as a tool.
    - Think about how to work with correctional partners to do enough screening to get the process started, but also be sensitive to the fact that people are not as open about their health and history with substance use disorder on the correctional side in comparison to the behavioral health systems of care.
    - Calls to better understand the clinical perspective on how kids should be screened and the role of ACEs.
    - There are costs of migrating to a single tool. For providers, there is also a huge cost of having multiple tools out there.

    - Nearly all stakeholders agree that there is no way to select and implement new level of care assessment tool by 2021. Support for a phased roll-out process.
    - Multiple members agree using the CANS is a good starting point. CANS is also being used in child welfare, so it makes sense to be consistent.
    - Call to think about tools that people can use as guidance to help them think about levels of care rather than yes or no criteria. Tools shouldn't be used to deny treatment or care.

- Finally, members of the public were invited to comment. Three members of the public shared their comments. Below is a summary.
    - Keep in mind cultural competency and linguistic translation. Many folks can't get an accurate assessment because it doesn't translate well. Also, DHCS should investigate the disparities in access to the mild/moderate benefit especially for communities of color.
    - Support the adoption of a statewide tool. Child welfare is using the CANS. Counties say it is a heavy lift, but it helps with cross system work and gives folks a common language. Also echoed the call to think carefully about those who are conserved.
    - The popularity of a tool does not always translate into quality. Also, a step down often means that folks lose access to psycho-social supports. Caution against stepping people down and stripping away needed maintenance services and care.

Next Steps for DHCS:

The BH Workgroup will convene to discuss medical necessity again on January 30, 2020. In the January 30 meeting, the workgroup will carry over the slides about inpatient medical necessity criteria.

A Behavioral Health Stakeholder Advisory Committee will take place on January 6, 2020.