Systems and Medicaid Committee March 2020 Letter to DHCS Re: CalAIM Initiative

California Behavioral Health Planning Council

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- Advocacy
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March 4, 2020

Jacey Cooper, State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue Sacramento, CA 95814

Dear Ms. Cooper:

The California Behavioral Health Planning Council thanks you for the opportunity to comment on the proposed changes to the Medi-Cal waivers and California Advancing and Innovating Medi-Cal (CalAIM) Initiative. Pursuant to state law, the Council serves as an advisory body to the Legislature and Administration on the policies and priorities that this state should be pursuing in developing its behavioral health system. Our membership includes persons with lived experience as consumers and family members, professionals, providers, and representatives from state departments whose populations touch the behavioral health system. Their perspectives are essential to our view on the challenges and successes of behavioral health services and best practices in California.

The Council's Systems and Medicaid Committee (SMC), in collaboration with various stakeholders across California, have evaluated barriers to effective care in California's public behavioral health system and created recommendations for the CalAIM Initiative. In October 2019, the SMC hosted a stakeholder forum with the goal of gathering stakeholder input on how to improve California's behavioral health system and sharing these with DHCS. We've incorporated some of that feedback in our comments below. The SMC supports the CalAIM Initiative as it strives to improve quality outcomes through payment reform and value-based strategies, increases flexibility and reduces complexity in the current system.

Given the mass changes that the CalAIM is considering, the SMC felt that it would be more appropriate and time-effective to provide comments in two specific areas, Medical Necessity and the Administrative Integration of Mental Health and Substance Use Disorder Services as they impact the immediate and proper care of individuals with behavioral health conditions. We believe the following recommendations will strengthen these proposals to ensure consumers of the public behavioral health system are able to access and receive high-quality services to lead full and purposeful lives.

These recommendations encompass providing culturally appropriate and competent care with respect to all populations including but not limited to immigrant and refugees, children and families, LGBTQI2S and ethnic populations.

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Recommendations for Medical Necessity

The SMC recommends the following changes to improve the Medical Necessity proposal:

1) Support the proposal to amend Medical Necessity requirements to enable providers to deliver and be paid for services prior to determining a diagnosis.

2) Strongly recommend that the No Wrong Door policy be applicable to both adults and children.

3) Support the No Wrong Door approach by allowing care to be provided and paid for at the initial health setting that the client presents to receive care to mitigate the "ping-pong" effect of moving individuals between Managed Care Plans (MCPs) and County Mental Health Plans (MHPs).

4) We recommend the following to generate a true No Wrong Door approach for client transitions between systems of care:

    - Create statewide standards to operationalize warm-handoffs and referrals in the Memorandum of Understanding (MOU) between MCPs and MHPs.

    - Use Health Information Exchanges (HIEs) for client information sharing.

    - Implement a transition process that includes client agreement and active communication between providers through the use of a lean standardized transition tool.

5) Implement a lean standardized assessment tool to prevent duplicative assessments and re-traumatizing of clients when determining the appropriate level of care for a client.
    - We recommend the assessment tool be equipped with the option for providers to include additional elements to the assessment.

Recommendations for the Administrative Integration of Mental Health and Substance Use Disorder Services

The SMC recommends the following changes to improve the Administrative Integration of Mental Health and Substance Use Disorder Services proposal:

1) Strongly recommend the implementation of statewide peer specialist certification and training for community mentor programs.

2) Allow licensed providers to deliver both mental health and substance use disorder services if they possess the education and training to treat multiple diagnoses.

3) Increase flexibility for the provider enrollment process and reduce the rigidity for provider enrollment applications.
    - We support DHCS increasing resources and staffing to reduce the backlog in enrolling and licensing providers.

4) Implement a statewide integrated data system and provide technical assistance to counties and community-based organizations to transition into one system.

5) Streamline licensing reviews in facilities for mental health and substance use disorder services simultaneously.

Reasoning for Medical Necessity

Please find below details regarding our suggestions for improving the Medical Necessity Proposal.

1. Support the proposal to amend Medical Necessity requirements to enable providers to deliver and be paid for services prior to determining a diagnosis.

Requiring a diagnosis directly correlated to eligibility within a particular system often causes confusion and misinterpretation that may restrict a client's access to care and lead to disallowed claims. We support the proposal as it would expand access to care and allow providers more time to determine treatment options before diagnosing a client, which can lead to better treatment outcomes. Additional time allows for the provider to conduct assessments and explore the client's symptoms, risk factors, and level-of-functioning to validate their diagnosis after the initial appointment takes place. Additionally, the provider may be incentivized to deliver value-based care when payment is ensured.

2. Strongly recommend that the No Wrong Door policy be applicable to both adults and children.

The No Wrong Door approach aims to mitigate the bifurcation of the behavioral health system and allow clients to access care at any entry point. This will help ensure services are received more immediately and without the risk of losing the client through the process.

All individuals should have access to care wherever they present in the system. Families should be considered in the treatment process to reduce potential feelings of isolation and trauma that may come from separation as the client moves through various levels of care.

3. Support the No Wrong Door approach by allowing care to be provided and paid for at the initial health setting that the client presents to receive care to mitigate the "ping-pong" effect of moving individuals between MCPs and MHPs.

When a client currently presents in a care setting and needs to be triaged into a different care system, the provider will refer this individual to what they believe is the appropriate care setting. This becomes problematic if the new provider rejects the referral and sends the client back to the system in which the client originally presented, thus creating a "ping-pong" effect and contributing to lack of access and negative outcomes for the client.

The No Wrong Door approach has the capacity to avoid a back-and-forth effect between services provided in MCPs and MHPs as it allows for services to be provided through multiple entities and varying levels of care simultaneously. We support the ability for clients to receive care through multiple care settings and recommend that MCP and MHP entities are in active communication to ensure non-duplicative services as outlined in their Memorandum of Understanding (MOU).

To strengthen the No Wrong Door approach and mitigate the "ping-ponging" between systems of care, we agree with DHCS' proposal to allow providers to deliver and be paid for services in the initial care setting while triaging clients to the appropriate system of care, before a diagnosis is determined. We support the use of a standardized screening tool to be used before triaging to different care systems and request that MOUs between MCPs and MHPs include details on how information will be shared across systems and providers.

4. Generate a true No Wrong Door approach for client transitions between systems of care.

It is common for a client's symptoms to improve or worsen throughout the course of treatment. In attempting to navigate the bifurcated behavioral health system, clients may find themselves lost in the transition process

between MCPs and MHPs when the systems themselves do not communicate or have standardized procedures in place for warm hand-offs and client information sharing. This often results in barriers to access as well as negative health outcomes for the client who is unable to maneuver successfully through complex and disconnected systems.

In order to ensure successful client transitions, we recommend that the state develop standards detailing the elements that must be included in the Memorandum of Understanding to facilitate referrals. The MOU between MCPs and MHPs should include a detailed plan on how they will work to triage clients who move between levels of care or receive their care at both MCPs and county systems. This includes a process to allow for warm hand-off referrals between MCP contracted providers such as community clinics and county providers.

We recommend the use of Health Information Exchanges (HIE) to facilitate communication between MCPs and MHPs. HIEs can increase collaboration between multiple systems to improve timeliness and access to services.

We recommend the following guidelines to ensure a successful transition process:

- The therapeutic alliance between a provider and client is unique. Therefore, we support the requirement for client agreement to change providers before a transition process is initiated (as outlined in the instructions for Sacramento County's Bi-Directional Medi-Cal Transition of Care Request Form).

- The clinical impression of the provider following an assessment of the client's current symptoms, risk factors, and level of functioning should be determined prior to transition. We support the use of a lean standardized assessment tool containing core elements to assess level of functioning to ensure that providers across systems have similar determinations of the client's level of impairment.

- Active communication between MCPs and MHPs is necessary to ensure continuity of care during client transitions. We recommend that the state develop standards detailing the elements that must be included in MOUs to facilitate referrals. Health information exchanges can also facilitate communication between MCPs and MHPs and increase collaboration between multiple systems to improve timeliness and access to services.

- We support DHCS' proposal to standardize the Sacramento County Bi-Directional Medi-Cal Transition of Request Form as the transition tool between providers in different systems of care.

- To ensure continuity of care, providers should be required to obtain the client's first appointment information during the transition process.
- A patient-signed disclosure document should be implemented to ensure that client information is protected during transitions. This document would allow for information sharing solely on items that the client feels comfortable disclosing to new providers.
- Clients should be able to move their own health record during the transition from one provider to another.

5. Implement a lean standardized assessment tool to prevent duplicative assessments and re-traumatizing of clients when determining the appropriate level of care.
The SMC would like providers to have the option to ask more information from clients if the assessment done by the previous provider does not already include those details.

We support the implementation of a lean standardized assessment tool shared between MCPs and MHPs which would include a section for clinicians to include their own elements to the assessment as needed. Standards for the assessment tool should reiterate the minimum data elements needed by the state with the option to add to it as needed. We also request that DHCS field staff and compliance be trained to understand the tool to clearly differentiate added elements. We request that entities are only held to the core standards in the assessment tool.

To ensure sensitivity to client needs, we recommend that providers inform clients of the information that will be shared if a transition between the systems of care is initiated. Clients should be given the opportunity to choose what sensitive information they would like to disclose such as immigration status (if shared) or sexual orientation.

Reasoning for the Administrative Integration of Mental Health and Substance Use Disorder Services

Please find below details regarding our suggestions for improving the Administrative Integration of Mental Health and Substance Use Disorder Services Proposal.

1. Strongly recommend the implementation of statewide peer specialist certification and training for community mentor programs.
The use of peer specialists embodies community-based recovery and is a natural and cost-effective resource. Therefore, we support statewide peer specialist certification programs. In addition to peer specialists, community leaders and mentors should receive training to support individuals who

reside in cultural and rural communities. Models such as the Promotoras Project and Friendship Bench are examples of these community mentor programs.

2. Allow licensed providers to deliver both mental health and substance use disorder services if they possess the education and training to treat multiple diagnoses.

Licensed providers are often equipped with the skills to provide treatment for multiple conditions but are only able to provide treatment for a primary diagnosis. This can be problematic if a client presents with a secondary diagnosis because the provider must defer to another agency to provide that service. To help ensure a successful No Wrong Door policy, licensed providers should be able to provide all services that reside within their clinical scope.

We recognize that a level of specialization is needed to provide adequate treatment. We recommend that providers be trained to deliver a wide range of services while maintaining a level of specialization and refer to higher levels of care when needed.

3. Increase flexibility for the provider enrollment process and reduce the rigidity for provider enrollment applications. We recommend that DHCS increase resources and staffing to reduce the backlog in enrolling and licensing providers.

Counties face challenges in meeting network adequacy requirements when there is an insufficient quantity of qualified providers registered to deliver services. It is recommended that DHCS reduce the stringent review of provider enrollment applications involving minor errors that result in rejected applications. The provider enrollment process should be shortened and simplified with added flexibility so that providers do not wait years before they are enrolled. We support DHCS increasing resources and staffing to reduce the backlog in enrolling and licensing providers.

4. Implement a statewide integrated data system and provide technical assistance to counties and community-based organizations to transition into one system.

Currently, the separate data systems and confidentiality rules around protected patient health information pose challenges to coordinate care for clients. To improve care coordination across systems, we recommend the implementation of a statewide integrated data system. Electronic Health Records should be used in a way to track data and reduce duplicative data entries. Standardized questionnaires may help providers collect data and measure outcomes as well.

We encourage DHCS to help counties and health plans navigate 42CFR confidentiality requirements for substance use disorder services so that client information can be shared while protecting client confidentiality.

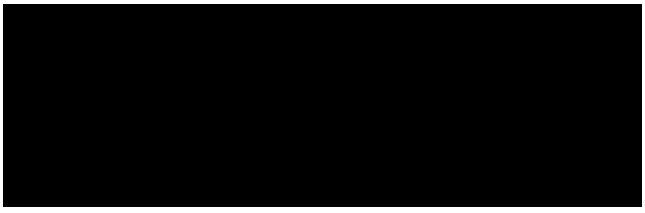
The shift from the current administrative processes may create challenges for current staff in county behavioral health departments and community-based organizations to adapt to new processes proposed in the CalAIM Initiative. Technical and financial assistance should be provided to counties and cultural communities to assist with the merging of administrative processes to reduce any confusion or backlog that may occur with the transition.

5. Streamline licensing reviews in facilities for mental health and substance use disorder services simultaneously.
Under the current system, it can take several years to license providers and behavioral health facilities to provide care to clients with high-level needs for care. Therefore, the process to license facilities should be streamlined for both mental health and substance use disorder services. It is also critical to recognize that mental health and substance use disorder services are not integrated in nature but rather two issues that are closely tied together.

We hope that the recommendations put forth in this letter are taken into consideration as the Department of Health Care Services makes amendments to the CalAIM Initiative. We appreciate the opportunity to submit comments, and ask to be included in conversations hosted on this topic. If you have any questions, please contact Jane Adcock, Executive Officer, at Jane.Adcock@cbhpc.dhcs.ca.gov.

cc: Kelly Pfeifer, M.D., Behavioral Health Deputy Director
California Department of Health Care Services

Sincerely,



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