DEPARTMENT OF HEALTH CARE SERVICES
Behavioral Health Stakeholder Advisory Committee (BH-SAC)
October 21, 2021
9:30 a.m. – 12:30 p.m.

MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI; MJ Diaz, SEIU; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health Plans of California; Farrah McDaid Ting, California State Association of Counties; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; 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; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, California Health and Human Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Britta Guerrero, Sacramento Native American Health Center; Alex Dodd, Aegis Treatment Centers; Sarah-Michael Gaston, Youth Forward; Robert McCarron, California Psychiatric Association; Jonathan Sherin, Los Angeles County Department of Mental Health; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Kelly Pfeifer, Marlies Perez, Shaina Zurlin, Rene Mollow, Jeffrey Callison, and Morgan Clair.

Public Attending: There were 214 members of the public attending.

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

Baass welcomed members to her first BH-SAC meeting as DHCS Director. She offered a brief overview of her background as an introduction. Baass said that her priorities are the successful implementation of the many efforts already underway in DHCS, including CalAIM, the expansion of Medi-Cal to undocumented persons over age 50, the managed care procurement, behavioral health initiatives, and the Home and Community-Based Services (HCBS) Spending Plan. She noted that this is a time to redefine how we think about healthy communities, how we achieve equity in our communities, and how we hold the health care delivery system and ourselves accountable for a healthier California for all. She said that it is critical to engage and listen to consumers and partners. By incorporating what the community's experiences are, we will create better policies and programs.

Baass recognized and thanked Sarah Arnquist, who is leaving BH-SAC. She thanked the California Health Care Foundation for its ongoing support of BH-SAC.

Director's Update

Michelle Baass and Jacey Cooper, DHCS

Slides: https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf

Cooper provided an update on the 1115 and 1915(b) waiver requests. DHCS has submitted formal responses to the Centers for Medicare & Medicaid Services (CMS) on the 1915(b) waiver, which includes a consolidation of Medi-Cal managed care plans (MCP), mental health plans (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS), and dental managed care plans into one consolidated waiver. In the 1915(b) waiver, DHCS also requested federal authority for contingency management. Discussions on the 1915(b) waiver are going well with CMS, and DHCS is optimistic about approval by the end of the year. The 1115 waiver includes ambitious requests, such as the justice package and the Projects for Assistance in Transition from Homelessness (PATH) model. There has not been a CMS response on the request to include faith/natural healers, and DHCS will continue to pursue this initiative. DHCS also submitted the State Plan Amendments (SPA) tied to CalAIM implementation, including the DMC-ODS SPA.

Cooper presented maps of COVID-19 vaccination data for Medi-Cal beneficiaries that are updated every other week on the DHCS website. Medi-Cal vaccination rates are still trending behind all Californians. Cooper provided an update on the Vaccination Incentive Program with MCPs. All MCPs submitted a vaccine response plan, and most are participating in the direct member incentives.

Cooper provided information about planning for the end of the COVID-19 public health emergency (PHE), most recently extended by the Secretary of the U.S. Department of Health and Human Services through January 2022. DHCS has begun planning for what it will take to unwind the comprehensive set of federal flexibilities in place, and what SPAs would be required for the items California will continue outside of the PHE flexibilities. DHCS is particularly focused on the full redetermination of Medi-Cal beneficiaries over a 12-month period. By the end of the PHE, it will be close to two years with no redeterminations, and many beneficiaries have moved or changed other circumstances. DHCS is working with health navigators, advocates, MCPs, community-based organizations (CBOs), and others to communicate the need to update beneficiary contact information. DHCS will mail an FAQ to all Medi-Cal beneficiaries and expects that 9-10

million beneficiaries will go through the redetermination process. Only a portion of individuals will be able to use the *ex parte* process.

Questions and Comments

Senderling: Building on Jacey's comments, caregivers and support people are critical in this process to update beneficiary information and help with messaging to the community to keep an eye out for communications. We will use the *ex parte* process to the extent possible, but don't expect a high success rate given that so much time has passed.

Sanchez: I notice that the spread on vaccination rates by race and ethnicity is 20-30 percent. Is there more recent data that shows the closure of rates for those populations?

Cooper: On the DHCS dashboard, you can see more precise data by race, ethnicity, and county. It does vary across the state and by race and ethnic groups.

Lewis: Do you expect waivers to be approved by CMS by the end of December? Are there any parts of the waivers that CMS won't approve?

Cooper: I feel confident about the 1915(b) waiver being approved by the end of the year. The 1115 waiver is more complicated and far-reaching. Discussions are going well, and there is nothing to flag as a significant concern. We meet with CMS twice a week, which is an unprecedented amount of time and attention from them.

Lewis: Can you clarify the number of people going through redetermination? We shared a letter with ideas about how to improve the processes for contact information, and we hope there is a creative way to not cut people off immediately while we work to make contact.

Cooper: There are between 14.2 and 14.5 million people in the program. We estimate 9-10 million may require the full redetermination process, not *ex parte*. We continue to plan accordingly, but given that large number, we are focused on getting contact information updated and communicating on the ground to pay attention to their Medi-Cal renewal. In California, we will need a full 12 months for this.

Sangwan-Savage: I have questions on two different issues. Is there more information about the likelihood of approval for tribal healers? On the vaccine updates, will you be posting or sharing the response plans submitted by MCPs? It appears that some counties' rates have improved, and others are stalled or gone backwards. It would help to know what MCPs in those counties are doing and what gaps remain.

Cooper: We have no questions from CMS on natural healers; they have not said no, but without any questions, this may signal they are not focused on it. This may be an area of potential advocacy. I will follow up on vaccination plans to see how we might share them.

Koopmans: Thank you for the overview of the Vaccine Incentive Program for MCPs. The activities outlined illustrate the work that's going on locally. One note: as vaccination rates increase within a plan, the overall county rates of vaccination also increase so closing the gap remains challenging. It is the right goal, and it is ambitious. Are there any indications

that the PHE could continue into 2022?

Cooper: The official extension, which is typically a 90-day timeline, extends into January 2022. With the potential of a winter surge, flu outbreaks, and children's vaccinations during the fall and winter, I think the federal flexibilities that come with the PHE will be important to keep in place. We expect the enhanced federal match will extend to March 2022. Further guidance from the federal government could potentially change that timing or extend it.

Veniegas: What are the implications from the extension of the PHE for counties planning to implement the new linkage through BenefitsCal?

Cooper: I need to follow up with you on this.

DHCS Major Initiatives Crosswalk
Jacey Cooper, DHCS
https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf

Cooper provided an overview and timeline of the initiatives. New Medi-Cal benefits approved in the 2021-22 budget were highlighted. She reviewed eligibility and enrollment changes to expand Medi-Cal. Cooper delineated payment reforms, incentive payments, and rate changes set for implementation through 2023. She outlined incentive payments, including CalAIM Enhanced Care Management (ECM) and Community Supports. Beyond CalAIM, there are $1.3 billion in additional housing and homelessness incentives approved in the HCBS Spending Plan. Others include COVID-19 vaccine incentives, behavioral health school incentives, and the expansion of Medi-Cal services in schools. She also outlined two rate changes: 1) unfreezing intermediate care facilities for developmentally disabled and freestanding pediatric subacute rates; and 2) regional capitation rates.

Cooper reviewed DHCS' overall efforts to standardize and simplify. This will include Medi-Cal enrollment of the majority of beneficiaries into MCPs by 2023. The only individuals remaining in fee-for-service will be restricted scope and share of cost beneficiaries. Benefits will also be standardized, including long-term care, specialty mental health, and dental initiatives that will move from pilots to standard benefits. Other standardization initiatives include DHCS requiring accreditation from National Committee for Quality Assurance (NCQA) for MCPs by 2026 and demographic information for beneficiaries. DHCS will also move forward to standardize county oversight of California Children's Services and county eligibility.

Cooper outlined three major initiatives under behavioral health (BH) that are scheduled for implementation from 2022 to 2024: Behavioral Health Continuum Infrastructure, the Institutions of Mental Disease (IMD) waiver, and the Children and Youth Behavioral Health Initiative (CYBHI). Overall, the long term plan is to integrate specialty mental health and substance use disorders by 2027, from an administrative and clinical point of view. Cooper outlined specific steps for the CYBHI to build the statewide infrastructure, including a stakeholder think tank to develop policy and the launch of the virtual platform with a statewide BH network in schools and community organizations. Along with these efforts, DHCS is addressing administrative claiming through Local Education Agency Billing Option Program (LEA BOP) and Senate Bill (SB) 75 to improve access through schools. By 2024,

DHCS will also increase access to Medi-Cal services in schools through MCPs.

Population health is a cornerstone of CalAIM, and many of the initiatives will prepare for the 2023 launch of population health policies and services, focusing on data, information gathering, risk stratification, tiering, and care coordination to ensure upstream efforts and focus on wellness prevention as well as care for complex patients. Cooper reviewed the comprehensive CalAIM justice package to ensure a coordinated reentry from incarceration and ensure services are available post-incarceration through Medi-Cal. She reviewed the CalAIM plan for more robust managed long-term care services and supports (MLTSS) by expanding services, standardizing the process, and ensuring data transparency. DHCS is implementing these ambitious initiatives and also looking ahead to plan for the next waiver.

Questions and Comments

Pitts: Can you say more about the Current Procedural Terminology (CPT) code transition given that some codes are restricted use to some types of providers?

Cooper: Billing for BH services lists things under mental health services, without specifics on the type of mental health services. CPT code billing that will begin in July 2023 will provide more information about the types of providers and the BH services being provided. We are working with counties to change the systems and train providers for this lift.

Tsai: I strongly support the behavioral health administrative integration. As I have spent time in Los Angeles County, I have recognized that there are both benefits and drawbacks to having separate mental health and substance use systems. One of the primary benefits of having separate systems is dedicated focus and leadership. There are obvious drawbacks of having split systems as well. What is your vision for how to achieve BH integration through the lens of having robust mental health and substance use disorder (SUD) systems and through the lens of BH parity? Traditionally there has been more focus and resources on the mental health system. Even when we use the terminology of BH, it can end up as mainly a focus on mental health.

Cooper: We agree this is complex. That’s why DHCS will take five years to accomplish this. We want to achieve exactly what you're saying, making sure that both mental health and SUD are fully available for all Medi-Cal beneficiaries, but finding opportunities where we can streamline and standardize for state and county operations, and from the perspective of beneficiaries. L.A. County is one of the places that is not integrated at the county level. In the long run, it will be better for counties, the state, and beneficiaries.

Pfeifer: It is complicated. We integrated three departments at the state and it did not result in SUD treatment taking a back seat, compared to mental health. SUD treatment, mental health, and medical care are all priorities, and one can’t be subjugated to the other.

Stoner-Mertz: Is there a time frame for rolling out the CPT codes? Can you offer more detail on the statewide CBO network?

Cooper: There is a CPT code crosswalk being developed that we will share once available. On the network, one thing we need to do with the children and youth behavioral health

virtual platform is to have CBOs across the state and be able to connect children and families with local CBOs that can meet their needs and are wellness focused, and are a connection they relate to. Through the virtual platform, we want people to see locally who is in the community that can help, and connect them when that launches in 2024.

Koopmans: What is the timing and status of full integration plan pilots?

Cooper: It will be 2027 at the earliest, and would be tied to the submission and approval of the next 1915(b) waiver.

CalAIM Behavioral Health Initiatives, including Contingency Management
Kelly Pfeifer, MD, DHCS
https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf

Pfeifer offered introductory remarks on the CalAIM BH initiatives and provided a timeline for go-live dates. Each of the policies was developed collaboratively with stakeholders to craft the right language and then finalized in Assembly Bill (AB) 133. The goal is to make it easy to get help, especially for children and youth, who experience many barriers. We want to make sure that children who have experienced trauma, but do not yet have a mental health diagnosis, can get help upstream and early.

Pfeifer reviewed DMC-ODS policy changes, many of which were approved to implement in 2021 and are extended in the waiver. A new contingency management pilot is proposed for DMC-ODS in spring 2022, with services to launch July 2022.

Zurlin reviewed changes on documentation redesign to go live in July 2022. A redesign workgroup was formed to operationalize changes that are streamlined, clinically effective, and reduce unnecessary burden or documentation. Policies reflect moving away from a static treatment plan to a dynamic problem list comparable to documentation standards in medical practices. Other changes mean that assessments will conform to required domains rather than the current status where assessments are variable across the state. Complex, lengthy note requirements will be replaced by more streamlined documentation. Also, disallowances for variation in documentation will be replaced with disallowances for fraud, waste, abuse, and corrective action plans will be used when variations in quality are identified.

Co-occurring treatment policy is going live in July 2022. Overall, clinically appropriate services can be provided regardless of the system of care, and disallowances for a wrong primary diagnosis in relation to whether it's an SUD treatment episode or a mental health treatment episode are removed. This will support integration and make sure that individuals receive appropriate services regardless of where they enter for care.

Pfeifer said the No Wrong Door policy will help ensure patients get appropriate treatment when they need it, despite California’s multiple systems of care. She outlined activities for next year to include technical assistance webinars and developing updates and guidance to manuals, Memorandums of Understanding, and contracts.

Zurlin reported on the progress in designing standard screening and transition tools to ensure beneficiaries are screened efficiently, referred to care in the right system, and transitioned between systems seamlessly, improving communication between MCPs and MHPs. The screening tool is intended to be used by call center staff at MCPs and MHPs. The transition tool is designed to be utilized when a beneficiary in one system of care could benefit from services in the other system of care. A broad stakeholder group developed tools that are in the process of beta-testing. Data is coming in and being synthesized to make adjustments to the tool, and next there will be wider piloting in selected areas. In summer 2021, the workgroup expanded to participants with expertise in children's services to support development of the children's tool. That tool is in its beginning phases of development.

Pfeifer outlined payment reforms to address the challenges and unintended consequences of a cost-based payment system. On July 1, 2023, DHCS will go live with a fee schedule for rate-based payments in DMC-ODS and MHP and transition from the Certified Public Expenditure methodology to Intergovernmental Transfers along with changing coding to CPT codes. This will ensure better data about the services provided in behavioral health.

Pfeifer also reviewed peer certification for peer support specialists, a new provider type and service. Counties have identified the California Mental Health Services Authority (CalMHSA) as the entity to represent them in the implementation of a state-approved Medi-Cal Peer Support Specialist Certification Program. The certification program will be in place for peers to be certified starting in July 2022, which meets the law’s requirements.

Pfeifer provided an overview of contingency management. It combines motivational incentives with counseling and is the only consistently proven treatment for stimulant use disorder. Given that this is a complicated launch, motivational incentives will start as a pilot. DHCS is working with a small workgroup, including national experts, to create a policy paper for review by stakeholders about how to launch contingency management in July 2022. Funding is approved for the pilot through the HCBS Spending Plan, and there are discussions with CMS for this to be in the waiver. Counties will apply for the pilot by agreeing to the rules of the rollout to ensure motivational incentives are used appropriately and safeguards against fraud, waste, and abuse. Incentive payments will operate through an app and a web-based incentive distribution company for those without a smartphone.

Questions and Comments

Pitts: The time allotted to develop peer certification seems quite modest, given my experience around test development. To develop this type of test, there is often a test company involved. Even though the core competencies exist, they are quite broad and require more refinement to develop a blueprint and then refine test questions. In addition, the stakeholders involved in that process should only be peers. In my own experience where I am on a workgroup with my national association doing this, it is taking a year to complete the process. It seems ambitious to have July 2022 as the timeline for the test to be available. I would like more transparency from CalMHSA on this. They are vetting the training curriculum options, but I see nothing about test development on their website.

Pfeifer: It is an aggressive timeline, but we also feel a lot of urgency. We have never done

more stakeholder engagement than we've done for peers, integrating hundreds of comments. We will be working with CalMHSA over the coming months to make sure that we are as inclusive as possible as we finalize the certification pathway.

Pitts: Let me clarify to acknowledge the substantial effort to secure stakeholder feedback on this process. I'm talking specifically about the test development, including the design, writing, focus, and vetting of the questions. There has been no invitation on the CalMHSA website for stakeholders to blueprint or test question development.

Pfeifer: Thanks, I will take this back for discussion.

Ramirez: Through the presentations, I wondered about where the deployment of oversight and accountability plays a role, particularly around mental health money. I support Dr. Tsai's comments and emphasize the importance of accountability and oversight, especially since we are talking about a significant amount of money as well as the time that the community has provided. Debra's point highlights something there is still an opportunity to work on. There has been difficulty contacting CalMHSA to get information. Latinx make up the majority of residents in Los Angeles County, yet there was not much effort to reach out to the population, and that was disappointing. We wish there could be a proactive approach to engaging our communities and being more transparent. I hope that this can be enhanced as we move forward. There are so many amazing efforts, and we don't want to have something distract from the great work. Thank you for the opportunity to represent my community, my peers. I do see DHCS listening to many of our recommendations.

Clark Harvey: There has been a lot of involvement of stakeholders, and we want that to continue. I know others join me in thanking you for the work on behavioral health documentation redesign. It's also wonderful there is a crosswalk for the CPT codes. I think there would be utility to involving providers on the transition tool workgroups, as our members have expertise to lend to the process.

Cabrera: Thank you to DHCS for the massive amount of change on structural issues that will move us to a more beneficiary-centered and streamlined system. DHCS has had the willingness to get into challenging details and to pull things apart and put them back together in ways that make more sense. We're appreciative of documentation redesign and the contingency management benefit.

Lewis: I appreciate DHCS' work on many different fronts. The tools for screening and transition are needed to solve the many problems inherent in having separate mental health, behavioral health, and managed care programs. I have seen the adult tool. Are you circulating drafts of the under age 21 tool? Can you offer more information about the expanded workgroup and who is on it?

Zurlin: There is no draft of the under age 21 tool yet. We are starting with a national landscape assessment and learning what other states are doing. Over the next month, we will convene the workgroup to review that information, discuss the nuances of a youth screening and transition tool, and begin to identify what will work in California.

SOGI Data Collection/Compliance with AB 959

Rene Mollow, DHCS
https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf

Mollow offered background on efforts with CMS that date to 2015 regarding sexual orientation and gender identity (SOGI) data collection within the Medi-Cal application. This effort was undertaken with Covered California because of the shared Single Streamline Application (SSApp) used for insurance affordability programs. Early discussions focused on changes that were possible for online and paper applications. Changes are made to the online application, but not to the paper version of the SSApp. In 2017, questions were developed for the Medi-Cal application working with advocates and other stakeholders in the LGBTQ community. The questions were added to the Statewide Automated Welfare System (SAWS) eligibility system and the California Healthcare, Eligibility, Enrollment, and Retention System (CalHEERS). When a person applies online now, the questions are included. DHCS is preparing changes to the paper version of the SSApp to incorporate these questions to submit to CMS for their review and approval. When the Affordable Care Act (ACA) passed, it required us to get approval from CMS for the SSApp. Initially, DHCS engaged with CMS regarding the placement of these questions on the paper SSApp however these efforts stalled. Now we are adding the questions to the paper version of the SSApp to make consistent with the current online application.

There is an option on the online application for non-binary individuals, and with CMS approval, that will be updated on the paper application and made available in all threshold languages. Gender remains a required data point on the application, and SOGI questions must be considered optional. In response to concerns raised, the identification card will no longer indicate “male” or “female”. She also noted that several years ago, DHCS removed gender requirements for any services. There were barriers based on gender identification in the system that no longer exist. DHCS is providing guidance to counties for respectful communication to reference individuals by their self-identified pronoun and gender identity. DHCS is working with LGBTQ communities to update guidance on the steps to be taken if someone wants to update their eligibility file in terms of SOGI.

Questions and Comments

Teare: This is important work that will make a big difference, particularly in the BH context, given everything we know about the disproportionate burden for LGBTQ communities.

Africa: I appreciate the work here. The terminology for people who are transitioning should be gender reaffirming services. There is both a technical challenge, obviously with the administrative issues, as well as a culture change that needs to shift. Asking the question and in a sensitive way that invites inclusion and belonging is important. Who are the LGBTQ stakeholders? There is diversity among stakeholders and different perspectives. I invite a conversation with counties and others who identify as part of this community to assist. We struggle when people are coming into the system in the middle of transitioning and there seem to be problems getting services because their gender is different from how they are presenting, and maybe their legal documents don't reflect that. Another part of the complexity of gender and gender identities are the cultural components.

Mollow: Thank you for those very thoughtful comments. We have been working with a

variety of individuals and advocacy organizations. Much of this work initially transpired through diverse consumer stakeholder workgroup meetings. It has been both a challenge to reconcile the differing input as well as our ability to change questions already in the application. Another challenge that dates back to the passage of AB 959 is that we do not have a set of properly vetted questions for universal use across our various programs. There is an opportunity to bring this issue to a cross-department workgroup on language access. Within DHCS, we have incorporated the questions in the online application into other program applications outside Medi-Cal, such as the Family Planning, Access, Care, and Treatment Program and Every Woman Counts.

Lewis: Thank you for this work. Consumer advocates raised concerns about the lack of materials that create barriers for individuals seeking gender transforming services in terms of eligibility, service access, and other issues. Jei's points were important about how this shows up and is a barrier for consumers seeking care. I appreciate DHCS moving this forward. My other question is whether there is collection of SOGI data from applications?

Mollow: SOGI is part of many changes in the paper application and is a priority for us. It will be submitted to CMS by January or February 2022. On SOGI data collection, we are not able to share the data at this point given the small counts and need for confidentiality.

Behavioral Health Infrastructure Planning
Marlies Perez, DHCS
https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf

Perez provided an update on the Behavioral Health Continuum Infrastructure Program (BHCIP) and the Community of Care Expansion (CCE) Program, as well as the federal mobile crisis planning grants and preparation for 988 implementation. The BHCIP will roll out in six different competitive rounds for counties, tribal, nonprofit and for-profit entities. The timeframe is rapid because some of the funding is linked to the first federal stimulus funding that must be obligated in 2024.

Round one is mobile crisis funding to support development and expansion of crisis care mobile units (CCMU) and direct crisis and non-crisis services. There are two tracks of funding, planning, and implementation. Awards were made in October for 47 counties and tribal entities. Planning grants up to $200,000 will be used to assess the need and develop an action plan for mobile crisis and non-crisis programs. Implementation grants include a base allocation of $500,000 and competitive awards beyond that to implement new or expand existing CCMU infrastructure for mobile crisis. Not all of the $205 million was awarded in the first release of the Request for Application (RFA), and DHCS will release the RFA for a second round to counties and tribal applicants.

Round Two planning grants will incorporate a companion infrastructure opportunity for CCE for counties and tribes. The Round Three launch ready RFA is set for release in January 2022. Again, the focus is on increasing the number of BH facilities and expanding the capacity of existing facilities. Round Four is focused on children and youth, and then Rounds Five and Six focus on the gaps identified in the needs assessment.

Perez reported on the one-year $850,000 federal mobile crisis planning grant from CMS in

partnership with the County Behavioral Health Directors Association to fund community-based mobile crisis intervention services in Medi-Cal, including assessments, capacity expansion, training, planning, and technical assistance. She reported on the 988 award to Didi Hirsch as the administrator of 13 crisis call centers including a review of the current system, and identifying how to expand to 988 and how to liaise with county partners.

Questions and Comments

Porteus: I represent a federally qualified health center (FQHC) with an extensive BH continuum. On one slide, you referenced counties, tribal entities, and nonprofits and for-profits, and the subsequent slides only reference counties and tribal entities. Are nonprofits and for-profits allowed in the mix of funding?

Perez: The first two rounds (mobile crisis and planning grants) are specifically for counties and tribes. For other rounds, it will include counties, tribes, nonprofits, and for-profits. I can't ensure that all entities will be eligible for each round because it will depend on the state's focus in a particular round as to which are the eligible entities to apply.

Fields: Where is there information on what launch ready means? Does it mean site control of a place? When will we see what the elements are that make you a launch ready project?

Perez: We are looking at that internally now in order to define it clearly. Site control or permits are elements we are discussing. We will make this public soon.

Fields: Who will be eligible for the launch ready round?

Perez: The statute allows for counties, tribal, nonprofit, and for-profit entities. Counties often work with partners, and the application will be a joint one with the Department of Social Services for the Community Care Expansion opportunity. Each round will be different in this respect.

Fields: As this unfolds, how will DHCS monitor the stakeholder process that goes into the county-level development of a proposal, particularly to ensure that people with lived experience and consumers have had an important role in proposals that are going forward from the counties or entities?

Perez: How a county is conducting stakeholder engagement will be assessed in the RFA for each of the rounds. We will want to know how counties are working with partners, including beyond BH.

Sangwan-Savage: When we think about crisis response and building out the continuum, it is a criminal justice issue because what we have right now is a response for people of color who need crisis support that is primarily law enforcement-based; that's violent, harmful. I hope this is an opportunity to move away from that, but it won’t happen automatically. I hope to see a more explicit call-out of that in the future as these programs move forward. What are our goals with these dollars in terms of reducing racial disparities, and what kind of data do we need to collect? It will be a missed opportunity not to think about particularly impacted communities and the language access needs. There are several opportunities

going in similar directions and all rolling out right now. I'm concerned there is no statewide strategy. This is not just a DHCS issue. It could be transformational and I'm worried that we are approaching it project by project and not building a system of care from that racial justice perspective to change the paradigm for how people of color experiencing serious mental health needs are treated. Are there goals for reducing racial disparities?

Perez: Yes, that has been a lens of DHCS for everything we are doing. We are looking at lessons learned from the California Department of Social Services (CDSS) in Homekey around racial justice and looking to incorporate them. We want to make this more effective at the local level.

Baass: To underscore that, we are working with CDSS on this entire continuum, these projects, HCBS, and homeless funding as part of a comprehensive effort to address equity.

Senella: Can you explain the rationale for the two initial rounds of funding going to county or tribal communities only? If the first round didn't fully utilize the dollars, would it be useful to open it up more broadly? Is the timeline set because, especially during COVID-19, these projects fall behind getting through plan check, permits, etc.?

Perez: Almost all funding was allocated in the first round, but there was not sufficient outreach to ensure tribal entities had time to apply, so the second round is intended to address this. There are no concerns that the funding will not be awarded to counties and tribes. Limiting it to counties and tribal entities ensures that the mobile crisis response is coordinated at the county level. On the timeframes, we are hearing that there are projects ready to launch. In addition, the federal funding is time limited with no extensions.

Eisen: Is there a vision for a connection between 988 and mobile crisis? This is related to the comments about impacting racial justice and alternatives to policing. Many communities will not use 911 because it could mean their death.

Perez: There is a definite connection, and this is an area we are continuing to adjust to make sure the funding opportunities connect mobile crisis and 988. The mobile crisis response at the local level is not limited to individuals who have Medi-Cal or county funded services.

Cabrera: On mobile crisis, we surveyed members and found that 35 of the more populous counties have some mobile crisis infrastructure in place today. We may be starting from scratch in smaller, more rural communities and the expectations of a mobile crisis system change based on density. There are issues to sort out on the financing side to support services because there is not much now. If we hope for an all-payer system of 24/7 services available to everybody, we don't really have a financing mechanism to support consistency around that throughout the state. I want to flag that we have great opportunity in the 85 percent federal match rate, if California opts into that for Medi-Cal, but that leaves 70 percent of our state's population without a guaranteed funding source for mobile crisis, to say nothing about the dispatch functions. Our call centers are amazing at providing emotional support for people with suicide risk, yet they are not structured today to do complex crisis triage or dispatch services. We need to have a conversation about the transition of the hotline and whether we are saying it is access to a mobile crisis team. We

haven't made that decision as a state and haven't secured resources for that. These are some of the outstanding conversations that I wanted to call out. We are grateful for the infrastructure, and there's more work to be done here.

Veniegas: First, I want to recognize the use of needs assessments to guide the future rounds. Many colleagues have been calling for counties to do BH needs assessments, and this supports that kind of effort. One thing to anticipate and perhaps recommend would be to consider allowing for costs around community engagement. The siting of these types of facilities that would be acquired, rehabbed, or renovated requires conversation with community members who now also experience challenges regarding their support for people experiencing homelessness in L.A. County.

Perez: Thanks for all of this. We will definitely take these comments into consideration. We are going to be providing extensive technical assistance for individuals when they apply and on all of these issues because we recognize the complexity.

Public Comment

Poshi Walker, CalVoices: I want to speak to the SOGI data collection work and echo the comments of Jei Africa and Kim Lewis. I would also like to recommend that you work with subject matter experts on SOGI data collection, not just people who identify as LGBTQ, because there is a difference. I have a question in the 1915(b) waiver. It states that peers are supposed to be working with members of the LGBTQ community. But when you go into the data collection portion, they are not being asked their sexual orientation and their gender identity questions. I'm deeply concerned about that because only male, female, or non-binary is not an appropriate way to ask for or report out gender identity. The comment that you're using SOGI data questions across programs is concerning, when for peer certification that's not being done.

Hannah Bichkoff, CalVoices: I wanted to speak to our concern related to Dr. Pfeifer's presentation and specifically the peer support specialist benefit on her slide and in many related DHCS materials that states that counties have identified CalMHSA as the entity that will represent a state-approved Medi-Cal peer support specialist program. We were informed that CBHDA facilitated this selection process and that it was executed informally with a process that was not transparent to the public. So I'm wondering if DHCS can share how the counties selected CalMHSA as a certifying entity and if or where the public record of this is? We find this especially concerning because when the behavioral health directors were selected to speak on behalf of their counties, other important stakeholders, such as Board of Supervisor appointed Behavioral Health Advisory Board members and citizens, were left out of the decision making process.

Paul Rains, Commonspirit: We received about $3 million in grants to expand our medication-assisted treatment (MAT) outpatient programs. We are focused on the underserved and the previously incarcerated, including having some monies available to provide residential sober living. The reason I'm mentioning this is to collaborate with anyone who is interested. We also have a graduate medical education psychiatry residency program here in Stockton that provides a tremendous opportunity to provide

training for residents. We want to be able to take part as a nonprofit partner in the execution of programs. I'm excited to be able to partner and accept referrals given the funding to cover the cost of treatment as well as residential opportunities, and having a great opportunity to be a proving ground for programming.

Stacie Hiromoto, Racial and Ethnic Mental Health Disparities Coalition: I strongly support the comments of Kiran Savage-Sangwan of CPEHN regarding the mobile crisis centers and taking into consideration communities of color and other underserved communities' fear of calling the police. I want to thank Hector Ramirez for his comments regarding the peer certification process. I went to a couple meetings this week and heard what was going on with SB 803 and the peer certification process. I just found out there are community input sessions taking place in October and it's already the third week. I do not believe that organizations that serve underserved communities of color and LGBTQ communities have been made aware. The CalMHSA stakeholder advisory council has no requirements for cultural competence or slots for people who are experts in reducing disparities. As Poshi Walker said, just because you're of a certain community doesn't mean you know how to reduce disparities or how to serve that community. I'm extremely concerned that the peer certification process will not be culturally competent and will not reduce disparities. Lastly, on the student mental health and other projects, I'm concerned that we are talking a lot about evidence-based practices. If evidence-based practices are utilized, the provider and program must prove that they will be serving children, youth, and family from communities of color and LGBTQ communities. Programs utilizing community-defined practices should be weighed equally or even prioritized over those utilizing evidence-based practices.

Tara Gamboa-Eastman, Steinberg Institute: I want to thank DHCS for the $20 million commitment for 988. We know that 988 is coming online and while the broader framework is being worked out in the legislative framework of AB 908, I'm grateful that that investment was made. I also want to lift up and thank Kiran Savage-Sangwan and Vitka Eisen for their comments. The racial justice component is so essential. We know that people don't feel safe calling 911, one in four police shootings are of people with a mental illness, and we need to create a true alternative to 911 for mental health crises. We are looking forward to continuing to work with DHCS and everyone on the call today to build out that framework.

Jeff Farber, LA Youth Services Policy Group: We commend DHCS for the achievements over the last year and the steps toward enhancing our behavioral health services system. It's been an incredibly challenging time over the last 18 months, and the work you have done is incredible. I want to echo the comments of Dr. Tsai and Kelly Pfeifer regarding the continuous push to ensure BH parity for SUD treatment services. As a provider of mental health and SUD services, we recognize the need for a coordinated and integrated system of care. I want to ask whether the recent signing of AB 638 by Governor Newsom opens the opportunity for dedicated SUD services as part of the Mental Health Services Act (MHSA). Will DHCS be directing counties to partner and share funding resources with SUD treatment providers as part of the MHSA plan moving forward?

Lilyane Glamben, Contract Program Resources: I was at the very first meeting held at The California Endowment in 2019, and it is amazing how much you've accomplished. I want to acknowledge my colleagues, especially Stacie Hiromoto, and underscore everything she said, especially around community-defined practices. Also, something that was noticeable

at that first meeting is that, of the 25 plus folks on the committee, there was not one person of African American descent, and I can see you've been addressing that. I want to make this pitch as you roll out stakeholder engagement strategies: do not ignore the breathtaking disparities and disproportionality of African Americans. We are overrepresented in homelessness, formerly incarcerated, and foster care, and we know the traumatic connections. I would highly recommend a population specific stakeholder outreach strategy, with partners and CBOs to address these disparities. You ignore this to the detriment of all that you're trying to do. You have wonderful things underway and it would be a shame if this issue of disproportionality is not addressed in a way that involves us.

Katrina Copple, CalVoices: On the mobile crisis teams, as we start working within different counties, will there be a focused effort to make sure that the peers who work on mobile crisis teams connect with individuals in the communities to be peer trained or peer certified through the state certification beginning in January?

Steve McNally, Orange County: I am on a county-appointed Behavioral Health Advisory Board. My comments are my own. I appreciate many of you for your transparency, openness, and honesty in speaking up. I think that, as close as you are to the families and the loved ones who use the system, the line between you and us is filled with blockers - people who don't believe in community engagement or don't practice community engagement. I'm confused on mobile crisis, not because what you presented was confusing, but we have cities using CARES Act and American Rescue Act grant money; we have counties with funding; we have so many people doing different things, and none of it includes the community. We need your help to open eyes that the community matters.

Ben Avey, Wellspace Health: Thank you DHCS for all the work around 988, and the funding that you have allocated to crisis centers. It is key and will help us scale up and be even more prepared for when 988 goes live in July 2022. As Michelle mentioned, there is no long-term sustainable funding for 988 and the services. I think that we made great progress on AB 908 this past year, and we hope to get it across the finish line next year, because we do not have room to wait. We are very excited to see the counties getting involved with suicide prevention this past year with 988, and hope that we will come up with a system that builds on the structure that's been there for decades, builds on our experience, and builds on our work to truly expand to many more people that need to get served. We are grateful to have that opportunity and look forward to continuing to be the foundation of suicide prevention and crisis support in our local communities.

Plans for 2022 Meetings, Next Steps, and Adjourn
Michelle Baass, DHCS

Thank you for the discussion today. We appreciate everyone's partnership, dialogue, and feedback as we work to improve the many initiatives we discussed. The 2022 SAC dates are scheduled. The February meeting will be virtual, and we will decide later about how the following meetings will be held, whether virtual, hybrid, or in person. I want to thank you all for your participation today and for the warm welcome to my tenure.

- February 17, 2022 – 1:30 p.m. – 4:30 p.m.
- May 12, 2022 – 9:30 a.m. – 12:30 p.m.

- July 21, 2022 – 1:30 p.m. – 4:30 p.m.
- October 27, 2022 –9:30 a.m. – 12:30 p.m.