DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

Hybrid Meeting

February 15, 2024

1 to 3 p.m.

BH-SAC MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Kirsten Barlow, California Hospital Association; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Vitka Eisen, HealthRIGHT 360; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, Service Employees Service Union; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Samuel Jain, Disability Rights California; Meshanette Johnson-Sims, Carelon Behavioral Health; Veronica Kelley, Orange County; Linnea Koopmans, Local Health Plans of California; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law Program; Hector Ramirez, Consumer Los Angeles County; Jason Robison, SHARE!, Kiran Savage-Sangwan, California Pan-Ethnic Health Network; 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; Angela Vasquez, The Children's Partnership; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Jei Africa, Marin County Health Services Agency; Ken Berrick, Seneca Family of Agencies; Dannie Cesena, California LGBT Health And Human Services Network; Jessica Cruz, NAMI; Eileen Cubanski, County Welfare Directors Association of California; Steve Fields, Progress Foundation; Sarah- Michael Gaston, Youth Forward; 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.

DHCS Staff Attending: Michelle Baass, Palav Babaria, Tyler Sadwith, Brian Fitzgerald, Paula Wilhelm, Ivan Bhardwaj, Erika Cristo.

Public Attending: There were 186 members of the public attending in person and virtually.

Welcome, Roll Call, and Today's Agenda
Michelle Baass, DHCS

Baass welcomed BH-SAC members.

Behavioral Health Payment Reform Update
Tyler Sadwith and Brian Fitzgerald, DHCS
Slides available: https://www.dhcs.ca.gov/Documents/021524-SAC-BHSAC-Meeting-Presentation.pdf
Fitzgerald provided background for the discussion of the Behavioral Health Payment Reform initiative. He noted that psychiatric inpatient rates were studied based on cost information and

market trends and determined to be insufficient. DHCS submitted a new State Plan Amendment to the Centers for Medicare & Medicaid Services (CMS) in December 2023 that makes changes to allow counties to negotiate new rates with contracted hospitals.

Sadwith commented that behavioral payment reform is a significant change, and DHCS is working closely with counties and providers to maintain access to care during the early implementation and transition period. He outlined steps counties can take to protect and prioritize access to care as well as considerations for rate setting that were communicated in a letter to counties. The letter reminded counties of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate, including but not limited to intensive care coordination, intensive home-based services, and Drug Medi-Cal (DMC) Organized Delivery System services and DMC services in DMC counties. The letter reinforced existing network adequacy requirements, particularly standards for timely access to care services. Sadwith reported that county Mental Health Plans and Drug Medi-Cal Organized Delivery Systems are required to report significant changes in the provider network, and three counties filed significant changes associated with payment reform. DHCS developed principles for rate setting and contract and rate negotiations, including recognizing that clinic-based models of care delivery naturally have higher productivity rates than in-home or field-based models of care and that the rates should reflect productivity rates inherent to care models.

Fitzgerald reviewed an example of how the rate methodology works. For example, DHCS included a price elasticity of labor adjustment to deal with high vacancy rates at the county level. He then introduced county and provider guest speakers to discuss their experience with payment form.

Katy Eckert, Monterey County Behavioral Health Bureau Chief/Behavioral Health Director, shared highlights of contract and provider discussions in Monterey County. She commented that conversations started early, focused on transparency, and included provider and staff training. The county emphasized the interdependence of partners and services and collaboration needed to create a system of care. Discussions also highlighted the opportunity to earn additional federal dollars, and Eckert made a commitment to providers to pass through additional federal dollars to reinvest in priority areas. She commented that Monterey tailored the rates for each provider based on data from past experience, cost reports, and other tools, and committed to maintain the same level of county funding as the starting point, while also including considerations for programs requiring travel and field work. She noted that the bridge year has been very helpful to the transition. Eckert reported that substance use disorder providers are exceeding initial Medi-Cal service expectations. Generally, providers express appreciation for the process and are partnering with the county to explore innovative ways to increase services and funding opportunities together. Eckert noted they are thinking as partners about how to deliver the services that the community needs.

Sherri Terao, Santa Clara County Director of Behavioral Health, spoke about their experience with the payment reform transition to a new rate structure and fee for service billing. Even with 18 to 24 months of joint planning and preparation, the transition has been challenging. Prior to implementation, the county retained Optumas, a health care economist and actuary firm, to assist with rate setting and rate development. There was an extensive data gathering process with contract providers. Then, Optumas met individually with each provider to review the data, including staffing, wages and benefits, productivity, and indirect and operating expenses. The county developed rates by provider type, recognizing that some are community-based, and some are more intensive, then added a differential on top of the base rate for each intensive service delivered. The county is monitoring closely to assess service volume, claim submission, productivity, program operations, and the financial health of each contract provider and their broader system of care. The county offered a second cash advance in October as the transition began because many agencies were still configuring billing systems. The county recently agreed with providers that it would make sense to reanalyze data for the first half of the fiscal year and is currently working with Optumas and

providers to develop a framework for fiscal year 2025-26 rate setting that includes a level of care analysis and rate differential to address the need for intensive community-based treatment models with additional incentives for outcomes beyond productivity.

Dawan Utecht, Telecare Senior Vice President and Chief Development Officer, offered remarks as a provider in multiple counties. She commented that Santa Clara County already had a practice in place for dosages based on levels of intensity related to the amount of care delivered to the client in recognition that more care is needed for some populations. That was helpful to providers and enabled the county to create the rate premium structure they are implementing. The experience of working with Optumas to review the cost information used to establish the rates was also helpful in that initial phase. One of the biggest challenges is outreach and engagement, which is addressed through the rate premium in Santa Clara County. The misperception that Medi-Cal no longer pays for travel and documentation leaves providers thinking there is a disincentive to pursue clients who are difficult to engage. It can take extensive effort to locate people, and that is where rates become problematic. She spoke about their work to analyze outreach and engagement, such as the level of effort needed, the number of attempts to find people, and what collateral information is being utilized to locate them. She offered information about collaborative documentation where they document care alongside the person served. She also talked about their use of geo mapping to assign clients to geographically based teams that reduces travel.

Questions and Comments

Lewis: It was great to have this on the agenda. I want to applaud DHCS for the letter to underscore the obligations in Medi-Cal, particularly for youth under EPSDT. That obligation permeates the rate issue to ensure an adequate network of providers, especially the home and community-based services, where going to schools and other venues is important to locate and engage kids and families. I appreciate the creativity being described to make sure services happen equitably, whether in homeless, foster care, or other systems, and not use a one-size approach.

Stoner-Mertz: We also appreciate the letter to mental health plans (MHPs). Our Monterey County providers agree that things are going well, but that is not a universal picture across the state. There are vast differences, depending on the counties and capacities. Some providers are struggling and may end this year in serious financial situations. I am glad to hear about Santa Clara County's practice of a mid-year review as a strategy that may alleviate this. I want to emphasize the need for support for technical assistance (TA) and training for providers as well as counties. This is a huge lift, and most importantly we want to make sure services are provided, especially in places where it takes time and travel to reach clients.

Cabrera: This is a significant transition, and it is interconnected with other simultaneous changes, such as the coding transition. Many counties and providers are transitioning to electronic health records as well. There are smaller contract providers who have narrower margins and counties with a lower tax base or other sources of funding to do all the things that were described by Santa Clara County. We are providing extra TA and support for county partners through the County Behavioral Health Directors Association of California and want to support providers as well. There are places where the providers have resources or capacity to identify ways to tackle issues, like no-shows, and collaborate with the county to document a request for more funding. Counties are beginning to review some contracts because the provider is generating so many services that they need to exceed the contract cap and that demonstrates how this can be a win-win. Counties need information and collaboration from providers to change payments. There are many lessons learned and more to do moving forward to adjust as we go.

Harris: I want to go back to a problem identified earlier - the minimum wage increase. Clients need continuity of care. We need to provide decent wages to stop turnover and have continuity of services

and high-quality services. We don't factor in the external costs associated with paying minimum wage. Getting food stamps, Medi-Cal, and other government services must be added into the cost of a person working with poor pay. This is not about finding blame, but we do need to fix this part of the system by paying people who provide the services.

Clark Harvey: The DHCS letter provided important clarification for everyone. Additional communications like that letter would be helpful. I also appreciate the advice and practices DHCS shared about adjusting rates in real time. Having more TA and webinars and doing that together makes us a stronger safety net. I'm glad that DHCS is tracking closures and I want to add that sometimes it's not that the whole agency, but specific programs that are being closed and that is important too, because they may be key programs in a community. California Council of Community Behavioral Health Agencies members would like to hear more lessons learned, like the comments on innovation for outreach and engagement, the cash advances, and re-analyzing data as we heard today.

Teare: What is the level of transparency on the significant changes in provider networks. Is there a report coming where we might see how that changed over the first six months or the first year? How might we understand the impact of the changes?

Sadwith: The reporting of significant change in the provider network is not something that DHCS posts publicly, but the network adequacy certification data is available. That information shows initial filings, any associated corrective action plans, and the final assessment. It is an indication of how network adequacy and provider networks change over time. Also, to the previous comment, when we request information on risk of closure, we do include programs and services, not just the agency level.

Quality and Population Health Management (QPHM): Overview and Stakeholder Engagement for Behavioral Health Components

Palav Babaria, MD, DHCS

Slides available: https://www.dhcs.ca.gov/Documents/021524-SAC-BHSAC-Meeting-Presentation.pdf

Babaria reported that DHCS launched the Population Health Management (PHM) program in January 2023, including a strategic framework and specific contract requirements for PHM activities in MCPs. Alongside PHM, the state budget included the PHM Service, designed to bring together DHCS and other state-level data to provide a whole person, longitudinal record. The vision for the PHM Service is to support PHM functions, like risk stratification, segmentation, tiering, and some social drivers of health more broadly than Medi-Cal. It will include data across DHCS, including behavioral health, fee-for-service data, and some smaller programs to become a shared tool across systems. DHCS has aggregated data in a centralized data warehouse. The PHM Service aims to make the data accessible to partners for clinical care, but the PHM Service is not yet configured.

Babaria reviewed an example of how PHM tools can function to administer screenings and assessments, aggregate data from screenings and assessments, and make the data available across the system to replace the duplicative completion of information. The data will also offer a way to better predict the risk of members from a behavioral health, physical health, and social drivers of health perspective. Currently, there are manual processes to predict and identify people at highest risk in need of additional engagement or services. The PHM Service will bring a consistent, transparent, and statewide approach to risk assessment. Eventually there will be provider access because we know that members receive care in multiple systems and have multiple case managers who are unable to have a full picture. She noted that DHCS will release a timeline that outlines when different elements will launch. There will be robust stakeholder engagement with BH-SAC, plans, and providers as the initiative moves forward.

Questions and Comments

Lewis: I'm excited about the PHM Program and PHM Service. Have you thought about how to use

the PHM Service to get real-time responses from members about what they need via phone or text?

Babaria: The member portal is very exciting and difficult to configure and launch, so it will likely come later. It will be in all threshold languages, and there will be an app so that it can function as one-stop shopping for understanding benefits. We are starting conversations with state partners to link processes. For example, if someone recently gave birth and is eligible for paid family leave or Women, Infants, and Children (WIC), how might they navigate to the right place to sign up for benefits. There's also robust health education and health literacy tools planned for the portal. Through the California Advancing and Innovating Medi-Cal (CalAIM) demographic information project, we envision a role for the portal to be used by members to directly update demographic information that will streamline the process and result in better data.

Cabrera: When does DHCS anticipate that MHPs might have access to these data? Will the data be used to support our joint accountability measures with MCPs?

Babaria: We must configure and test the system and then come back to you with a timeline. Yes, there is a functionality for most core measures and Healthcare Effectiveness Data and Information Set (HEDIS) measures in the PHM Service. I envision there will be quality applications.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT): Evidence-based Practices and Child and Adolescent Needs and Strengths Alignment

Tyler Sadwith, Paula Wilhelm, and Ivan Bhardwaj, DHCS

Slides available: https://www.dhcs.ca.gov/Documents/021524-SAC-BHSAC-Meeting-Presentation.pdf

Wilhelm briefly outlined that BH-CONNECT is an initiative with a package of policy changes intended to strengthen the full continuum of care for members living with significant behavioral health needs. The presentation focused on new coverage for Asserted Community Treatment (ACT), Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), and the updated Child and Adolescent Needs and Strengths (CANS) tool. She reviewed the process and timeline for submission and approval of BH-CONNECT by CMS; DHCS' goal is to launch some BH-CONNECT components in January 2025.

ACT is one of several new evidence-based practices that counties will be able to opt in to provide and receive federal financial participation. California is developing the coverage policy and rates to ensure high fidelity implementation (i.e., to support service implementation that mirrors the models supported by research). ACT provides a person-centered, comprehensive approach to care for people with complex behavioral health needs delivered by a multidisciplinary team in the home or community. Fidelity is important because ACT reduces the need for more intensive and costly levels of care if implemented well. DHCS convened a workgroup of academic partners and teams already delivering ACT to gather input, such as team training, fidelity assessments, accountability, oversight, and monitoring. The workgroup also discussed creating a balance between fidelity to the evidence base and flexibility to operate ACT in geographies without economies of scale. She highlighted that DHCS will establish one or more Centers of Excellence for TA and learning across new benefits like ACT and CSC for FEP.

Bhardwaj provided context for CSC for FEP, noting that 100,000 youth experience a first episode of psychosis each year in the United States (US). Evidence shows that individuals were much less likely to develop serious mental illness later in life if they receive CSC for FEP. California set aside 11% of its Community Mental Health Services Block Grant (MHBG) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support evidence-based services. Other states have used Medicaid and MHBG funding to support components of CSC, but no states currently authorize CSC as a bundled service in their State Plan. Bhardwaj reported on Mental Health

Services Act (MHSA) and other funding that has been used for implementation in several California counties. University of California, Davis (UCD) provides a learning network, TA, and training (named California Early Psychosis Intervention (EPI-CAL) to scale CSC for FEP in 39 counties. DHCS intends to cover all elements of CSC for FEP as a county option and will offer incentives for meeting performance outcomes. California is pursuing a SPA for CSC for FEP. The service components to be covered may include assessment, medication management, individual, group, and family therapy, vocational educational support services, peer and family peer support services, and person-centered planning.

Sadwith outlined work by DHCS and the California Department of Social Services (CDSS) to align the CANS tool. CANS is a tool designed to guide conversations about the well-being of children and youth by identifying needs and strengths, supporting decision making and planning, and monitoring services and outcomes. Currently, child welfare and specialty mental health (SMH) use different versions of CANS and have different requirements. The first phase of work is to ensure alignment on the tool itself, its modules and questions, and its administration so it is consistent, whether conducted by SMH or Child Welfare Services. This will support effective service planning across the departments and systems. For example, there are differences related to the age range for youth who receive CANS assessments in each system. CDSS requires additional modules beyond what DHCS requires, and there are other differences in approach.

Wilhelm reviewed timeline milestones for implementation of the evidence-based practices and the Request for Information (RFI) for the Centers of Excellence. DHCS will develop and submit the SPA, solicit public comment, and then develop implementation and policy guidance. She highlighted stakeholder engagement already conducted and outlined future discussions with BH-SAC.

Questions and Comments

Stoner-Mertz: We are excited about the alignment of the CANS tool. In addition to different county departments doing CANS, providers frequently do this as well. How do we avoid assessing and reassessing youth and families over and over?

Sadwith: We want to ensure we take out any duplicative requirements and will look to the guidance to prevent unnecessary requirements. *Larsen:* Implementation of evidence-based practices happens because those practices are shown to improve outcomes. My question is about how we will track outcomes along with implementation. One of the mistakes we make when implementing these big changes is that we fail to identify the outcomes we want to track from the very beginning, so we can get the right data. Where does continuous quality improvement and TA come in on an ongoing basis with the implementation of these evidence-based practices?

Wilhelm: The continuous improvement and shared learning will be supported by the Centers of Excellence, which is the reason we issued the RFI early. They will play a key role in ensuring that counties and providers implement the practices successfully. I appreciate your points around evaluating outcomes. There are three incentive programs proposed in BH-Connect, and one of them incentivizes the adoption and successful implementation of the new practices. We are conducting informational interviews to learn about what key outcomes we should measure. Then we will tie that back to the Centers of Excellence to develop data and reporting structures.

Sadwith: In addition, I would highlight that 1115 demonstrations require an independent evaluation. As part of that evaluation, we want to know if interventions like ACT and CSC result in the outcomes that the literature shows.

Public Comment

There was no public comment.

Next Steps and Adjourn

Michelle Baass, DHCS

Baass commented that hybrid meetings will continue through 2024. Meeting dates for the remainder of the year are:

- Wednesday, May 29, 2024
- Wednesday, July 24, 2024
- Wednesday, October 16, 2024