DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

Hybrid Meeting

May 24, 2023

2:00 to 3:30 p.m.

BH-SAC MEETINGSUMMARY

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; Dannie Cesena, California LGBT Health And Human Services Network; 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; Virginia Hedrick, California Consortium of Urban Indian Health; 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; 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; 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; 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: Jessica Cruz, NAMI; Sarah- Michael Gaston, Youth Forward; Jonathan Porteus, WellSpace Health; Catherine Teare, California Health Care Foundation.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Palav Babaria, Janelle Ito-Orille, Tyler Sadwith, Erika Cristo, Jacob Lam, Brian Fitzgerald, Lindy Harrington, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

Public Attending: There were 220 members of the public attending in person and virtually.

Welcome, 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.

New Waiver for Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)
Tyler Sadwith, DHCS
Slides available

Sadwith introduced the session as an opportunity for a deep-dive discussion that leverages members' expertise and gathers input on the Cross-Sector Incentive Program. Sadwith reviewed the vision and objectives as well as the demonstration approach, continuum of care, and updated timeline for the BH-CONNECT demonstration proposal. Sadwith also provided information about the continuum of care and noted elements that are part of existing initiatives (e.g., CalAIM) versus part of the BH-CONNECT proposal. He highlighted a new opt-in service on the continuum of care, the clubhouse model, not previously discussed in the context of this waiver.

Sadwith provided a review of the BH-Connect Cross-Sector Incentive Program, an opportunity for Medi-Cal managed care plans (MCPs), county mental health plans (MHPs), and child welfare service (CWS) agencies to work jointly toward quality and outcome metrics and receive incentive funds for meeting specified measures related to care for children and youth in the child welfare system. The guiding principles are to coordinate across service systems for a more integrated experience to achieve alignment, simplification, and streamlining on behalf of youth in multiple systems. Sadwith then outlined example process and outcome metrics over the waiver period and the next steps to finalize and submit BH-CONNECT.

Sadwith provided guiding questions for input from BH-SAC members.

1. What current challenges have the greatest impact on MCPs', MHPs', and/or CWS' ability to care for the population addressed by this program?
2. What would effective cross-sector collaboration look like between MCPs, MHPs, and CWS to deliver care for this population? What is the most important role for each system to play?
3. What outcome(s) would best demonstrate "success"?
4. Which quality metrics would best measure progress toward program objectives?

Questions and Comments

Stoner-Mertz: Could you provide more detail on components of the waiver that intersect with workforce? How do you envision private providers that are already working with children and youth across these systems engaging in the incentive program?

Sadwith: On workforce, as part of the Governor's proposal to modernize the behavioral health system, MHSA funding will be used to draw down additional federal funding through this waiver. This is still under development, and we can share more information in the future.

Cooper: The proposal is to use $36 million of Mental Health Services Act (MHSA) funding.

Cabrera: I want to highlight that much of the concept is based on anticipated Medi-Cal savings to counties from federal financial participation (FFP). Our estimate differs significantly from the state projection. We believe counties are generally leveraging Medi-Cal where possible. We have concerns about the ability of the county to participate in the full set of options outlined because counties must fund the non-federal share. The phased implementation timeline is a good approach to build the capacity for programs and we appreciate the addition of rental for temporary

housing and community health workers to perform outreach engagement. The incentive pool concept allows county CWS, MHPs, and MCPs to make upfront investments for system changes and then would be eligible for incentive payments, correct?

Sadwith: Correct. There is no start-up funding being disbursed.

Cabrera: We look forward to providing input on some of the other measures as well. For example, substance use disorder (SUD) outcomes for youth can be especially challenging given the voluntary nature of services. Also, the Children and Youth Behavioral Health Initiative (CYBHI) proposed fee schedule may further limit our ability to draw on MHSA funds to pay for school-based SUD and other services and limit our ability to deliver services to foster youth and other populations.

Clark-Harvey: I echo the workforce and capacity concerns voiced previously and am excited about the innovations outlined. I am supportive of the Clubhouse model from my previous experience in Wisconsin. It will be important to look at this creatively and that is challenging with existing resources. Is there an opportunity to use the clubhouse model for youth?

Harris: Can the workforce for clubhouse be considered for CHWs to draw down FFP?

Sadwith: CHWs are a covered Medi-Cal benefit through MCPs. Through BH CONNECT, we propose covering that same type of service specifically for the population served by county BH.

Harris: Can you also match Proposition 64 spending?

Baass: It depends on how the youth prevention cannabis dollars are used at the local level. It is something we should think about. As part of efforts to modernize the behavioral health system and reform MHSA, we want counties to look at all their funding sources, including Prop. 64, and determine how to leverage the dollars and programs.

Lewis: Can you clarify the Institution for Mental Disease (IMD) opportunity? Are the IMD and the other opportunities connected or separate?

Sadwith: For services to adults, counties can cover new services being implemented through BH CONNECT, such as Assertive Community Treatment (ACT) and Forensic ACT (FACT), supported employment, community health worker services, first-episode psychosis, and transitional rent. They can do all of that without pursuing the IMD opportunity. That is all available to counties, along with the cross-sector incentive programs. If counties want to cover IMD, they must do all of these.

Lewis: Therefore, you can't just do the IMD and not do the other services, but you can do the other services and not the IMD. There is promise in looking at outcomes and metrics to drive improvements. Since we are focused on foster youth, how do we create those opportunities where there isn't a MCP involved? There is 48 percent of foster youth in fee-for-service (FFS). I think we need to look at outcomes specific to an integrated model, such as incentivizing using wraparound as a team planning process and require the Enhance Care Management (ECM) providers and physical health providers to be integrated into the care model. With foster youth, exactly what might that look like with CWS, MHPs, and the MCP all at the table? Can we incentivize integration that focuses on outcomes generally as a measure of how well they are doing, like school participation and not just access to care as a process measure? Are they using fewer intensive services over time, having fewer hospitalizations?

Vasquez: One piece that is missing, especially for foster youth, is schools, not just school-based services, but also conducting assessments and making referrals for special education and that can surface cognitive disabilities. I think it is important to highlight and uplift professionals in schools and have schools be true partners in the process for foster youth.

Behavioral Health Payment Reform
Jacob Lam, and Brian Fitzgerald, DHCS and Gary Tsai, MD, Los Angeles County Department of Public Health
Slides available

Lam presented on BH payment reform focused on the change for counties from cost-based reimbursement to FFS reimbursement as of July 1, 2023. Lam described the three transitions that are part of this overall reform, 1) move to FFS reimbursement; 2) end Certified Public Expenditures and move to Intergovernmental Transfer financing; and 3) change provider billing to CPT codes.

Fitzgerald began by thanking partners for their extensive work to develop rate methodologies. He provided specific information on the rate-setting process and methods for setting the fee schedule. Rates are by service and county and will be updated annually. There are rate adjustments intended to draw workforce into SMHS and SUD systems. Fitzgerald also spoke to the specifics of rates for inpatient professional services (fee schedule), inpatient day rates (single statewide rate), and administrative/quality assurance rates (remain as certified public expenditure). He outlined the next steps and timeline for implementation.

Tsai presented the approach for payment reform in the Los Angeles County Specialty SUD System. He outlined three key goals: 1) developing rates for the future, not the system of today, 2) recognizing that the shift to FFS is significant and requires training, and 3) establishing incentive payments as a driver for practice change. Tsai described capacity building funds that are designed to prepare providers to meet metrics and prepare for value-based reimbursement. He also spoke to incentive funds paid to an SUD provider after achieving a performance metric. Tsai offered detailed information on the tiers for base rates, capacity-building funds, and incentive funds.

Questions and Comments

Eisen: On the SUD rate side, there is remaining uncertainty about payment for Medication Assisted Treatment physician rates within residential services. There is an assumption that it is paid for through reductions in inpatient rates. There are also parity issues related to SUD and MH rates. For example, the outpatient reimbursement for a Licensed Practitioner of the Healing Arts (LPHA) for mental health services is higher than SUD providers with the same requirements. We understand travel and documentation cannot be built into rates and think there are unintended consequences. Field-based services won't be provided due because the cost of travel is not included, and group services won't be provided due to the extra time for documentation. Finally, there is no acuity adjustment, and this could be used to cover the travel. What Behavioral Health Information Notice (BHIN) covers the county requirement of cost reporting?

Fitzgerald: The BHIN will be released soon and outlines that counties cannot require providers to submit a cost report. Would it be possible to give us examples of the parity issues? We designed the rates to have parity between delivery systems and were mindful of developing equal rates. If you can provide codes, I can provide a more specific answer.

Stoner-Mertz: We support the vision here and want to flag that the way this is rolling out on the ground will impact services, beginning with the way providers are being told what the rates will be. There is no negotiation. Providers are notifying me that they must reorganize services or lose millions of dollars. We have not solved the documentation issues that are a companion to this process. One county is providing rates paid in 2020 with all the documentation requirements. I hope we will all work together to figure out the solutions. Also, I want to add that we can all learn from what Los Angeles County is doing.

Fitzgerald: We agree that L.A. County has achieved a lot. On negotiation, the goal is for counties to negotiate with local providers for rates that are adequate and develop an adequate network. We are hearing that the protracted timeline for rate development did not leave counties time to do that, and they had to roll out rates as a placeholder. My hope would be that they revisit as needed. There are no productivity requirements, yet we do understand that FFS reimbursement incentivizes direct patient care.

Lewis: I am concerned to hear the conversation about rates and the focus on efficiency rather than incentivizing the early and periodic screening, diagnostic, and treatment (EPSDT) services that are required. What is required under medical necessity for some youth is home and community-based care. What is needed is what should drive services, not convenience or efficiency within brick-and-mortar. I am hearing alarm bells that services we fought hard to make available will go away. I am hearing a take-it-or-leave-it approach in counties. We need to be thinking about a case rate of other approach to make sure that those services are not left on the cutting floor of what we're trying to create in California.

Lam: We are very sensitive to the concerns Kim and Chris raised associated with the community-based services and the impact FFS may have on the delivery of those services. When we developed the rate methodology, we started with the cost of providing services as the basis, not efficiency. I think there are opportunities at the county and provider level to negotiate payment models that reflect certain provider types or delivery models. Again, we hear the concern and will monitor to ensure no unintended consequences.

Kelley: Just a reminder that this is one of many initiatives counties are trying to implement with historic workforce shortages. On the timeline for trueing up old cost reports, where are we on that as we move ahead on payment reform? Our last settled year was 2014-15.

Fitzgerald: DHCS is working with partners to develop a roadmap for discussion with counties. There are internal challenges to get cost reports updated and sent out. We want to make as clean a transition as possible between cost reporting and FFS and are trying to expedite the process.

Senella: We are working closely with the LA team on the payment reform. I agree with Kim that we don’t have the rates right yet on youth services and need to take a careful look in order not to have negative impacts. On Vitka’s comments, I agree that taking out travel time from field services and documentation time is a major issue. The rates do not bake in the time to deliver sufficient service. There are some elements that require further study and quick resolution.

Lam: We will continue to monitor. Just to reiterate, the rate schedule that was developed by DHCS is the rate paid to counties for the delivery of this service. If there are concerns from the provider about reimbursement for travel and documentation time, that is a conversation to have with county partners.

Clark-Harvey: Payment reform in theory is a wonderful thing and how it is implemented is very important. For example, the survey sent out as a foundation for building the rates was problematic. It was a snapshot during a pandemic year and there are many expenses not accounted for accurately in that snapshot. There are lots of concerns to work out for providers. Some counties are working with providers very seamlessly and slowing down implementation and there are many that are not. There are disparate approaches impacting providers and they are struggling. We must do better.

Harris: The old school SUD rates are lower because of stigma and there is no equity in the system. It will always be underfunded and that means sub-optimal SUD services. We need to pay attention to the historic stigma around drug use and balance the rates to offer real treatment for the real issues of today.

Berrick: We need to be careful about what we are incentivizing. If I am a school-based provider where I can maximize service delivery, it is a different scenario from community-based services with complex youth and families. If we incentivize services that require outreach and community-based engagement, the system will be much better served in the long run.

Cabrera: Thank you to the DHCS and local teams for the work to develop rates that could win approval by the Centers for Medicare & Medicaid Services and trying to account for equity in the rates for SUD. In the effort to get rates accomplished in a short timeline, there are counties that were not able to model and negotiate the many provider contracts required. I would caution us not to make sudden moves. We don't want providers completely shifting how they operate or design services based on these preliminary rates. In some cases, counties have provided initial rates and have a plan for additional incentive payments. There are many threads to payment reform that need to be finalized on financing and rates. I know this is unsatisfactory, but I urge providers to consult with their counties before making major changes.

Public Comment

Aaron Bailey: I work with outpatient substance use disorder and mental health treatment centers in Orange County, most notably, The Edge Treatment Center. I have two questions regarding the critically necessary transition to mandatory licensing of substance use disorder facilities. First, how can SUD providers and mental health providers get involved in building out the extensive processes and supporting regulations that are required to switch from optional certification to a mandatory licensing model? And related, what support staff training resources is DHCS planning to provide to the licensing and certification division as they go through that substantial transition from a relatively broad set of voluntary standards to more robust regulations and processes necessary for this?

Next Steps and Adjourn

Bobbie Wunsch requested that members who could not comment on the BH-CONNECT demonstration due to time constraints forward their comments to her or Tyler Sadwith. She thanked members for their participation and announced that the next meeting would be held on July 20, 2023.