DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

Hybrid Meeting

February 16, 2023

2 to 3:30 p.m.

BH-SAC MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Jei Africa, Marin County Health Services Agency; Barbara Aday-Garcia, California Association of DUI Treatment Programs; Kirsten Barlow, California Hospital Association; 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; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Laura Grossman, Beacon Health Solutions; Robert Harris, Service Employees Service Union; Virginia Hedrick, California Consortium of Urban Indian Health; Veronica Kelley, Orange County; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law Program; Jolie Onodera, California State Association of Counties; 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; 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.

BH-SAC Members Not Attending: Alex Dodd, Aegis Treatment Centers; Sarah-Michael Gaston, Youth Forward; Andy Imparato, Disability Rights California; Linnea Koopmans, Local Health Plans of California; Robert McCarron, California Psychiatric Association; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jonathan Porteus, WellSpace Health; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program; Jevon Wilkes, California Coalition for Youth.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Tyler Sadwith, Janelle Ito-Orille, Denise Galvez, Paula Wilhelm, Erika Cristo, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

Public Attending: There were 122 members of the public attending in person and virtually.

Welcome, Director's Opening Comments, Introduction of New Member, Roll Call, and Today's Agenda

Michelle Baass, DHCS Director

Baass welcomed BH-SAC members. She noted that the December BH-SAC meeting was a special session, and today's meeting is another separate BH-SAC meeting with presentations on key priorities for DHCS. She encouraged members to share ideas for additional topics that would benefit from a separate meeting of BH-SAC.

Medications for Addiction Treatment in Residential Substance Use Disorder Care

Tyler Sadwith and Janelle Ito-Orille, DHCS

Presentation Slides

Sadwith reported on the evolution of medication guidance for addiction treatment. Various authorities and specialty associations, including the U.S. Surgeon General, Centers for Medicare & Medicaid Services (CMS), and U.S. Department of Justice, emphasize that medications for addiction should be treated like other medications, and that Medication Assisted Treatment (MAT) is the standard of care for opioid use disorder (OUD).

Sadwith shared information from a 2019 survey of residential substance use disorder (SUD) treatment providers. They reported a range of methods for accessing MAT while in the facilities, with the most common being referrals to other providers, such as Narcotic Treatment Programs and primary care sites. Only 27 provided MAT onsite. Of the 61 percent of programs responding that did not provide MAT onsite, the majority (60 percent) indicated they plan to do so in the next 12 months.

Ito-Orille noted that Senate Bill (SB) 184 (2022) expanded the availability of MAT services, both within licensed residential and outpatient SUD treatment facilities, by requiring they offer MAT services directly or have an effective referral process in place, including for transportation. DHCS released a draft BH Information Notice in January, and is currently reviewing a high volume of stakeholder feedback. New providers will be required to submit a MAT policy as part of their initial application package.

Sadwith highlighted state budget investments to support providers, particularly residential treatment programs, to expand access to MAT. With new resources, DHCS is expanding technical assistance, grant opportunities, and other supports, including a MAT toolkit for residential treatment facilities and clinician warm line.

Questions and Comments

Tsai: Was the data specific to Drug Medi-Cal (DMC), or was it across all of Medi-Cal?

Sadwith: It included all medications regardless of how they were provided.

Tsai: It would be great for counties to access these data since a lot of MAT is accessed outside of the specialty SUD system via fee-for-service (FFS) Medi-Cal and other systems. County data are often limited to the local DMC system. Also, MAT is sometimes considered harm reduction, and in other countries individuals flow between treatment and harm reduction more easily than here, where there is a stronger distinction. We must break down this barrier, and MAT is a way to do that, and better integrate and scale resources at local and state levels. Harm reduction is a primary tool to reach people who are not accessing SUD treatment.

Eisen: It's a challenge to link clients entering residential treatment to methadone because of the DEA prescriber and dispensing restrictions, which are not in DHCS' control. However, we should consider if there are steps that are within state control. It would also be great if the state could convene on embedding harm reduction practices within traditional SUD treatment (e.g., addressing clients who have a recurrence within residential treatment). The state could invest in training, workgroups, and resources about how to never lose contact with clients.

Sadwith: I am looking forward to SAMHSA's updated methadone regulations. A medication unit with counseling might be a pathway to access for methadone. On harm reduction, let us know your specific ideas for policy or technical assistance. Our DMC-ODS guidance clarified that providers cannot refuse access to medication for those not ready to participate in counseling, and recommends additional engagement therapeutic approaches.

Veniegas: Los Angeles County has a standing committee on correctional health services. Jail Health Services estimates that 1,500 people every day could benefit from MAT for OUD, but only 100-150 people access it. Jail health is unlikely to initiate MAT unless the person comes in with a prescription. As people are transitioning, there is a real concern for overdose prevention among those who will hopefully be connected to a residential opportunity. Is there an opportunity to consider a policy linkage for individuals moving out of jails within 90 days to ensure MAT initiation and a smooth transition?

Sadwith: Ensuring continued access and provision of MAT, as well as initiating it, are imperative in correctional settings. Please share any restrictions preventing this that you are aware of. Meanwhile, ongoing funding and technical assistance, including the MAT in Jails Project and the CalAIM Justice-Involved Initiative, should increase MAT access during that 90-day period prior to release, along with warm handoffs and continuity of medication.

Veniegas: The main barrier cited to the hospital commission is cost, which will partially be addressed by the Justice-Involved Initiative, but we are concerned about the disparity between who would benefit from MAT, and who is actually receiving it.

Senella: We need the draft bulletin mentioned as soon as possible, and also need to monitor providers' compliance with it. We know there is resistance among our

colleagues in both outpatient and residential settings, and this will help us move forward. On the harm reduction discussion, I agree with everything recommended so far and would add field-based services. Right now, the rules are overly restrictive, whether from CMS or DHCS. We should do anything we can to open up-field-based SUD services and MAT. MAT can be done outside the four walls but the tools to accomplish it aren't there. There's been a push at the federal level to open methadone to any practice.

Fields: I'd like to highlight the increase in dual diagnosis residential treatment, especially on the mental health side, such as crisis residential programs receiving clients out of emergency rooms. Most individuals coming to mental health services are seriously involved with substances and would benefit from SUD treatment; however, they are licensed differently and certified through Medicaid. To increase the capacity of community-based systems, we must understand that there are residential programs for SUD and also a variation for mental health only. However, as we talk about integration and add populations like justice-involved, we must do outreach on the mental health side to build their MAT capacity. Sometimes it's the county authorities, not the providers, that resist this model. We must integrate our responses to those with severe, acute mental illness and struggling with SUD.

Lewis: I strongly support all these comments about integration for those with dual diagnosis. It is more difficult to get services for co-occurring disorders. It's challenging for our existing network that was built on silos and especially important to build the community-based continuum, not just residential treatment. From the survey, it's clear that MAT is not being offered everywhere despite the requirement, so how is DHCS planning enforcement to move the needle? Also, given how staff beliefs shape the use of MAT, it seems important to look periodically at actual MAT uptake and utilization, not just the enabling policies.

Sadwith: These are great suggestions. If you look at national rates of pharmacotherapy for OUD, we are nowhere near where we want to be. The draft regulations mentioned are quite comprehensive and will be folded into existing licensure and compliance site reviews to see if policies are being followed in practice. We can follow up offline to look at uptake and utilization.

Clark Harvey: I support all the suggestions, including making field-based services accessible.

Sadwith: Are people aware of any state policies or challenges with providing community-based MAT services outside the four walls? Our guidance for DMC-ODS is that MAT can be provided in a clinic or non-clinic setting so we think this is already in place for providers.

Senella: The variability of counties is a barrier.

Clark Harvey: I hear from providers that how counties interpret the framework is variable.

Tsai: We are looking to expand field-based services in Los Angeles. We are analyzing Title 9 Alcohol and Other Drug certification licensing to identify the areas where historically there were challenges implementing a system conducive to MAT and harm reduction. We will provide that to DHCS.

Harris: I also think it is important to talk to the Department of Justice (DOJ) about the Controlled Substance Utilization Review and Evaluation System (CURES) registry and how they treat people who prescribe, including nurse practitioners. When they investigate providers, it makes them afraid to prescribe. Until a policy discussion is held, it will be hard to get more providers offering MAT. DOJ seems to think buprenorphine is like morphine or heroin.

Youth Substance Use Disorder Prevention

Denise Galvez, DHCS

Slide Presentation

Galvez reported on the increased investment in SUD prevention in California over recent years. Galvez shared that Proposition 64 Elevate Youth California has awarded 246 grants totaling more than $189 million. There are changes to the Substance Abuse Prevention block grants over the next year. DHCS is developing a Behavioral Health Prevention Plan (BHPP) to better support counties and provide state leadership. The plan will include a formal needs assessment and capacity readiness that identifies emerging trends in California. Galvez shared that through this process the state hopes to collect data that demonstrates proof of programs' effectiveness and uncovers opportunities to improve. Through implementation of the plan, DHCS will promote the use of evidence-based and community-defined practices, which is timely because there are grants through the Children and Youth Behavioral Health Initiative (CYBHI) that aim to scale up evidence-based practices in California.

Questions and Comments

Cabrera: On the Proposition 64 grants, are county behavioral health agencies eligible?

Galvez: The recent Request for Application (RFA) specifies that counties providing direct prevention services are eligible to apply. Pass throughs are not permitted.

Cabrera: Will the planned assessment be contracted, or will DHCS work directly with counties?

Galvez: DHCS contracted with the Center for Applied Research Solutions to develop the needs assessment. We also have a State Epidemiology Workgroup comprised of county representatives, researchers, epidemiologists, and others to provide feedback.

Veniegas: The California Community Foundation has supported an analysis of the utilization of the Los Angeles Proposition 64 funding, and that report will be published this quarter. We would be happy to share it. That report is being conducted by groups

that support youth organizing, so there is a network of leaders that might be potential informants to your assessment.

Grealish: A lot of justice-involved youth suffer from SUD and/or are at high risk for SUD. There is a lot happening in probation. How might we better connect the work of DHCS and probation to ensure that at-promise and justice-involved youth are covered in your plan?

Galvez: Decisions about goals and strategies will be locally controlled by counties, so if they see a need in their communities, they could propose that linkage.

California Behavioral Health Community-Based Continuum Demonstration (CalBH-CBC)

Tyler Sadwith, Paula Wilhelm, and Erika Cristo, DHCS

Slide Presentation

Sadwith reported on the CalBH-CBC, a section of an existing waiver that DHCS will submit to CMS later this year. Sadwith recapped some past steps, including meeting with BH-SAC in November to discuss the proposed approach, posting a concept paper, and soliciting comments on the concept paper. The concept paper describes a proposed approach to strengthen accountability and oversight for county mental health plans.

Sadwith walked through the major themes of stakeholder feedback to the concept paper and noted that overall, there is significant support for the demonstration. He also shared next steps, which include continuing to assess written feedback and incorporate into the draft Section 1115 application that will be posted for public comment this spring. This will include a public hearing and opportunity for written comments, submission to CMS, and federal public comment period.

Questions and Comments

Fields: I hope there has been analysis of what happened in previous implementations of the clubhouse model in the 1970s as well as the impact of the Institutions for Mental Disease (IMD) on the system of care in the 1980s when I believe it increased institutionalization and held back the development of community-based programs. I'm puzzled by how a strong report could include IMD expansion when there is no evidence that putting people in large for-profit skilled nursing environments has good outcomes. I encourage DHCS to look at the requirements for counties before they are incentivized to expand beds covered by Medi-Cal since blocked Medicaid coverage is the only thing that kept IMDs from becoming a national model. Counties need help developing an appropriate continuum of 24-hour treatment programs as alternatives to institutional settings. SB 184 struggled because counties didn't have the capacity to stand up those programs, so I'd like to see a more intensive description for counties that want to develop an IMD program of what is required to avoid institutionalization.

Berrick: This cross-sector incentive pool is a strong way to incentivize the cross-system collaboration we want to achieve. It won't work unless it is robust enough to create an incentive, given we are integrating large initiatives like community schools and CYBHI. Moving forward with community-defined practices, I hope we incorporate research partnerships into the Centers of Excellence to study, validate, promulgate, and incorporate the models into well-defined practices. Most evidence-based practices are at least 10 years old, and we need a forum to surface new ones.

Barlow: It would be helpful for DHCS to clarify what would be permissible to be paid for in IMD or institutional settings. The California Hospital Association understands that advocates are concerned about expanding institutional settings, but it seems the purpose of the demonstration opportunity is to build more capacity for inpatient psychiatric care and residential mental health treatment, neither of which is a large institutional skilled nursing facility setting. We should be clear that severe mental illness can be debilitating and chronic, sometimes people need access to inpatient settings, and we should get help from the federal government in paying for those medically necessary stays. We have far too little community residential treatment in California to help people with mental health disorders be stabilized and returned to the community.

Sadwith: I agree with everything you said. This opportunity is specifically limited to short-term inpatient and residential stays in facilities that are either certified by CDPH as hospitals or accredited by a national accrediting body. CMS defines short term as an average length of less than 30 days, and no individual stay can be longer than 60 days to be part of this demonstration. Short-term inpatient psychiatric care is part of the continuum of care for mental health and can be medically necessary. DHCS will work closely with counties that opt in to the IMD opportunity to ensure a continuum of care with community-based services is available.

Cooper: From our perspective, this is about building out the community-based continuum, it's not a traditional IMD waiver, and we are investing a lot in new benefits on the community side.

Ramirez: Stakeholders in California helped advance the utilization of traditional and faith healers within Native American and Latino communities. These are not necessarily considered evidence-based, but they are historically-based and have been used to supplement other services. We often don't have targeted services for Two-Spirit populations where there is a significant rate of human trafficking, suicide, and unhoused. These demonstration waivers offer opportunities to fund culturally relevant services, and I hope we can take up some of the beneficial services excluded from past funding.

Cabrera: We support this waiver concept because individuals will sometimes need inpatient/residential treatment, and Medi-Cal plans have to provide it, but federal law has excluded larger facilities to the point where we had to get a waiver to provide residential SUD treatment. The length of stay limitation really corrals this, and we think it's a relatively small portion of our delivery system that will benefit from this (e.g., Psychiatric Health Facilities that primarily do inpatient short stays). This proposal is

about prevention and also step-down flexibilities with housing and other supports. We generally get reimbursed through Medi-Cal for Forensic Assertive Community Treatment, as well as first-episode psychosis, but supportive employment, rent, and community health worker outreach and engagement are not covered, so we are eager to see this potential. Ultimately, the return on investment seems limited because of the federal structure that constrains this kind of waiver. We think getting to fidelity on these services and programs will take work since they require staffing and housing that are challenges right now. We plan to take a continuous quality improvement (CQI) approach and need resources to achieve the aspirational vision.

Harris: Is there oversight to ensure the supported employment efforts across the various agencies and departments are coordinated?

Cooper: Yes, we are working on this and talking to directors from other agencies. There's a lot of work and technical assistance for counties that will be needed to provide this benefit. We are connected and aligned in how we want to provide this.

Public Comment

Zeke Sandoval, PATH: We want to thank the state for its ambitious effort to launch CalAIM. We're one of the largest homeless service providers in California, serving more than 16 percent of the state's homeless population, and currently operating CalAIM programs with partners in Los Angeles, Orange, and San Diego counties. CalAIM is an important step in addressing homelessness in health care. Right now, the process for referring a patient to CalAIM for coverage is overly complex. We need providers to be able to refer participants to managed care plans (MCPs) and for Community Supports providers to identify clients' existing care managers so we can better coordinate care. Another opportunity for enhancement is to ensure local health plans enable any health care provider access to available recuperative care beds in short-term post-hospitalization housing availability with an expedited workflow to ensure timely transfers. We've experienced low utilization of these resources at the same time that local health care providers report difficulty making such referrals, so effective access is critical to keeping these resources online and helping people recuperate in safe and stable situations. Additionally, we're concerned about potential challenges that could occur as MCP coverage is consolidated by 2024 in counties affected by DHCS' recent MCP procurement. Typically, these shifts can lead to disruptions for our participants, resulting in loss of services and possible loss of authorization. We welcome coordination from the state during the transition and recommend providing a temporary continuity of care provision to protect providers, ensuring continuity of care or services to members during the transition. We could also use some assistance clarifying the counties' role in CalAIM when working with community-based organizations and homeless service providers that contract with MCPs. It would be helpful to better understand how the push to renew local funding sources like Measure H in Los Angeles County will affect homeless service providers' participation in CalAIM. We are excited about the proposal to add transitional rent into CalAIM in the Governor's Budget proposal. This kind of short-term prevention measure can have positive impacts for those on the verge of homelessness who may just need a little help with rising rent. A

longer timeframe could produce even greater results, but this proposal has significant merit if enacted. We welcome the opportunity to work with the state, counties, and other providers to continue to improve CalAIM.

Carmen Comsti, California Nurses Association: We want to thank DHCS for continued work on the BH Community-Based Continuum Demonstration project. As DHCS develops its demonstration project application, CNA hopes that BH-SAC and DHCS weave together measures to include and address behavioral health emergency service needs in general and acute care hospitals through the demonstration project or other programs. Many patients enter general acute care facilities through the emergency departments and experience behavioral crises within those facilities or while awaiting transfer or admission. We hope that through the application for the demonstration, we can include clear plans to ensure that the quality of behavioral health care services provided to patients in general acute care facilities is assured, and that patients awaiting community services being boarded inappropriately in emergency departments are included in these plans.

Next Steps and Adjourn

Michelle Baass, DHCS

Baass thanked the committee for its participation and announced that the next meeting would be held on May 24, 2023, from 9:30 a.m. to 1:30 p.m. The meeting was adjourned.