DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

November 15, 2022

11:30 a.m. – 12:45 p.m.

Virtual Meeting

BH-SAC MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Jei Africa, Marin County Health Services Agency; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, SEIU; Veronica Kelley, San Bernardino County; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health Plans of California; Cathy Senderling, County Welfare Directors Association of California; 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; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Kirsten Barlow, CHA; Ken Berrick, Seneca Family of Agencies; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Laura Grossman, Beacon Health Solutions; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Andy Imparato, Disability Rights California; Karen Larsen, Steinberg Institute; Robert McCarron, California Psychiatric Association; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jolie Onodera, California State Association of Counties; 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; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program; An-Chi Tsou, SEIU.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Tyler Sadwith, Janelle Ito-Orille, Marlies Perez, Erika Cristo, Palav Babaria, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

Public Attending: 135 members of the public attended.

Welcome and Overview
Michelle Baass, DHCS Director

Baass welcomed members to a special session of the BH-SAC. The purpose of the meeting was to review the proposed California Behavioral Health Community-Based Continuum Section 1115 Demonstration (CalBH-CBC). CalBH-CBC builds on recent state investments to build out behavioral health services to reduce lengths of stays in institutions and maximize community-based care. The objective and vision are to support individuals in the least restrictive environment possible, improve transitions of care in discharge planning, and focus on high-quality and evidence-based practices. There is a focus on three populations: children and youth, persons experiencing homelessness, and justice-involved individuals.

California Behavioral Health Community–Based Continuum Section 1115 Demonstration *Tyler Sadwith, Janelle Ito-Orille, Marlies Perez, Erika Cristo, and Palav Babaria*, *DHCS*
Slides: https://www.dhcs.ca.gov/Documents/CalBH-CBC-Overview-Posting-11-15-22.pdf

Sadwith provided an in-depth overview of CalBH-CBC, which supports adults with serious mental illness (SMI) and children and youth with serious emotional disturbance (SED). He noted that DHCS plans to submit the CalBH-CBC demonstration to the Centers for Medicare & Medicaid Services (CMS) following a robust stakeholder process. DHCS does not consider this to be an Institution for Mental Disease (IMD) waiver. Sadwith also reviewed guidance and flexibilities issued by CMS that describe specific goals for IMD stays. Sadwith reviewed the vision and objectives and the proposed approach, including:

- Strengthening the statewide continuum of community-based services and evidence-based practices available through Medi-Cal, leveraging concurrent funding initiatives, and including clarifying coverage requirements for evidence-based practices for children and youth.
- Supporting statewide practice transformations and improvements.
- Improving statewide county accountability.
- Establishing a county option to enhance community-based services.
- Establishing a county option to receive federal financial participation (FFP) for services provided during short-term stays in IMDs.

Sadwith offered details of the continuum of care and each population of focus included in CalBH-CBC. He also described how the proposal is designed to complement existing state initiatives to build out the continuum of care for individuals living with SMI and SED. The waiver approach includes a two-pronged structure of statewide service

improvements and supports and additional demonstration components available as a county option.

Statewide Approaches:

- Clarification of evidence-based family and in-home therapies.
- Targeted improvements for youth in child welfare.
- Statewide practice transformation

County Options:

- Enhance community-based services, including Assertive Community Treatment, Forensic Assertive Community Treatment, Supported Employment, Coordinated Specialty Care for First Episode Psychosis, Community Health Worker Services, and Rent/Temporary Housing.
- FFP for short-term stays in IMDs that requires compliance with CMS and state requirements as well as implementing all new community-based services.

Sadwith reviewed a series of milestones that must be met for statewide and county opt-in services as outlined by CMS. He also outlined next steps, including the distribution of the concept paper for public and stakeholder review and written input through January 13, 2023. Subsequently, the draft 1115 waiver application will be posted for public comment, and DHCS will conduct webinar sessions. DHCS will then submit the CalBH-CBC demonstration to CMS, and there will be a federal comment period.

Discussion

Clark-Harvey: I am excited about many of the provisions in the proposal. The activity stipends and focus on justice-involved benefits and coordination with CARE Court are important. It is heartening to see support for counties to roll this out. What do the incentives for counties to opt-in look like? Will they be sufficient for a county to want to opt-in?

Sadwith: I can clarify the incentives and the value proposition for counties. First, DHCS will implement a county behavioral health performance incentive opportunity, regardless of whether the county opts-in to the waiver, so that counties can enhance their quality improvement infrastructure. Startup funding will expand capacities, such as data exchange and measurement reporting. In later years, the incentive would transition toward pay-for-performance that would not impact reimbursement, but would offer incentives based on improvement of clinical quality measures. The measures are consistent with the Comprehensive Quality Strategy in Medi-Cal, the 1915(b) waiver, and other measure sets. Additionally, counties would have the opportunity to cover community-based services, such as Assertive Community Treatment (ACT), as county options. Counties that opt-in to the IMD opportunity are expected to cover all new community-based services and would receive an incentive related to infrastructure.

Kelley: Can you clarify how counties might leverage existing Full-Service Partnerships (FSP) that are required as part of funding for the Mental Health Services Act (MHSA)? They were created to enhance ACT. Instead of opt-in for ACT and other programs, it seems there should be a way to leverage FSPs that have many of the requirements of ACT. In particular, if the target is homelessness, a key part of FSP is to ensure individuals with SMI are housed. I am concerned about workforce. When fully staffed, I would opt-in to support what the state is doing. Right now, I can barely meet current requirements and serve patients in care. We are experiencing a 30 percent staff vacancy rate, and contracted providers also don't have a workforce.

S*adwith*: The intersection of ACT and FSP is complex, and it may look different in each county due to the way counties have designed FSPs to meet the needs of their local communities. The concept for ACT is informed by the behavioral health assessment DHCS conducted and input from stakeholders. The goal is to maximize federal funding so that ACT is available in Medi-Cal and FFP can be accessed. This would free up MHSA funds previously used to support Medi-Cal reimbursable services so that resources can be reinvested in community-based behavioral health care. It is complex, and we look forward to ongoing discussion. There is no silver bullet on workforce, but we look forward to partnering with counties and provider associations on solutions.

Baass: On the workforce issue, the addition of community health workers as an optional benefit for counties provides the opportunity to add non-clinical workforce to county mental health plans that may extend the capacity of the clinical workforce. In addition to the statewide incentives and the county opt-in incentives, there is a cross sector incentive program for managed care plans (MCPs), county behavioral health departments, and child welfare departments to measure and reward the three systems based on outcomes of children in the child welfare system.

Cabrera: The opportunity to bring community health workers and unique housing options into county behavioral health, given the complexity of clients, is extremely important. When assessing the ACT models, we found that the main elements that are not Medi-Cal reimbursed are the housing and outreach and engagement components that may be covered by the optional benefits. There may be limited value to making the first episode psychosis a new benefit because most of the services can be covered by Medi-Cal. Historically, peers were not covered, but that will change with the new peer benefit. There is a lot included here, and I want to emphasize a need to streamline and to be judicious about expectations on IMD stays given the workforce challenges. On the incentive concepts, I want to flag that county behavioral health plans are not MCPs and are not able to hold profit; therefore, frontloading investments will be a challenge. We look forward to hearing more about how to phase this in as it will take time and workforce to build out new benefits like supported employment.

Veniegas: I appreciate the infographic with the spectrum of services depicting what is existing and new, and how it blends with other initiatives. Our learnings from the Drug

Medi-Cal Organized Delivery System experience are that some of the stays are for individuals with recurring episodes, and that makes the total cap of days quite a challenge. A related concept is that it took cycles of iteration and change over time to establish a more reasonable rate for stays.

Grealish: That was an excellent walkthrough. There are many justice-involved youth who are in both the justice system and in child welfare, and there are perhaps 20 percent of youth who are justice-involved, but not in the child welfare system. I want to flag that to know if there is a way to include those youth and the probation system as well. In the homeless category, it included people with SMI, and I want to clarify that SED is covered given the co-occurring population for people who are unhoused. Housing is a challenge, and there may be an opportunity to bring the housing and development sector into the conversation given the significant resources available for new housing. On the county opt-in milestones, is there an opportunity to have a milestone related to reducing the prevalence of people with behavioral health conditions or co-occurring mental health in jails and prisons?

Lewis: I want to highlight some of our concerns. There is continuing opposition to the use of IMDs in California, particularly for children and youth, and we don't think institutionalization is a model of care that should receive additional investment. There are opportunities to accomplish this without seeking IMD waiver approval, and we want the state to focus on the obligations under Early and Periodic Screening, Diagnostic, and Treatment for services not provided statewide. There is data that the lack of services results in over-reliance on institutionalization or hospitalization. A county-by-county incentive approach is missing the opportunity for a statewide approach to Medicaid, including services for all adults where they live. We would like to see detail on the funding incentives as it is not clear what is considered Medicaid, what is not Medicaid reimbursable currently, what requires a waiver, and what the waiver funds will be used for. We want to understand what is being incentivized, particularly for non-traditional services that should be provided, such as equine therapy. Many of the services can be covered without federal approval or a waiver.

Senderling: We are pleased about the robust engagement and opportunities for feedback. We appreciate the connection between mental health plans, MCPs, child welfare agencies, and other cross-sector connections, such as developmental disabilities. It will be important to think through the expectations, roles, and opportunities across our different agencies. Also, there is $5 million in the state budget for substance use disorder (SUD) pilots for children and youth in foster care. We look forward to partnering to build capacity for SUD services and co-occurring disorders for children and youth through the services proposed in the concept paper and appreciate the inclusion of a foster care liaison for MCPs.

Public Comment

Alison Monroe, Alameda County Families Advocating for the Seriously Mentally Ill:

Many of us have family members, mainly adults, who cycle between homelessness and jail. They have drug abuse issues. They often have anosognosia. They don't believe they are ill, so they aren't present at discussions like this, and we have to advocate for them. I came to this meeting because I heard we were finally going to ask for an IMD waiver for the seriously mentally ill. Instead, there's a very complicated proposal with all kinds of incentives for counties to do this and that. What I would like to see is not counties opting in or out, but for the state to ask for money so that we can pay people to take care of our family members in IMDs, both locked and unlocked, because they are saving lives, and they have saved my daughter's life. They are very expensive, and they are thinking about discharging my daughter to another county to deal with the economic problems she causes. Our family members move from county to county when they're homeless and in jail. They need to be kept alive, and it is expensive. There is federal money to keep them alive. As a state, we should ask the feds for the money and get a waiver of the IMD exclusion for serious mental illness. Thanks.

Angela Vasquez, The Children's Partnership: We urge DHCS to consider how this waiver might help end the practice of out-of-pocket expenses for court-ordered behavioral health services for parents with child welfare involved children. While not necessarily justice-involved, these adults are absolutely system involved and have children who are categorically eligible for specialty mental health services. The reality is that racialized poverty is one of the primary root causes of child welfare involvement. If the state is serious about family preservation and reunification as the best outcome for children, we must recommit supporting their families of origin. Second, I urge DHCS to consider crafting a waiver that is inclusive of future policy opportunities to expand peer support, including state certification for youth under age 18. DHCS is in the process of subcontracting with The Children's Partnership to implement a $10 million high school peer support program to establish best practices across the state. We hope the state will be supportive of policy options that will extend certification to youth under age 18. Finally, I hope that DHCS would consider developing opportunities to expand primary, upstream universal prevention, particularly for early childhood mental health programs. These programs are not necessarily conducive to a billable acute need, but are upstream prevention to support whole classrooms of young children who are Medi-Cal enrolled or who are likely Medi-Cal enrolled, particularly subsidized childcare and preschool programs. Thanks so much.

Lindsay Schachinger, Alameda County Families Advocating for the Seriously Mentally Ill: I am a family member and I also thought this was going to be about the IMD exclusion waiver. I feel that it is crucial to providing appropriate care for our most vulnerable people, those with SMI. It will save lives, and we need to have it statewide, not on a county-by-county basis.

Theresa Comstock, California Association of Local Behavioral Health Boards and Commissions and a member of the State Rehabilitation Council that advises California's Department of Rehabilitation: There are three areas I want to comment on. First, to show improvements in community-based mental health care, you must consider what's

going on with board and care facilities. We know that the Department of Social Services is now tracking the closures for people with SMI in board and care. Hundreds of facilities are continuing to close, and thousands of people are losing their ability to stay in those facilities as part of the continuum of housing or the continuum of care. In terms of employment, I was glad to see that is incorporated in your thoughts, although I don't see people engaged with employment here as participants today. The Department of Rehabilitation and their staff should be part of the conversation that would also include the California Association of State Rehabilitation Agencies since they have experience braiding funding from multiple sources to provide employment services. Within California, there are currently 19 mental health cooperatives, which are behavioral health agencies that have a cooperative agreement with the Department of Rehabilitation to provide employment services. We know that it would be great if they were billing Medi-Cal. There may be billing for some of the services, and I want to make sure that they are part of the conversation. I saw in the federal guidance document that there could be a Medicaid buy-in for people with income higher than allowed for Medi-Cal so they could buy in and continue with their current providers. Finally, also in the federal guidance, I saw that psychiatric advance directives is one of the items that could be billed or provided, and that that it is an important tool.

Douglas Dunn, family member and member of the Contra Costa Mental Health Commission: I don't see lived experience or family voices represented in this group from either the children and adolescents or the adult perspective. Yes, I am talking about everything, including the IMD waiver, which needs to be statewide and not just county opt-in. We have a loved one with a SMI. He is in a one-year renewable conservatorship, but at the same time he's been in a hospital psychiatric ward for three months. That's a SMI situation. How will the proposed waiver cover situations like that? That is something that needs to be looked at for thousands of families and loved ones across the state. Thank you.

Elizabeth Kaino Hopper, Sacramento region volunteer and member of an Advisory Board for Sacramento County Behavioral Health: I'm encouraged about this alternative funding, and I think it will likely help with programs we are trying to launch. At the same time, I'm very well aware that Sacramento County has a Board of Supervisors meeting coming up on the topic of a new jail annex. Many residents are suggesting the possibility of not having a jail be a setting for psychiatric treatment and are interested in building or expanding IMD beds. My concern is whether, knowing that this is on the horizon, this will be helpful. I am concerned about our needs for expanding housing units that could divert people from jail who are being held incompetent to stand trial or other psychiatric needs that go beyond 15 days, 30 days, 60 days. Funding could be available to us. It sounds like that would be contingent on participating in the 1115 waiver. At the same time, I see there is a possibility that there may be a need for the IMD expansion, especially with criteria for reducing the wait list for state hospitals. I was thrilled to hear there was inclusion of the forensic side. Thank you very much.

Tori Casanova, Families Advocating for the Seriously Mentally Ill and NAMI: I am the

mother of a son with SMI. He has fluctuating insight and suffers from anosognosia at times. When in crisis, he goes AWOL from all voluntary services. I support the full repeal of the IMD exclusion. I would not like arbitrary inpatient day limits, and California should file for the statewide waiver. We are told all the time that our children cannot get help in our hospitals. They are constantly being prematurely discharged. We are told it is because of a lack of funding, and we are often advised the only way we can get them help is if we could manage to get our children incarcerated. This is just unacceptable, and we need to properly fund our IMDs. Thank you.

Next Steps

Baass extended thanks to all who participated in the conversation. She commented that DHCS appreciates the engagement and looks forward to receiving comments and feedback on the proposal, as well as future discussions. The CalBH-CBC concept is available online.