DEPARTMENT OF HEALTH CARE SERVICES
Behavioral Health Stakeholder Advisory Committee (BH-SAC)
July 29, 2021
1:30 p.m. – 4:30 p.m.

MEETING SUMMARY

BH-SAC Members Attending (by webinar): Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Sarah Arnquist, Beacon Health Options; 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; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI; MJ Diaz, SEIU; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health Plans of California; Farrah McDaid Ting, California State Association of Counties; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; 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; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, California Health and Human Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Britta Guerrero, Sacramento Native American Health Center; Robert McCarron, California Psychiatric Association; Cathy Senderling, County Welfare Directors Association of California; Jonathan Sherin, Los Angeles County Department of Mental Health.

DHCS Staff Attending: Will Lightbourne, Jacey Cooper, Bambi Cisneros, Palav Babaria, Kelly Pfeifer, Jim Kooler, Shaina Zurlin, Brian Fitzgerald, Michelle Retke, Tyler Sadwith, Norman Williams, Jeffrey Callison, Morgan Clair.

Public Attending: There were 187 members of the public attending.

Welcome, Roll Call and Today's Agenda
Will Lightbourne, DHCS Director
Director Lightbourne welcomed all members.

Director's Update
Will Lightbourne and Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentations-072921.pdf

Director's Update
Will Lightbourne and Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-072921.pdf

Director Lightbourne highlighted the major health provisions of the state budget recently signed by Governor Newsom. Taken together, the bills for health, human services, social services, developmental services, housing and community development represent an extraordinary investment in addressing the needs of underserved people and a huge step toward addressing the equity gaps we have discussed here over the past year. There are many implications for DHCS, such as funding of full-scope Medi-Cal coverage for undocumented individuals age 50 and older and full funding for the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Other notable items in the budget included:

- A population health management (PHM) platform.
- Providing Access and Transforming Health (PATH) funds to support in-reach to prisons and jails to ensure warm handoff transitions for people leaving incarceration.
- Community Health Workers (CHWs) authorized to become a covered provider type in 2022.
- Doula services included as a covered Medi-Cal benefit.
- Authority to lift, then eliminate asset caps, for seniors and persons with disabilities.
- Postpartum Medi-Cal coverage for undocumented women extended from 60 days to one year without the previous requirement of a behavioral health diagnosis.
- Budget resources for health equity mapping and a dashboard.
- Approval of the Office of Medicare Innovation and Integration that will focus on dual eligible and Medicare-only beneficiaries to promote the availability of home and community-based services (HCBS).
- The behavioral health continuum infrastructure program increased from $750 million to $2.4 billion in the budget with an immediate investment in local support.
- Behavioral health services for children and the approval of dyadic care as a Medi-Cal benefit.

Federal funding through the American Rescue Plan Act provided resources for an expansion of HCBS of approximately $3 billion of workforce development across DHCS, the Department of Social Services (CDSS), and the Department of Developmental Services (DDS), and program enhancements in support of homeless interventions, expansions of community navigation opportunities and more. The spending plan has been submitted to the Centers for Medicare & Medicaid Services (CMS) and DHCS expects to receive approval soon.

Jacey Cooper offered additional information on the initial implementation and integration of these initiatives. She noted that the various budget components reflect DHCS priorities on

access, equity, HCBS, social determinants of health, and behavioral health reform, which are all connected to CalAIM. Staff are working to map how the components fit together in a complementary fashion. For example, in the HCBS spending plan, there is a housing and homelessness incentive program, in addition to the CalAIM incentive program, that complements both Enhanced Care Management (ECM) and In Lieu of Service (ILOS) offerings in CalAIM. This will allow managed care plans (MCPs), counties, and continuum of care providers to draw down additional administrative dollars.

Cooper reported that there are additional PATH funds for homelessness and HCBS provider infrastructure capacity. DHCS is focusing on how to weave the additional budget resources into the infrastructure already rolling out. There is a significant opportunity for community-based residential continuum pilots that are partnerships of providers and MCPs to test and pilot different residential settings similar to long-term care at home. DHCS wants to innovate using residential models for individuals with behavioral health needs within the community to reduce the institutional footprint, using a combination of federal and state funds.

Lightbourne reported that, related to the Medi-Cal Rx initiative, DHCS has accepted a conflict avoidance plan with Magellan Medicaid Administration (MMA), Inc., a subsidiary of Magellan Health, Inc. (Magellan), and the initiative will be implemented on January 1, 2022. The January 2021 launch date was delayed due to the COVID-19 pandemic response and because, in the interim, the vendor, Magellan notified DHCS it was potentially being acquired by Centene. On July 27, 2021, DHCS announced it accepted a conflict avoidance plan submitted by MMA Inc. to mitigate conflicts associated with the proposed acquisition of Magellan by Centene Corporation. DHCS has posted the conflict avoidance plan on its website.

Cooper provided an update on CalAIM and the 1115 and 1915(b) waivers, reporting that the applications were submitted to CMS on June 30, 2021. The 30-day federal comment period for the 1115 waiver has opened and will end on August 13, 2021. There is no formal comment period for the 1915(b) waiver. DHCS has met with CMS and will engage with them over the next several months to complete the work. There are modified timelines for some of the behavioral health elements in CalAIM based on discussions with counties.

Shaina Zurlin from DHCS reported that stakeholders are excited about the improvements and are equally aware of the complexities of the work to get it all implemented. Feedback highlighted the need to pace implementation based on the many impacts on beneficiaries, counties, and plans. DHCS is making adjustments in the timelines for go-live so that everyone is set up for success. The plan is to maintain the intensity of work and also add time for technical assistance, training, and pilot periods. Zurlin reviewed the modified timelines on slide 6.

Cooper reported on COVID-19 vaccination disparities for Medi-Cal beneficiaries. Rates of vaccinations are lower for Medi-Cal beneficiaries than the general population in every county in the state. As of July 18, 45.6 percent of Medi-Cal beneficiaries, 12 years of age and older, were vaccinated, compared to 70.5 percent of all Californians. The disparities are across all ages, as well as lower rates for African Americans and American Indians and Alaska Natives. DHCS is engaging with local organizations, schools, and local health

departments to remedy these disparities. This is a priority for DHCS and a stark reminder of the inequities across California.

Questions and Comments

Cabrera: This is a hopeful moment for the public behavioral health safety net system. We are grateful for the agreement to move the payment reform timeline out by a year even though we are anxious to start payment reform. It will need that lead time to shift gears for this significant change. It will come on top of the work county behavioral health plans will be doing with MCPs on ECM and ILOS, as well as infrastructure investments, workforce investments, mobile crisis, and HCBS.

Savage Sangwan: Do you have any indication of CMS' willingness to accept tribal healers in the Drug Medi-Cal Organized Delivery System (DMC-ODS)?

Cooper: We are engaging with CMS. If you are planning to submit a letter of support, I encourage you to emphasize the importance of that and California's interest in this. Having broad support will help accomplish that.

Lewis: I want to understand why the co-occurring treatment and no wrong door, and especially the transition screening tools, are being delayed given how important they are.

Zurlin: DHCS convened a work group to develop screening and transition tools. Through multiple rounds of stakeholder engagement, we have a draft for adult screening and transition tools and are gearing up to launch a beta testing series. Over 30 days, we will have 2,000 assessments to understand how the tools work. We are launching development of the children's screening and transition tools, which are complex and may take longer. Through the dialogue of developing tools, we heard the need to do extensive testing before this rolls out statewide given the impact on beneficiaries. We want to have enough data after the person is placed in a system of care so we can determine if it was, in fact, the right place for them. We also want to ensure the tool is culturally competent and works across different-sized counties and systems statewide.

There are pieces of co-occurring treatment and no wrong door initiatives that can move forward before July 2022, but because some technicalities are embedded in documentation redesign, there would be a disconnect if those went forward ahead of documentation redesign. To keep everything in concert, we have those three timelines aligned.

Lewis: Will there be opportunities to look at the tools and policies in draft form?

Zurlin: Absolutely.

Taylor: I want to flag that we are not able to understand how this will look in the LGBTQ population because we are not collecting sexual orientation and gender identity data. We are definitely not getting this information for vaccinations for Medi-Cal or non-Medi-Cal. I want to encourage DHCS to move forward on collecting that data, in addition to the Medi-Cal streamlined application that, to my knowledge, is the only place it is being collected for

DHCS.

Kelley: Thank you for this informative timeline update. With the added year on the payment reform timeline, do we believe there will be sufficient time to settle outstanding cost reports, which for my county is five years of cost reports?

Fitzgerald: DHCS is actively trying to expedite that process. There will not be a clean break between payment reform and audits being completed. However, we are working to make sure there is less overlap.

Pfeifer: We are working to make this as tight as possible, but we can't ensure there will not be any overlap. It does take time for counties to submit the data, have it validated, and then give counties an opportunity to respond and make corrections. We are working hard to improve this.

Kelley: Several of us participated in the Community Vaccine Advisory Committee (CVAC) related to COVID-19 vaccination outreach. Is there discussion of reinstating CVAC to help with issues on vaccination disparities?

Cooper: Even if CVAC is not reconvened, we will work with field partners on vaccination disparities.

Ramirez: I am a beneficiary of the Los Angeles County Department of Mental Health and want to thank DHCS and the Governor for the budget. As a stakeholder, I see some of the biggest disparities in our behavioral health care system. Both CalAIM and the budget address the biggest issues that we face. I want to uplift the expansion of benefits for undocumented Californians, many of whom have been providing frontline and emergency services for our community throughout the pandemic. This is an example of how we rebuild trust in communities and build an equitable behavioral health care system by addressing the most marginalized and impacted among us. The involvement of stakeholders and beneficiaries like myself, who utilize the services and can bring feedback from peers, is particularly important to increase cultural proficiency in the way agencies provide services. And most importantly, on the issue of accountability and oversight, even in one of the largest public mental health systems in the country, we haven't been able to have deaf or hard-of-hearing contract services for consumers for more than three months. Along with systems and care becoming racialized, they have also become able-ized. It is important to address these issues as we move forward.

Koopmans: On the HCBS Spending Plan, can we expect that all of the programs will be implemented as soon as possible given the relatively short period of time that states have to utilize the funding? If so, what's the process and timeline for developing the program design, in particular the homeless incentive program? On Medi-Cal Rx, as you are aware, local health plans have had long standing concerns about the impact of the pharmacy carve-out on care delivery and access. That said, we acknowledge this is proceeding. Can you speak to the process for monitoring the conflict avoidance consequences for violations or breaches and the process for making plans and other stakeholders aware? Lastly, on the vaccination rates, local plans have continued to focus on increasing the rates of vaccination and on strategies to reach members. Plans have developed internal

dashboards for specific populations, pivoted to smaller events, partnered with faith-based and community-based organizations (CBOs), and supported providers to become vaccinators. The pace will be slower as strategies are evolving.

Cooper: I want to reiterate our appreciation for the plans' partnership with us to close the vaccination disparities and all the work you are doing. On the HCBS Spending Plan, there are 30 initiatives being implemented by multiple departments, and DHCS is leading nine of them. The housing and homelessness incentive program can move sooner, and we are working to get guidance out. The timelines on other pieces will vary. The community-based residential continuum pilots will be harder, others are easier, like eliminating the assisted living waiver list. We are working to amend that waiver submission to CMS. We are building the budget interaction tracker and will communicate the timelines.

Lightbourne: The conflict avoidance plan says that if Centene acquires Magellan Medicaid Administration, the unit of Magellan with the contract for the pharmacy benefit management, it will not be integrated into the larger entity. The data systems and staffing will be kept separate. Magellan will appoint a conflict avoidance executive to train staff and ensure they fully understand every obligation to which the corporation has agreed. Also, there will be a third-party monitor named by DHCS to make sure that preventive steps are being taken, and that there are no breaches of the agreement. In the event there are breaches, we would pursue contract remedies, including liquidated damages. Centene has affirmed all of these provisions. The final component of the conflict avoidance plan is that if Centene is contemplating any business activity that could be a conflict, they will consult the third-party monitor for an interpretation and would not proceed until we have agreed on it.

Pitts: Could you review the documentation redesign elements and any behavioral health workforce recommendations as part of CalAIM?

Cooper: There are not significant workforce initiatives in CalAIM itself. However, there are behavioral health workforce investments in the budget that other departments are leading in partnership with DHCS. There is also workforce investment through the Children and Youth Behavioral Health Initiative to be discussed later today.

Zurlin: Documentation redesign covers all of the main elements of the documentation process. For assessments, there will be universal domains to structure the processes and allow flexibility on which assessment tools are used. This responds to the needs of various populations and brings uniformity through the domains. Redesign is trying to determine where the treatment plan adds value and better align with MCP documentation. In addition, redesign is reviewing the content of progress notes to determine what to include. There is also work to determine how that bundle of documentation relates to audits and ensure all documentation adds value to the beneficiary experience and doesn't set up additional mandates.

Pfeifer: We understand that to achieve our goals, we need a robust workforce and there are many gaps in our current workforce, especially for children and youth. That is why there is a significant investment in the children's initiative. The peer specialist is a new workforce being adding to Medi-Cal, and there are grants going out to train and support that. In addition, we have Substance Abuse and Mental Health Services Administration

(SAMHSA) funding from recent federal initiatives, and some of those grants are for workforce.

Imparato: I agree with the comment that it could be useful to tap into the expertise of the CVAC stakeholder group by convening or polling the group for suggestions. I am sure people would be happy to talk about outreach to Medicaid beneficiaries. I know that the Medicaid gap is a problem across the country, and we may be able to learn from other states what they have done with MCPs or CBOs or gather information directly from Medicaid recipients who have not been vaccinated to understand the barriers.

Cooper: This is not unique to California, and we are gathering best practices and toolkits, and speaking with public health departments from other states. We also spoke to CMS about similar Medicare disparities they are seeing and how we might partner. We are very focused on pulling resources and partners together, even informally, to discuss how we can move the needle. I think it is a thoughtful idea to poll unvaccinated Medi-Cal beneficiaries.

Coyle: Thanks for all the effort going into this historic investment in behavioral health. Could DHCS create a concise chart or document to help us track the funding and the purposes across the multiple budget bills?

Cooper: Yes, we are working on a digestible way of communicating that.

Stoner-Mertz: I want to emphasize the importance of moving forward on the documentation efforts. I am glad to see this happening in 2022, although sooner is better. This is directly linked to the issue of workforce because as we reduce documentation requirements, we will see an improvement in workforce. It is a reason we lose staff. A question on rates: what are some elements of payment reform for the peer groupings and rate changes? Will there be pilots prior to 2023?

Fitzgerald: There are several buckets of work: 1) identify the data components, 2) determine a rate-setting methodology, and 3) peer grouping. There are three delivery systems impacted and many layers of policy and statute that contribute to a delayed launch. We have uncovered layers of embedded policy and want the payment methodologies to be equitable in each county, so that is where peer grouping comes in. I don't believe there will be a pilot. However, the idea of the extension is to allow for technical assistance (TA) and financial modeling.

Fields: On the infrastructure expansion, I have concerns about how information, historical background, and system program planning is being gathered. Most counties do not have experience developing, launching, and operating residential treatment programs. Expertise for this is in the community and nonprofit sector. I want to ensure there is outreach to include the expertise in the provider community about what a continuum of care looks like, what elements are included, what precedent there is, and to learn about opening programs. I don’t want a lack of experience to impede building out alternatives to skilled nursing, to inpatient hospitalization, and not open more Institution for Mental Disease (IMD) beds. The Association of Social Rehabilitation Agencies and others stand ready to offer TA to stand up continuum of care opportunities effectively and use this money very efficiently

Lightbourne: We welcome that input. There is an imperative for us to work through the county and tribal structure both for the long-term operation and because they have a role in land use. In any case, we definitely want to partner with the nonprofit community as well. In addition, the budget included $150 million for mobile crisis response on an urgent basis, and DHCS released a Request for Proposal (RFP) this week.

Fields: I agree the county is essential for operational issues. My concern is that because of neighborhood opposition, counties are risk averse to developing programs in the community. CBOs are willing to challenge this, and we win. I would regret it if counties didn't even try to improve access in neighborhoods due to potential opposition.

Vitka: Is there any plan or framework for how the multi-state opioid settlement will be used?

Lightbourne: There are discussions ongoing between the attorneys general, state, and local governments, and we can speak to it when it is more settled.

Diaz: What are the next steps and process for the behavioral health infrastructure funding in the budget? Will there be public forums to engage outside of DHCS working with the counties?

Cooper: We are still working through what the process looks like. We are working on a survey to counties to identify gaps and opportunities and inform where funds should be used - across the continuum, from residential to community-based wellness centers.

Ramirez: Coming back to vaccination, the Latino population has been greatly impacted, and yet I see hesitancy to get the vaccine, especially in young people, due to the spread of misinformation on social media. Twitter and Facebook particularly are highly utilized in our community and people rely on them for information and communication. When a simple message is put out, it spreads like wildfire. It's difficult to convince our loved ones because we don't have the necessary training on how to really approach them with better information. This may be important to consider as a barrier.

Cooper: That is exactly the kind of information we are grappling with, to identify trusted community voices, if family can't get through. Social media can be hard for getting messages like this out, but clearly is a driver for misinformation.

Africa: Counties are implementing and do not expect to be the expert in all areas. We need to build this as a partnership, and it is important for all of us to have that mindset to be successful. On the vaccination barriers, there is also distrust of government. What we are seeing is beyond the issue of vaccination. We need to think about it system-wide and systematically as related to racism and other injustice.

Senella: Congratulations for getting the postpartum benefit changed. When will it go live?

Cooper: It will go live on April 1, 2022. The timing is connected to the American Rescue Plan Act (ARPA). I would also flag that since we are still under the COVID-19 public health emergency, no one is being disenrolled from Medi-Cal.

Managed Care Procurement Update
Michelle Retke and Bambi Cisneros, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentations-072921.pdf

Cisneros provided an update on the MCP procurement process for commercial plans. With more than 86 percent of all Medi-Cal members enrolled in managed care and even more transitioning as part of CalAIM, DHCS views the MCP procurement as a major initiative to improve access and quality of care. The procurement will further CalAIM's goals to:

- Identify and manage member risk and need through whole person care approaches and addressing social determinants of health.
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Cisneros reviewed each category of comments, offered a summary of themes emerging from them, and reported on the current plans for follow-up action. She noted that the contract updates highlighted today are not all inclusive of changes that DHCS is considering for the final RFP. She reported on the timeline and next steps for changes and thanked all who submitted comments.

Questions and Comments

Veniegas: The HCBS Spending Plan includes the implementation of incentives. Will this open an opportunity to add language or considerations to the MCP procurement for incentives available because of ARPA? Second, based on the learnings published in May 2021 by the UCLA Center for Health Policy Research on the Whole Person Care (WPC) implementation as well as reporting from the Legislative Analyst's Office, housing stability and housing services access will be key issues in the procurement process. There were 14 counties in WPC that focused on homeless populations and another nine focused on at-risk-for-homelessness populations. We do not, as a stakeholder advisory committee, have a visible engagement with providers from this sector. How might we include them in future engagement?

Cisneros: We want to preserve the great work gleaned from WPC and would look to MCPs to bring in community-based providers that provide those services. Toward that end, we have engaged Manatt, Phelps & Phillips, LLP to lead provider engagement, with a goal of informing and educating the provider community about the requirements under WPC. I will share this information with you.

Cooper: HCBS funds must be expended by March 2024, and MCP procurement contracts will begin on January 1, 2024, so the timing is not aligned. DHCS will provide guidance to MCPs on additional incentive dollars focused on housing and homelessness through the HCBS Spending Plan, likely through an APL. DHCS will engage housing and homelessness partners for the PATH funds to provide technical assistance, ensuring

partnerships between MCPs and providers. DHCS is negotiating the PATH funds with CMS as a part of the waiver. We will get information out soon on the HCBS Spending Plan and incorporate it into the CalAIM incentives and structure.

Veniegas: If there's an opportunity to hear from providers, the foundation will support a cohort of two dozen providers and offer them as a resource.

Cooper: We can connect you with the team working on that, and thank you for that offer.

Lewis: Can you comment on the fact that the RFP does not necessarily reflect what the contracts will ultimately look like in terms of requirements, and highlight items not currently in the RFP, such as PHM, ECM, ILOS, and behavioral health reforms that are coming through additional documents, guidance letters, or requirements in the final contract?

Cooper: This is important to track. The RFP will be released at the end of 2021, but the plans won't go live until January 2024, so the final contract will look different than the RFP. DHCS is making sure there is clarity via the RFP so plans understand the commitment to the various components that would be required by January 2024. However, not all details will be available at the time the RFP is posted. For example, PHM begins in January 2023, and we will continue stakeholder engagement on that through 2022. There will be a combination of the contract and APLs providing guidance. In addition, we are revamping our comprehensive quality strategy and equity roadmap. In combination, those will spell out what MCPs are expected to provide as of 2024. The RFP narrative questions will be important to demonstrate how plans will meet expectations. The narrative questions will include equity, behavioral health integration, and CalAIM components, and will be evaluated and scored. The process is fluid and continuous through the beginning of 2024.

Tsai: MCPs are central to the work the county does and how central they are to the success of CalAIM. I hope DHCS will keep in mind the importance of recognizing incentives and how the governance of the process of value-based care and setting up incentives will shape outcomes. For example, we have had productive discussions with MCPs, and it is clear that decisions being made as to what ILOS options to pursue come from a lens of value cost-effectiveness for the MCP. I highlight that because the county has broad responsibilities and takes risks beyond the systems of care. If we don't do a good job on substance use disorder services, we see impact in law enforcement and other partners. I want to plant the idea of how important it is that counties be integrally involved in setting up incentives and value-based payments, even if they flow through the MCPs, as that success includes priorities beyond the MCP. CalAIM is about improving communities as a whole, not only the beneficiaries of MCPs, and there may be instances where high value from a community perspective is not high value for a MCP.

Cooper: We agree with your core sentiment. Things that historically have not been the responsibility of the MCPs will be in the future. There will be a mandate that MCPs have a role in reentry. We want to ensure that MCPs and counties are partnering. The RFP includes stronger mandates and language on partnership, with public health, social services, and other county partners.

Children and Youth Behavioral Health Initiative
Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentations-072921.pdf

Cooper reviewed information about the $4 billion investment intended to transform behavioral health (BH) care for all children and youth, 0 to age 25, regardless of payer. She noted this is not a short-term budget item and will not roll out immediately as with other budget items. This requires planning, policy development, infrastructure investments, and scaling up over time to move upstream.

Questions and Comments

Pitts: I have worked for many years to have occupational therapists (OT) be recognized as a mental health provider in the public mental health system. There has been success in some counties, but typically OT is not considered a behavioral health provider. I appreciate the offline discussion with DHCS on this issue for adults. For children, OTs are already fully integrated into most school districts. Early intervention psychosis programs operated internationally, and at least two models developed here require an OT to be on the early intervention psychosis team. I want to advocate for OTs to be included in programs being developed.

Wilkes: I want to elevate the voice of communities of color and advocate to get resources out quickly. In schools, we need to tackle homelessness and unaccompanied youth, ages 14 and over. We need to pay attention to them and work with the Workforce Innovation Opportunity Act. We need to build a workforce and collaborate to connect young people to services. I also want to make sure that youth homelessness prevention centers are a part of the ecosystem we are creating to support young people and bring them into services. It is so important as part of engagement that we bring a variety of youth in and give them a voice. I want to make sure that we are aware that people are hurting now and 2024 is a long time from now. I believe we can get there by all of us stepping up, to make sure that we protect, serve, love, and build trust that respects our young people to be the next leaders, today and tomorrow.

Berrick: I want to acknowledge that this is an incredible opportunity. The portal gives us an opportunity to be a single state in the context of a county implemented system. Right now, providers are dealing with 10 different electronic medical records, access points, and systems of documentation that could all be streamlined if the portal becomes a single unified system, and we develop transitions to accounting and provider networks. I hope that we think of the portal as an opportunity to create a seamless statewide system so that when families and young people come in to receive services, the process doesn't fall apart when a young person is in one county and family members are in another. Are we thinking about how the current medical record system could change through this opportunity?

Cooper: Thank you, that is an interesting point. I will take this back for discussion.

Teare: As we build around the backbone of the virtual portal, some of us have real concerns about the equity implications. Virtual tools have been historically geared toward English-language services and don't emerge from or serve communities of color well. I

approach this with enthusiasm and concern about addressing that problem. Can you say how substance use disorder fits into the language of behavioral health?

Cooper: For DHCS, behavioral health always means both mental health and substance use.

Imparato: I have a suggestion as you think about the design. There is a way to frame this as clinical, and there's another way to frame it where mental illness is seen as a natural part of human diversity. When I was diagnosed with bipolar disorder, it was helpful to adopt a civil rights frame for this condition. It's worth thinking about how California can expose all children and their families to a civil rights frame for disability and mental illness and teach children and their families about their rights to accommodations in education, employment, and housing settings. I encourage us to think about some of these non-clinical interventions.

Cooper: Thank you for raising that.

Health Equity Roadmap
Sarah Brooks, Sellers Dorsey and Palav Babaria, MD, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/BH-SAC-presentations-072921.pdf

Lightbourne offered introductory context and a recap of SAC discussions. The dialogue started with a recognition that the extraordinary disparities in health outcomes based on race, income, and class are driven by racism in society and in the economy, and racism built into the health system. DHCS is embracing social determinants of health as a partial tool to mitigate the effects of the underlying social and economic racism. DHCS wants to explore what other tools may be available to address racism in the health care delivery system. To further this work, the California Health Care Foundation engaged external consultants, Sellers Dorsey, to identify potential short, medium, and long--term opportunities to establish measurable goals for DHCS consideration in its equity work going forward. Dr. Palav Babaria, Chief Quality Officer and Deputy Director of DHCS' Quality and Population Health Management, is leading a portfolio that includes this health equity conversation.

Sarah Brooks from Sellers Dorsey noted that the research conducted was completed in the beginning of 2021 and pre-dated the May Revision and so does not include the many actions taken with respect to health, disparities, and inequities in the final state budget. Sellers Dorsey was engaged to complete an assessment of DHCS' efforts related to race and ethnicity health disparities and equity, and to propose a roadmap for future activities and initiatives. Research was conducted at the state and national level, such as the National Quality Forum. The research resulted in six domains for the health equity roadmap: health equity structure and culture, community partnerships and collaboration, measurement and analytics, performance monitoring and evaluation, program policy changes and interventions, and payment structures and fiscal strategies.

Dr. Babaria commented that the roadmap has been very useful already, and DHCS is working to incorporate new initiatives from the budget. DHCS developed a simplified

framework, thinking through how this plays out at the state, health plan, and provider levels so that approaches to equity are consistent and have impact.

Internally, DHCS will continue to map current and planned initiatives and work with stakeholders to identify gaps and build capacity over the next three to five years to address disparities. We want to avoid unnecessary administrative complexity and align our efforts with ongoing national efforts to simplify the work for plans and the provider network. We are thinking through how the health equity strategy explicitly ties to the new benefits rolling out and will continue to partner with the California Pan-Ethnic Health Network and public health on cultural competence in county mental health plans.

Questions and Comments

Walker: I applaud DHCS for addressing health equity. Over the years, we have acknowledged the importance of measurement, to identify race and ethnicity in data systems to pinpoint disparities. We have moved through multiple phases and language and now we are addressing health equity. Underlying all of this, as the Director pointed out, is racism. This is the most important aspect. We are now recognizing the need to identify, call out, and address racism and acknowledge how much it impacts access to housing, jobs, and food.

Grealish: I want to let people know about the behavioral health data share with the California Department of Corrections and Rehabilitation (CDCR). I think DHCS, CDCR, and the Medicare Utilization Project data would be informative for us to look at.

Cabrera: My question is whether there will be a county behavioral health representative on the Quality Improvement Health Equity Committee to highlight and lift up behavioral health?

Cooper: Yes, counties are central to this effort.

Babaria: For both the quality and the equity strategy, I am planning to meet one on one with the county directors to learn about the challenges across the state. I hope we can come up with some common goals for both quality and health equity, like capturing accurate race information across all programs, inclusive of behavioral health. There will also be behavioral health specific goals. We will need detailed working sessions with content experts and stakeholders to develop the goals at a detailed level. Over the next year, we will get more clarity as the Department of Managed Health Care sets up the health equity committee, we continue to participate on the NCQA equity leadership team, and we engage stakeholders to figure out the goals.

Public Comment

Hellan Roth Dowden, Teachers for Healthy Kids: This work is remarkable. I notice there isn't anyone from a school district or from the school community on the BH-SAC. I suggest that you include a representative because the input of how it works in school is going to be important to make sure that this wonderful effort is a success.

Hannah Bichkoff, CalVoices: I applaud DHCS and the Governor for expanding full-scope Medi-Cal coverage to undocumented Californians, age 50 and over. We are thrilled about increased funding available through ARPA, and the investments in the Children's Behavioral Health Initiative. We hope that some of these funds become available for certification fees for peer support specialists through Senate Bill 803 implementation. As of now, applicants will be responsible for those fees, and this poses a barrier to becoming part of this essential mental health workforce.

Karen Fessel, Mental Health and Autism Insurance Project: Our organization works with teens and young adults to get coverage for medically necessary residential treatment. I am hopeful this money will be for longer term residential treatment than we currently see in the commercial sector, 90 days or more, if needed. We have many teens with suicidal history and severe substance abuse. They cannot be adequately treated in the outpatient setting. There was also a recent court case involving United Healthcare. It was a California case in which the judge ruled to be a federal case in California. The judge determined that it is not enough to stabilize the client; the underlying mental health comorbidities must be treated as well, and these cannot be done in a quick hospital stay of a few weeks. It takes longer to make meaningful change, and often these clients need a protected environment that includes therapy and even school.

Jane Adcock, California Behavioral Health Planning Council: I want to echo my colleagues in thanking DHCS. This has been an unprecedented stakeholder engagement process. Now with the budget, we have new opportunities. The council encourages DHCS to stay in touch with community-based services. Although your world is about Medicaid, and a lot of this is possible because of the directions you're willing to go under Medicaid, there is a whole other system. I echo Steve Field's comments about community-based services and providers that are rich and valuable, and have made the difference for many of the folks served. That is why health plans are starting to adopt our model with whole person care. So, the council encourages DHCS to continue and engage with more persons with lived experience. I think a lot more can be learned from them. Their insights are amazing. Thank you for all the work you've done; we think you've done a great job.

Robert Wayne, California Council of Community Behavioral Health Agencies: We appreciate the discussion today. In particular, we want to reiterate our support for the children's initiative. As it pertains to the documentation redesign and standardization pilots, we look forward to having a voice in the development of those pilots. We also appreciate the many comments and questions raised by our members, including HealthRIGHT 360 and Tarzana Treatment Centers, around changes to the substance use disorder system. Lastly, we're in support of the comments made by Ken Berrick from Seneca about the electronic portal.

Next Steps and Final Comments; Adjourn
Will Lightbourne, DHCS

Lightbourne introduced and welcomed Tyler Sadwith, the new Assistant Deputy Director for Behavioral Health. He came from consulting and previously worked with CMS. Lightbourne thanked participants for their input and comments and reminded members of the last quarterly meeting: October 21, 2021, from 9:30 a.m. – 12:30 p.m.

Addendum: Additional Questions from BH-SAC Members and DHCS Responses

Question: Is there a workgroup that is discussing supporting vulnerable youth populations like unaccompanied minors and youth?

> **DHCS Response:** At this time, we do not have a workgroup specifically addressing this topic.

Question: I wanted to ensure for the virtual platform that funding and partnerships will be considered, including aligning with the Federal Communications Commission and cell companies. CHCF spoke to the equity piece, which also includes a lack of bandwidth and technical infrastructure in remote areas, especially in large counties. Accessibility should be considered for persons who are visually impaired and deaf or hard of hearing. Additionally, many people with lower socioeconomic status don't have private areas to speak to a therapist virtually, and they may receive Wi-Fi in a public location, such as the library, a Starbucks, or other places that do not typically provide adequate privacy for therapeutic interventions via telehealth.

> **DHCS Response:** We will consider the feedback as we move forward with planning for the virtual platform.

Question: It would be helpful to hear more about how some of the CYBHI components fit together in the short term. For example, does DHCS see the BH infrastructure and capacity grants and the evidence-based practice grants intersecting with or supporting the managed care student BH incentive program? As health plans collaboratively map existing resources and identify gaps and needs, it seems like some of these same partners may apply for and receive funding through the grant programs or additional dollars through the Mental Health Student Services Act grants. How should this be coordinated so that we are not creating additional programs in silos?

> **DHCS Response:** DHCS is planning to coordinate efforts in the CYBHI with other DHCS BH efforts. At this stage of implementation, DHCS does not yet have specifics on how this will occur.