# Systems and Medicaid Committee (SMC)

Meeting Minutes
Quarterly Meeting – January 16, 2025

**Members Present:**

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| Uma Zykofksy, Chairperson | Karen Baylor, Chair-Elect | Milan Zavala |
| Catherine Moore | Noel O'Neill | Marina Rangel |
| Javier Moreno | Ian Kemmer | Susan Wilson |
| Elizabeth Oseguera | Dale Mueller | Deborah Pitts |

**Staff Present:** Ashneek Nanua, Naomi Ramirez

**Presenters:** Marlies Perez, Elissa Feld, Robb Layne, Ian Kemmer, Michelle Smith, Chil Lam, Glenda Aguilar

**Meeting Commenced at 8:30 a.m.**

## Item #1 Review and Accept October 2024 Draft Meeting Minutes

The Systems and Medicaid Committee reviewed the October 2024 draft meeting minutes. The committee accepted the meeting minutes with edits requested.

**Action/Resolution**
The approved minutes will be posted to the Council's Website.

**Responsible for Action-Due Date**
Ashneek Nanua – January 2025

## Item #2 Overview of Substance Use Disorder Services in Behavioral Health Services Act (BHSA) Full-Service Partnerships

Marlies Perez, the Behavioral Health Transformation Project Executive and Chief of the Community Services Division at the Department of Health Care Services, provided an overview of substance use disorder services in the Behavioral Health Services Act Full-Services Partnerships. The definition of substance use disorders is a diagnosed substance-related disorder that meets the diagnostic criteria of "severe" as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Marlies provided an overview of the Behavioral Health Transformation timeline and stated that counties must conduct Assertive Field-Based Initiation and Full-Service Partnership teams must be capable of supporting individuals with co-occurring mental health and substance use conditions. The Behavioral Health Services Act has a 35% funding allocation for Full-Service Partnerships.

Marlies Perez reviewed the required and allowable services for Full-Service Partnerships. There is a model for the adult Full-Service Partnership standards of care with Assertive Community Treatment as the highest level of care and Intensive Case Management as a step-down level of service. Marlies explained the components of each level of care and best practices for outreach and field-based programs. Counties can collaborate and pool together financial resources to expand and support field-based mobile services and open-access clinics. Counties may also refer residents across county programs. Counties must describe the program design and meet the requirements for Assertive Field-Based Treatment requirements by July 1, 2029.

The committee engaged Marlies Perez in a question-and-answer session upon conclusion of the presentation. The following key points were discussed:

- Committee members expressed concerns about the timeline for the 3-year integrated plan requirements. Marlies stated that the Department of Health Care Services will provide a template and guidance for the plan. She added that small counties (populations less than 200,000) may ask for an exemption for the housing intervention component of the first 3-year plan, and all counties may ask for transfer of funds to another category under the Behavioral Health Services Act. The Department of Health Care Services also has deadlines for reviewing the integrated plans.
- There was a question about whether telehealth was an acceptable practice for rapid response Medication-Assisted Treatment in rural and small counties. Marlies stated that telehealth models can be utilized.
- A committee member shared that the original Full-Service Partnerships required teams and asked if Level 1 of the Full-Service Partnerships includes a team-based model. Marlies confirmed that Level 1 is a team-based model.
- There were comments from the committee that regulatory changes will be needed to improve rapid access to Medication-Assisted Treatment. Leveraging the Narcotic Treatment Programs (NTP) network will be critical. Leadership and policy changes are also needed due to the policy barriers that prevent the expansion of Narcotic Treatment Program services. It is important to make improvements to the existing system and remove barriers instead of creating a new system. Marlies stated that this is a priority for the Department of Health Care Services and will require shifts about views on the need to provide Medication-Assisted Treatment.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #3 Public Comment

Kaino Hopper, a volunteer for National Alliance on Mental Illness (NAMI) Sacramento, expressed appreciation for the Full-Service Partnerships Substance Use Disorder Program and provided a family member perspective. Kaino expressed hope that there will be understanding that families and support networks are healthy and that individuals may choose who their support people are. She reminded the committee that families are an invisible workforce and natural supports willing to help provide education and assistance.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #4 Policy and Provider Perspective of Substance Use Disorder Services in Behavioral Health Services Act Full-Service Partnerships

Elissa Feld, the Director of Policy for the County Behavioral Health Directors Association (CBHDA), and Robb Layne, Executive Director for the California Association of Alcohol and Drug Program Executive, Inc. (CAADPE), presented to the committee on the challenges and opportunities for substance use disorder services in Behavioral Health Services Act Full-Service Partnerships. The presenters first explained the current landscape of Assertive Field-Based substance use disorder services which include mobile field-based programs, low barrier access to Medication-Assisted Treatment, and the support of co-occurring conditions in Full-Service Partnerships.

The California Association of Alcohol and Drug Program Executive, Inc. is using community treatment models with a whatever-it-takes approach in clinical settings. The organization is also integrating substance use disorder screenings as part of their workflows with linkages to residential care.

Tarzana Treatment Centers is known for their substance use disorder treatment and hold multiple Full-Service Partnership contracts that connect individuals to co-occurring care. The services are co-located and integrated. Tarzana's Full-Service Partnership model includes home visits, street outreach, mobile testing, and follow-up with transition-age youth experiencing or at-risk of experiencing homelessness. Robb Layne emphasized that Full-Service Partnerships should support individuals experiencing homelessness. Mobile approaches help individuals who may avoid traditional clinics due to stigma, transportation, or scheduling issues by meeting people where they are.

HealthRIGHT 360 has a successful model that integrates Alcohol and Other Drug (AOD) Counselors, Peer Support Specialists, and mental health clinicians in their Full-Service Partnership program to serve clients experiencing Serious Mental Illness (SMI) alongside their addiction. The organization also assists individuals with temporary and transitional supportive housing.

Robb Layne stated that providers that have embraced low-barrier models and minimum eligibility requirements have seen improvements in engagement and retention in treatment. By meeting the individual's immediate needs, providers have been able to address the gaps between seeking help and initiating medication. Additionally, including Alcohol and Other Drug (AOD) Specialists within Full-Service Partnership teams, ensuring consistent warm hand-offs between outpatient and residential care, and having aftercare planning are key best practices. Smoother transitions out of detox and better medication compliance for psychiatric and addiction medications are also important for success. Robb also emphasized a consumer-centered approach, flexible scheduling, and trauma-informed and culturally affirming practices as important.

The County Behavioral Health Directors Association surveyed the counties to identify what is already happening in Full-Service Partnerships. Elissa Feld stated that many outreach teams in the counties are currently funded by Mental Health Services Act funds. Counties have programs outside of behavioral health which include street medicine programs funded by other county departments or initiatives. The counties are working closely with Narcotic Treatment Program providers. Hospitals that work with county behavioral health departments engage in the California Bridge Program which includes partnerships with substance use disorder navigators. Medication-Assisted Treatment Clinics are built in accessible areas and not all counties have this. Many counties are engaging in Assertive Community Treatment. San Diego County and Santa Clara County are working with outside entities to assess their programs for fidelity.

Key discussion points for the county and provider challenges regarding substance use disorder services in Full-Service Partnerships include the following:

- **Workforce**
    - It is difficult to find prescribing providers to go into the field. Telehealth is an option for rural areas, but some clients have challenges building a therapeutic connection in a virtual format.
    - Smaller providers do not have robust or specialized training or the recruitment strategies that larger providers have, especially in rural communities. Smaller providers are often the culturally affirming programs. Smaller organizations also lose qualified staff to larger employers. This highlights equity and scaling issues for the behavioral health workforce.

- **Integration and training**
    - Substance use disorder residential treatment providers often do not have the training needed to support individuals with co-occurring disorders.
    - Riverside County is working with providers to provide services to clients with co-occurring conditions.

- There is a need to train both mental health and substance use providers on the fourth edition of the American Society of Addiction Medicine (ASAM).
- Integration and training are challenging for small and rural counties. Elissa Feld provided an example of success where a small county received a grant and worked with Aegis Treatment Centers to have mobile-field based services.
- It is important to know who is responsible for care outcomes. Providers, counties, and health plans need to work together to avoid duplication of services.
    - Los Angeles County has a program called the Care Health Action Management Platform (CHAMP) to view client records and track care plans in real time. The platform also requires a Memorandum of Understanding (MOU) to identify what provider handles physical health, mental health, substance use disorder treatment, and housing navigation. This prevents clients from going back and forth between multiple systems.
    - The Integrated Services for Mentally Ill Parolees (ISMIP) Program was designed to connect parolees with Serious Mental Illness to community-based mental health services upon release of carceral settings. The California Department of Corrections and Rehabilitation made contracts with local mental health and substance use disorder providers specifying responsibilities for medication management, housing, and case management. There were data sharing agreements, so providers have limited access to information like parole conditions and mental health history to develop integrated plans. The outcome was a single transition plan. This program has been cut.
    - The Enhanced Care Management Benefit under the California Advancing and Innovating Medi-Cal (CalAIM) Initiative supports integration but there are questions on what provider or entity is responsible for providing and billing for care coordination. Standardizing reporting and data sharing is an important piece under the leadership of the Department of Health Care Services via All Plan Letters (APLs) and Behavioral Health Information Notices (BHINs).
- The state is working on a data exchange through Part 2 regulation-compliant forms. There is a need for Part 2 of the substance use disorder data exchange centralized consent management platform to address barriers regarding 42 Code of Federal Regulations (CFR) Part II regulations. County behavioral health providers have been left out of data exchange funds and have advocated for this infrastructure to support counties, particularly small and medium-sized counties. Los Angeles County has been a leader in data exchange.

- **Stigma**
    - While stigma is difficult to measure, there is stigma in the substance use disorder community for both clients and providers.
    - Early dropouts occur in treatment programs due to stigma for medication.
    - Self-stigma also exists for clients. It is important to discuss trauma occurring with a substance use disorder diagnosis.
    - There is a need to integrate Harm Reduction Services in programs and Peer Support Specialists in care teams.
    - Committee members shared examples of substance use disorder providers who do not serve clients that have certain medications or mental health diagnoses.
    - There is stigma in reimbursement, paperwork, and parity. Substance use disorder providers receive the lowest reimbursement in the system and must fill out several forms for reimbursement.
    - There is a need to educate the public on Medication-Assisted Treatment.
    - The County Behavioral Health Directors Association worked on Assembly Bill 2995 which focused on removing stigmatizing language for mental health and substance use disorders.

- **Sustainability**
    - The Behavioral Health Services Act is a funding source created from the recalculation of Mental Health Services Act funding. Some counties face a net reduction of this funding, and the Act does not add clear value.
    - The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration is another funding source.
    - The Behavioral Health Services Oversight and Accountability Commission has funded workforce pilot programs.
    - The Department of Health Care Access and Information has distributed money for loan repayment programs.
    - Grant funding is critical. The California Health Care Foundation is funding a grant through the Department of Health Care Services to help small providers become certified in Substance Abuse Prevention and Control (SAPC). This is an example of how to support small providers to expand their networks.
    - San Diego County and Sacramento County have learning hubs or joint training sessions for mental health and substance use disorder providers. This is funded by the Mental Health Services Act or local workforce funds.
    - Los Angeles County is putting together a learning management system to help providers better understand substance use services, the updated American Society of Addiction Medicine criteria, and trainings to provide free continuing education credits.

- **Licensing and Certification**
    - The Department of Health Care Services has been engaging counties to ensure that multiple providers are present on multi-use campuses that have both substance use disorder and mental health services on the campus. One challenge for the campuses is the requirement for all outpatient substance use disorder programs be Alcohol and Other Drug (AOD) certified. There was a case where a county where counseling services were optional for with low barrier access to Medication-Assisted Treatment. The Department of Health Care Services updated the requirements to make counseling a required component for Medication-Assisted Treatment.

Key discussion points for the county and provider opportunities regarding substance use disorder services under the Behavioral Health Services Act Full-Service Partnerships include the following:

- **Further expansion of co-occurring teams**
    - Earn and Learn Programs help address the workforce issue and expand co-occurring teams.
    - There is a need to expand pay, training, and supervision. Supervision is often overlooked in budget planning. Flexible supervision may remove barriers for small organizations and counties to bring in workforce staff.
    - Alcohol and Other Drug Counselors have been added to the Mental Health State Plan Amendment to provide mental health services within their scope in the “Other Qualified Provider” billing code. However, it has been challenging to bill due to mental health and Drug Medi-Cal Certification. Alcohol and Other Drug Counselors can now bill for mental health services and receive the Alcohol and Other Drug Counselor rate rather than the lower rate for Other Qualified Providers. This will help sustainability.

- **Partnerships and collaboration**
    - Providers, colleges, and workforce agencies should collaborate to support the pipeline for behavioral health providers on integrated teams.
    - For-profit Medicaid providers can be part of the unified solution because they may have the culture of a non-profit.

- **California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Workforce Initiative**
    - The County Behavioral Health Directors Association advocated to prioritize Alcohol and Other Drug Counselors and prescribers working on the substance use delivery system. Alcohol and Other Drug Counselors are included in the loan repayment, scholarship, training programs, and recruitment and retention sections of the Workforce Initiative.
        - There is $120,000 student loan repayment funding for Alcohol and Other Drug Counselors.

        - Supervision is included for recruitment and retention to help with recertification, exam fees, and needed materials.
        - The Council should work with the Department of Health Care Access and Information to ensure small counties can access this funding.

- **Leveraging recent policy changes**
    - Providers assess whether they can afford to provide new services that the Department of Health Care Services offers.
    - Reimbursement rates need to be predictable.

- **Reducing stigma**
    - There is a need for a consumer-driven approach and ensuring a No Wrong Door Policy that fosters trust and consistent engagement to address stigma and access to services.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

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## Item #5 Public Comment

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Steve McNally from Orange County stated that he has a son with schizophrenia who receives county services. As a family member, Steve asked if stigma is the issue or if self-stigma is the issue. He expressed that it is important to model and talk about our own journeys. There is a need for a shared understanding between the state, counties, and family members and improved stakeholder processes to address communication issues. It is helpful to use and share an open data portal to see details at the county level and identify where the issues exist.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

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## Item #6 County Perspective of Substance Use Disorder Services in Behavioral Health Services Act Full-Service Partnerships

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Ian Kemmer, Behavioral Health Director for Orange County Health Care Agency, and Michelle Smith, Division Manager of Mental Health Services Act Programs, presented on enhancing co-occurring capabilities in the Orange County System of Care. Chil Lam, Program Manager for Intensive Outpatient Services and Glenda Aguilar,

Division Manager for substance use disorder services were present for the question-and-answer session with committee members.

Ian Kemmer discussed access to services via access lines, outreach and engagement, and No Wrong Door Policy. The following levels of care are included in the Drug Medi-Cal Organized Delivery System: outpatient treatment; intensive outpatient recovery services; residential treatment inclusive of individuals with co-occurring mental health challenges; low-intensity and high-intensity residential services; withdrawal management; and Medication-Assisted Treatment (MAT) Narcotic Treatment Programs (NTP). There are also supportive services such as housing services, supported employment, peer mentoring, and wellness centers. Specialty population services cater to Transition Age Youth, Pacific Asians, Older Adults, Latino, and Vietnamese populations.

The Full-Service Partnership model resides in Intensive Outpatient Treatment through contracted providers. Orange County also has the Assertive Community Treatment (ACT) model which is known as the county-operated Full-Service Partnership program. The first Full-Service Partnership program was for the older adult population. Ian shared the county's 10 Full-Service Partnership programs based on the populations of focus which include the populations mentioned above as well as the criminal justice population and collaborative courts.

The average adult population in Full-Service Partnerships had a co-occurring disorder. Co-Occurring services in the Full-Service Partnerships include multidisciplinary teams, comprehensive and integrated services, screening tools, and evidence-based practices. The process for individuals with co-occurring mental health and substance use disorders involve coordination and linking individuals from existing programs to the Drug Medi-Cal Organized Delivery System services.

The Enhanced Recovery Full-Service Partnership Co-Occurring Disorder Program is a voluntary program. The program includes voluntary drug testing and screening. In the program, participants attend 3 to 6 co-occurring groups per week, self help meetings twice per week, and check in weekly with the co-occurring treatment specialist. The program includes four stages based on amount of time in recovery. The program has 38 graduations to date.

Ian Kemmer shared current challenges and barriers to substance use disorder services. More training is needed to link individuals to substance use disorder services and have providers deliver co-occurring service. Stigma impacts client engagement and retention in services. There are also billing and documentation challenges such as ability for Alcohol and Other Drug Counselor to bill Medicaid for services to individuals with co-occurring disorders. Staff hiring and retention is a challenge as well as having limited providers.

Michelle Smith discussed changes to the continuum of care for the Behavioral Health Transformation based on Module 1 of the Behavioral Health Services Act. Full-Service

Partnerships would occur in outpatient and intensive outpatient services which is a step up in care from early intervention services and a step down from crisis and field-based services.

There was a higher percentage of funding for Full-Service Partnerships under the Mental Health Services Act Community Services and Supports funding category (51% of total funding) as compared to the Behavioral Health Services Act which requires 35% of total funds for Full-Service Partnerships. The Behavioral Health Services Act differs from the Mental Health Services Act because it defines the Full-Service Partnership levels of care into either high intensity services delivered to fidelity or Intensive Case Management. Additionally, the Behavioral Health Services Act requires counties to participate in Assertive Community Treatment (ACT) and Forensic Assertive Community Based Treatment (FACT), High Fidelity Wraparound, Individual Placement and Supports (IPS), and Assertive Field-Based Initiation for substance use disorders. The Mental Health Services Act did not require implementation of evidence-based practices to fidelity.

The Behavioral Health Services Act has opportunities to increase access to field-based outreach and linkage to services. There are also opportunities for staff training on evidence-based practices as well as billing and documentation. Medication-Assisted Treatment has also been added to the programs in Orange County. Another opportunity is increased collaboration for coordinated care between providers.

The committee engaged the presenters in a question-and-answer session upon conclusion of the presentation. The following key points were discussed:

- Committee members discussed potential reasons for a limited workforce such as providers leaving the field of behavioral health, older providers retiring from the field, and low reimbursement rates in the county system compared to private companies.
- A committee member asked about the licensing process for Full-Service Partnerships. The presenters shared that individuals with co-occurring disorders would still need a mental health diagnosis to qualify for Full-Service Partnerships under the Mental Health Plan Certification.
- Committee members discussed the use of Assertive Community Treatment as a service closer to the medical model in comparison to the original Full-Service Partnership model.
- There was a question on whether Orange County has a sobering center where law enforcement may take individuals to instead of carceral settings. The presenters shared there is one sobering station and law enforcement can drop the individual to the campus. The staff at the sobering centers then work with the individual to place them in the correct level of care if they accept treatment.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #7 Public Comment

Steve McNally from Orange County stated that making the system operate efficiently is important. He stated that it would help to make clients be seen as customers. CalOptima serves the mild to moderate and severe behavioral health populations. Steve emphasized the importance of communication and finding better ways to make legislators understand the system.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #8 Wrap Up/Next Steps

The Committee Officers will plan the agenda for the April 2025 Quarterly Meeting.

**Action/Resolution**
The Committee Officers will work with staff to plan the agenda for the subsequent quarterly meeting.

**Responsible for Action-Due Date**
Ashneek Nanua, Uma Zykofsky, Karen Baylor – April 2025