DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

Hybrid Meeting

October 19, 2023

1:30 to 3:30 p.m.

BH-SAC MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Ken Berrick, Seneca Family of Agencies; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, Service Employees Service Union; Samuel Jain, Disability Rights California; Meshanette Johnson-Sims, Carelon Behavioral Health; Veronica Kelley, Orange County; Linnea Koopmans, Local Health Plans of California; Eileen Cubanski, County Welfare Directors Association of California; Kim Lewis, National Health Law Program; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; 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; 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.

BH-SAC Members Not Attending: Jei Africa, Marin County Health Services Agency; Kirsten Barlow, California Hospital Association; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Dannie Cesena, California LGBT Health And Human Services Network; Sarah- Michael Gaston, Youth Forward; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Karen Larsen, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jolie Onodera, California State Association of Counties; Jonathan Porteus, WellSpace Health; Angela Vasquez, The Children's Partnership; Jevon Wilkes, California Coalition for Youth.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Jacob Lam, Brian Fitzgerald, Paula Wilhelm, Ivan Bhardwaj, Sandi Snelgrove.

Public Attending: There were 117 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
Jacob Lam and Brian Fitzgerald, DHCS

Fitzgerald provided an update on Behavioral Health Payment Reform initiative. He announced that in July 2023, a special fund for payment reform IGTs was created and is pre-funded with $250 million of State General Fund. This is intended for use as the non-federal share match for federal funding and state funding for claims during the initial months of payment reform. He highlighted that County IGT agreements must be sent to DHCS before any payments are made for behavioral health services. He clarified that claiming should be submitted now in order to work on the technical elements so that payments can be released when agreements are final. He noted several claiming issues emerging from a proactive analysis by DHCS, such as underclaiming. He also announced that DHCS submitted a SPA to clarify that peer support services, care coordination, MAT, and recovery services are all billable as standalone services on top of the residential day per diem rate. He noted that DHCS intends to carve these standalone services back into the per diem rate in two years, with the intent that those services will all be provided through the per diem rate.

Questions and Comments

Senella: On stand-alone services, can you clarify that this is everything except inpatient services? Previously those stand-alone services did apply to inpatient with the exception of care coordination. Could you clarify if it's care coordination that is part of the per diem and the other things remain stand-alone or is it accurate that all four are part of the per diem for inpatient services?

Fitzgerald: The current guidance distributed to counties is that those four services for residential treatments are allowed to be billed separate and above and that if a beneficiary resides in an inpatient setting, those cannot be billed. But let me take that back and confirm.

Senella: I offer a caution about rolling all stand-alone services into the per diem because I believe it will result in those services not being provided. Providers will see they've earned those services just by nature of providing the core residential bed day or inpatient bed day or outpatient groups and individual sessions and will be less likely to ensure those other services are properly provided.

Fitzgerald: We want to monitor this and ensure these value-added services are being provided. They were carved out because the information to develop the per diem rate didn't adequately include those services. We want to encourage providers to render those over the next two years. And as we see those services increase, we will provide guidance that those should continue to occur as we roll them back into the per diem with increases to account for those services.

Harris: An issue raised previously is that travel time is underfunded. Counties indicate travel time is included in the reimbursement rates to subcontracted agencies. I believe this is a misunderstanding between counties and DHCS. There are layoffs happening and services being dropped due to this.

Fitzgerald: The rate paid from DHCS to counties includes travel time and documentation. The county should work with providers to make sure their costs are reimbursed at the appropriate level for the venue of those services, whether in the clinic or in the field. We do see counties providing travel reimbursement, for example in Los Angeles. We want to make sure that field-based services are being rendered. We are looking at the location of the services through claiming and comparing that to historical data to identify outliers and ensure services are provided in the appropriate setting.

Clark-Harvey: The travel time issue is difficult. We appreciate DHCS hears the concern and there's a diversity of county readiness, willingness, and experience for this implementation. In the meantime, providers are bleeding and there are services being shut down as a result of inadequate rates. Counties are our partners, and we know that they are working hard. However, this is a crisis situation. This isn't an issue of providers having bad business models. The cost reimbursement model was in place for decades and the transition to something else was very quick.

Cooper: Could you send us information about particular counties we need to focus on?

Clark-Harvey: Yes. I sent information about counties that are working well with providers and good models and practices that we hope will be uplifted. We have shared those publicly as well.

Cabrera: This is a massive transition, decades of cost-based reimbursement, which means providers were being paid regardless of the level of service delivered and that worked well to support field-based services. We need to understand the impact of the shift to fee for service on those business models and whether or not fee for service rates adequately account for that is essential. There was a short timeline to move from published rates to rate renegotiation. I am not aware of any county cutting contracts as a result of payment reform although some providers have asked counties to make them whole, which means the old cost-based reimbursement model. Some counties are in a healthier financial position, and this has created false promise for other counties not in a position financially to buffer providers. In those other counties, they have stuck to the fee for service rate structure and created opportunities for providers to earn more. We are not past the first full quarter of implementation on this. Fee for service has great promise and opportunity for providers. That is a culture shift and there's only so much TA and assistance we've been able to accomplish in this short timeline. We do not want to lose providers. And, there is a difference between the rate isn't right and the business model isn't right. We need to work to separate those things. I have assurances from our members that this could change, but we need time and experience. And I'm hearing that providers don't feel like they have that time.

Cooper: The team has been meeting with stakeholders to understand what the issues are to find solutions for next year's fee schedule. We are committed to finding providers and counties we can talk to, to unpack things to understand whether it is a utilization or a rate issue. We are finding good information that sometimes it is a utilization issue, that going from cost-based reimbursement to fee for service utilization driven model is the issue.

Cabrera: For counties not agreeing to make providers whole, sometimes it was because there is no budget to guarantee that. Other times it was a need to make the leap to get to the experience necessary for the culture change and to inform where rates really need to be over time. We are committed to making this change happen. In the face of so much demand, incentivizing services may be fine, and we understand the workforce issues are real.

Eisen: Did I understand correctly that you are using the next two years with peer support, peer coordination, and other services carved out of the residential per diem rate to see what the spend is so that you can get real time cost information to reconsider rates? My greatest concern is MAT services because those are high costs.

Fitzgerald: Correct. We used a cost basis to develop the per diem rates through a provider survey. We assumed providers were providing stand-alone services in a robust manner. When we built out the per diem rate and published the guidance, there was pushback because providers said they were not providing the services, therefore they were not captured in the per diem. DHCS took a step back because these services are important for beneficiaries to receive in a residential setting. We opted to take the next two years to push for services to be rendered, billed, and paid to reevaluate what the associated costs are, then redevelop the per diem rate based on costs and utilization.

Eisen: Some counties didn't turn on the codes for those to be billed outside of the per diem rate. Some counties did. It's helpful to know there is an opportunity for reconsideration. I don't want to go back to a cost reconciliation process; however, the change has been incredibly dynamic and there's inconsistency from county to county about what is or isn't a billable service. It took years of planning for the state and the country to go from ICD 9 to ICD 10, and we went to CPT coding in a matter of months. In one county alone, in an outpatient program, we lost close to $300,000 in outpatient services in one month. I can't imagine how smaller providers are handling that. I'm not convinced that the rate negotiated between counties and providers, or the state and the counties take into consideration what it means to staff programs and become productive. If we can't pay our staff at the same rate as a county worker and we have to drive productivity, the nonprofit provider system will eventually collapse on itself. I want to make sure that we're tracking not just losses of programs, but changes in service patterns which may be driven by trying to maximize billing. If field-based services drop because it's hard to get reimbursed; if group counseling drops because it's not efficient, we have to be able to analyze why it happened.

Cooper: With specialty mental health, if it is in the fee schedule, then it is the responsibility of the county to provide that service. In Medicaid you can't choose when to provide a benefit if it's statewide and a mandate. We may need to look at our BHIN to make sure that is clear. There shouldn't be a case where a county didn't turn the code on. We need to keep talking this through and clarify so there is no variation from county to county. We will take the comments back for sure.

Lewis: We don't generally weigh in on rate issues, however we are alarmed by how the rollout has proceeded and the lack of urgency by counties and the state. For youth, these are mandated requirements regardless of the amount of money available. Allowing this to move toward wait lists and losing providers could mean a move toward a lawsuit, so we need to work together to intervene before the crisis worsens. We need to be more alarmed about this. This is not what kids and families need and want. They expect these services to be in schools, in the home and other places in the community where they need them when they're medically necessary. So I will weigh in on this rate issue because it is a fundamental failure of the entitlement if these services go away.

Senella: This speaks to my earlier concern about rolling valuable services into the per diem. This is an example of the damage that can be caused by that process. The transportation issue is an example of why we need to be extremely careful. I would also liken the rate topic to practice in health centers. They receive cap rates, and they get wraparound payments to

keep them whole.

Stoner-Mertz: This highlights how critical the focus on equity is in healthcare and behavioral healthcare. When you do look at who's going to be most at risk, if we can't figure this out together, it is going to be those small neighborhood-based organizations that probably have small contracts, often culturally responsive. Looking at the resources and supports for people to prepare for ECM and CS, it feels like we haven't brought that level of resources to payment reform. As a membership organization, we held a series of payment reform work groups. I wonder if there should be TA at a granular level available to bring counties and providers together to get this right.

Ramirez: Payment reform is essential. We already see damage in the adult sector, where providers only take certain clients depending on insurance or who don't have high needs. And because there's not equitable reimbursement in the adult sector, we have a high rate of unhoused and incarcerated individuals. Hospitals don't take my peers with complex behavioral needs because they see us as being too difficult or violent, but in reality, it is because we don't have insurance or enough insurance or we have high needs and they're not able to get good reimbursement. The access options become so limited that it contributes to the outcomes we have.

Documentation Redesign

Paula Wilhelm, DHCS

Wilhelm provided an update on Medi-Cal specialty behavioral health documentation requirements following up from the in-depth discussion at the July 2023 BH SAC meeting. DHCS will publish new documentation guidance this fall for implementation in 2024. The draft information notice was released for stakeholder review and there were many specific and helpful feedback comments. The goals remain moving away from requirements that are detailed and prescriptive toward guidance that is standardized, streamlined, and simplified. Wilhelm offered a detailed review of key topics in the guidance, such as simplifying treatment planning requirements, changes to progress notes, and updates to DMC/DMC-ODS assessment requirements. Language in the 1915 B waiver clarifies that documentation of targeted case management and intensive care coordination can be anywhere in the clinical record. SAMHSA also confirmed that the substance abuse block grant requirements do not include a specific format or approach to treatment planning. Previous requirements that ASAM assessments must happen in a specific timeline in DMC/DMC-ODS will be eliminated to align to standards for specialty mental health. Also, by January 2025, a validated ASAM tool must be in use. She provided an FAQ resource and reported on TA that will be offered. Wilhelm listed feedback topics received and noted that although some are out of scope for this documentation guidance, they are important operational or practice questions or pain points that stakeholders wanted to highlight and she offered discussion questions.

- What topics would you recommend DHCS prioritize for technical assistance?
- While providing comment on documentation policy, stakeholders have raised concerns about Medi-Cal specialty behavioral health requirements that are out of scope for this BHIN but impact quality of care. Examples of what to add:
    - Authorization policies
    - Guidance for inpatient DMC-ODS services

- Policies specific to residential settings
- Service manuals for children's services
- Co-practitioner claiming
- Interoperability of electronic health records and "double data entry"

Questions and Comments

Cabrera: There is so much that needs to be cleared out related to documentation to do our jobs in a more productive and meaningful way. This is painstaking and very technical and we appreciate all the work because it will make a difference. TA will be essential for counties and providers so that everyone has a shared understanding of why we're doing this and where we're going.

Senella: I would advocate adding authorization policies and interoperability. They are two areas of major concern across the continuum, while some of the others relate to smaller issues for providers.

Wilhelm: Thank you for the advice on how to prioritize these.

Stoner Mertz: We are appreciative of where you're taking this. Do you have any detailed information on the timeline? Having TA for providers and counties is very important. We are fielding very detailed questions, such as when does something need to be signed?

Wilhelm: The goal on timing is early November 2023.

Lewis: I was impressed by the number of drafts and iterations you developed to get to consensus. We sent letters to DHCS about how prior authorization denials are impacting access. And how they delay access even when it is not denied altogether. I am advocating that intensive home-based services, particularly for children's mental health services, be available without prior authorization. It's critical to ensure access is timely and available. Similarly, the service manual for children's services has been on the table for potential revision and I'm interested in that as well.

Clark Harvey: Thank you, Michelle, for understanding the request that CBHA and other providers made around the accrediting organizations putting something in writing. I'm glad to hear that that's helpful to folks and we look forward to working with you.

CARE Act Update

Ivan Bhardwaj, DHCS

Bhardwaj provided an update on the Community Assistance Recovery and Empowerment (CARE) Act. He outlined the roles and responsibilities for DHCS, including training and technical assistance, as well as the availability of resource materials and one-on-one coaching for counties. He highlighted roles for colleague departments as well, such as the Judicial Council. Bhardwaj reviewed the three BHIN documents, such as the CARE Act Data Collection and Reporting Requirements Guidance. He announced that CARE Act

Cohort One counties launched in October, including Glen, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and San Francisco. Los Angeles will implement by December 1, 2023 and Cohort Two counties will implement by December 1, 2024. He noted that TA is ongoing, and he outlined the annual report, which is shorter term information to keep a pulse on how the CARE Act is proceeding, and an independent evaluation to be released in year three and year five of the CARE Act, for a comprehensive view. Bhardwaj described upcoming milestones, including finalizing the selection of an independent evaluation vendor, developing annual performance indicators, and assessing lessons learned from Cohort One.

Questions and Comments

Lewis: Is there a data collection template already? What type of data is being collected?

Bhardwaj: Yes, the data dictionary is posted and is very detailed. The BHIN is 23-052.

Cabrera: I am working closely with Cohort One counties on the rollout, and I've been struck with the can-do attitude and readiness on this. There is interest from family members and law enforcement. We are cautious about the amount of information that has been requested by DHCS because we have not had the lead time necessary to build those elements into our workflows. We ask DHCS to pair back to what's doable right now.

Bhardwaj: I've also been impressed by the level of commitment of Cohort One counties. They are ready to undertake this work and we understand the challenges associated with it. We are committed to working with counties on data collection and make it as easy as possible.

Opioid Settlement Fund
Sandi Snelgrove, DHCS

Snelgrove introduced herself and offered background on the Opioid Settlement Fund that is a result of lawsuits against pharmaceutical companies, drug distribution companies, and pharmacies to recover costs associated with the opioid epidemic. California reached final agreements with several companies and there are proposed settlements that the state has yet to finalize with others. She offered specific information on the structure of how the estimated$4 billion in settlement funds will be distributed. She also reviewed the status of the settlement funds from the Mallinckrodt Pharmaceuticals bankruptcy and several other pending bankruptcy settlements. DHCS is the oversight entity for the expenditure of funds received from California's opioid settlements. This includes monitoring for compliance, conducting related stakeholder engagement, and preparation and distribution of annual reports. Snelgrove provided detailed information on how settlement funds will be used, such as the matching funds for the Behavioral Health Continuum Infrastructure Program, Naloxone, and other prevention, harm reduction and treatment services. . Cities and counties receiving funds from opioid settlements are required to prepare written reports at least annually to DHCS and those reports will be publicly available on the DHCS website. She also outlined available resources, such as FAQs and technical assistance documents and webinars.

Questions and Comments

Harris: It appears that in order to avoid being in a position of future liability, chain pharmacies are no longer stocking buprenorphine or making it difficult for people to get buprenorphine. I wanted to call that to your attention. Whose responsibility is it to make sure that they don't use future settlements as an excuse not to stock or provide buprenorphine? Naloxone's important to stop overdoses but we also need to make buprenorphine available to help people to get off of opioids.

Snelgrove: Thank you.

Public Comment

Bernadette Navarro-Simeon: My comment is on the documentation reform. Thank you for allowing the stakeholders to review and provide feedback. And I appreciate seeing that there's going to be a policy specific for residential treatment. DHCS understands that residential treatment is neither inpatient or outpatient, and counties are struggling to figure out which regulations we are in. I'm looking forward to when the policy specific to residential treatment comes out because social rehab facilities are anxious about the variation of regulation that's being imposed by counties. Thank you.

Next Steps, 2024 Meeting Dates and Adjourn
Michelle Baass, DHCS

Baass noted that hybrid meetings will continue through 2024. Calendar holds were sent for February 15, May 29, July 24, and October 16, 2024. Meeting times are 9:30 AM – 1:30 PM for the joint SAC-BH SAC meetings, and from 2:00 PM – 3:30 PM for BH SAC.