DEPARTMENT OF HEALTH CARE SERVICES
BEHAVIORAL HEALTH STAKEHOLDER ADVISORY COMMITTEE
January 6, 2020

MEETING SUMMARY

Members Attending: Sarah Arnquist, Beacon Health Options; Ken Berrick, Seneca Family of Agencies; Catherine Blakemore, Disability Rights California; Michelle Cabrera, County Behavioral Health Directors Association of California; Jessica Cruz, NAMI California; MJ Diaz, SEIU; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Veronica Kelley, San Bernardino County; Jim Kooler, California Friday Night Live Partnership; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Farrah McDaid Ting, California State Association of Counties; Frank Mecca, County Welfare Directors Association of California; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Chris Stoner- Mertz, California Alliance of Child and Family Services; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Stephanie Welch, Department of Corrections and Rehabilitation.

Members Attending by Phone: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Andrew Herring, California Bridge Program; Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation.

Members Not Attending: Carmela Coyle, California Hospital Association; Vanessa Cuevas-Romero, Sacramento Native American Health Center; Robert McCarron, California Psychiatric Association; Maggie Merritt, Steinberg Institute; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Jonathan Sherin, Department of Mental Health, County of Los Angeles; Catherine Teare, California Health Care Foundation; Dean True, County Behavioral Health Directors Association/Shasta County Health and Human Services Agency; Bill Walker, MD, Contra Costa Health Services.

DHCS Attending: Richard Figueroa, Mari Cantwell, Kelly Pfeifer, Rene Mollow, Brenda Grealish, Marlies Perez, Jacey Cooper, Lindy Harrington, Michelle Retke, Sandy Williams, Janelle Ito-Orille, Adam Weintraub, Morgan Clair.

Public in Attendance: 34 members of the public attended in person and there were 150 phone participants.

Welcome and Introductions of BH-SAC Members
Kelly Pfeifer, MD, and Brenda Grealish, DHCS

Note: CalAIM was renamed to Medi-Cal Healthier California for All on January 8, 2020.

The Cal-AIM proposal is ambitious, and we are pleased to have this additional meeting for discussion. Thanks to all the members who have provided feedback and input to the proposal. I also want to acknowledge that Jim Kooler will be joining DHCS next week and this will be his last meeting as a participant.

The format for today is to refer to the slides that contain a short overview but keep presentation to a minimum. There are questions for each section of the CalAIM proposal developed by state staff to prompt our discussion for dialog and comment. We have a tight timeline, so will keep to the timing for each section.

Brenda Grealish offered her thanks to the group for all the comments to date and for attending additional meeting today. It is an immense help as the concepts continue to evolve.

County Inmate Pre-Release Application Process
Rene Mollow, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

Rene Mollow referenced the overview slides and summarized a few key points related to the pre-release application process and timeline. She opened the discussion by referring to the questions for the advisory group.

Questions from DHCS

1. To ensure a seamless transition of the inmates into the community, what type of agreement/contracts are necessary with the County Sheriffs or a third-party entity?
2. What are the data sharing issues that need to be considered?
3. What roles and responsibilities would allow for effective coordination among all parties?
4. Due to the unpredictable release dates of the population, should there be a minimum time period to allow for the pre-release application to start?
5. It has been noted that access to care remains a critical issue in the pre-release process. What steps/guidance can DHCS take to coordinate with health plans to facilitate a seamless eligibility and enrollment end-to-end process?
6. What coordination would be necessary with courts and judges to effectuate this program?
7. What are some best practices that counties can leverage for a successful pre-release program?

Questions and Comments

Kim Lewis, National Health Law Program: I want to raise the issue of addressing the state law that terminates eligibility for inmates at the one-year point that we believe is inconsistent with federal law. Being incarcerated in county jail or state prison does not create an issue with eligibility and there is no reason to terminate eligibility at one year. This would create savings in the county eligibility process and would allow inmates to access services upon release without having to go through the eligibility process.

Rene Mollow, DHCS: Thank you for that. We did get the federal guidance in terms of juveniles. We will have to be mindful of policies related to renewals but understand the concern. We are looking to adjust our policies in light of the new federal guidance.

Farrah McDaid Ting, California State Association of Counties: We stand in strong support of this concept and agree there can be some efficiencies. I suggest that DHCS convene Sheriffs who run the county jails to ensure we are all on the same page and that what is proposed can work.

Veronica Kelley, San Bernardino County: Can you define what behavioral health services entail for those in custody? In my county jail, we have a behavioral health unit for the seriously mentally ill (SMI) and we have a general population who often receive medication. That population is huge. We don't have enough staff to connect that group (warm hand-off) because it is so large.

Rene Mollow, DHCS: We want to work with the workgroup that is envisioned for this proposal to help identify who this population will be and look at the criteria for the population. Our goal is to make sure people who get services and supports during incarceration get a warm hand-off and don't fall through cracks as they return to the community.

Veronica Kelley, San Bernardino County: The SMIs are carved out. It would be good to include managed care organizations (MCOs) in the conversation since many of the general population will be mild-to-moderate individuals and the MCOs will have responsibility to serve them in the community.

Jacey Cooper, DHCS: Yes, it will be important to define the populations. The SMI may be easier to identify but we agree with you we need more discussion about the mild-to-moderate population in the general jail or prison population.

Rosemary Veniegas, California Community Foundation: I would also encourage consideration of pharmacy benefits coordination for when inmates are released, often at 2 a.m. How will they be able to access pharmacy benefits so there is continuity?

Mari Cantwell, DHCS: That's a great comment and given our Medi-Cal Rx proposal to serve pharmacy through fee-for-service (FFS), it should be easier, but we should add that issue to the list for coordination discussions.

Frank Mecca, County Welfare Directors Association of California: Thank you for considering the issue of not terminating incarcerated individuals. We want to work with you to negotiate a simplified redetermination process so we can spend as few resources as necessary for those who have been incarcerated.

Rene Mollow, DHCS: I do want to emphasize that we have to look at whether we are treating incarcerated beneficiaries differently than other beneficiaries. We need to make sure we are treating all Medi-Cal populations the same.

Frank Mecca, County Welfare Directors Association of California: To the extent there is flexibility through the waiver process to treat populations differently, it is worth exploring. It seems there should be a way to simplify the process for this population. For example, we know their address and other relevant information, so perhaps we can use the waiver to create a simpler process.

Vitka Eisen, HealthRIGHT 360: I urge you to consider including provider representation on the workgroup. Providers across the state are doing this work on enrollment prior to release and have experience to share.

Stephanie Welch, Department of Corrections and Rehabilitation: In addition to counties, I think you should consider CDCR on the workgroup. My Council has been on record for several years, that if we could do suspension for more than one year, it would be helpful for both county jails and potentially for prisons.

Gary Tsai, MD, Los Angeles County: This gets to coordination. Since we don't know when an individual is going to be released, it's important to engage with law enforcement. It seems there are three options: 1) better schedule and coordinate releases; 2) have an intermediary community location available with a workforce to serve them; or 3) have a trained workforce readily available 24-7. The latter options are much less efficient, so this makes it important to engage law enforcement.

Steve Fields, Progress Foundation: I want to underscore having providers on the workgroup doing this work. What do we know about relationships between service providers and county jails? There is no reason we can't work out agreements that already exist in San Francisco, where county behavioral health providers go into the jail on a regular basis. This embedded service helps identify when they will be released. The Sheriff and staff have been very happy to have providers to evaluate and assess for services. In addition, we need to have services for people that are relevant for their needs when they are released. We need to continue to talk about an array of services in the community for those who will be released; and, they are the same as the needs for those already in the community. There are many places not prepared to do crisis residential, 24-hour substance abuse and other services.

Veronica Kelley, San Bernardino County: On coordination, it's also important to coordinate with Superior Courts, District Attorney (DA) and Public Defender (PD).

Sarah Arnquist, Beacon Health Options: My question is whether, if an individual is suspended, would they stay with the same MCO when they go back into community?

Rene Mollow, DHCS: Today, if they are suspended and then released, they have the choice to go back into the same plan. We can work on policies to solidify the process. People have choices to change on the physical health side although there is only the county plan on the mental health side. We would want to work on what the options are.

Sarah Arnquist, Beacon Health Options: For those who are mild-to-moderate, if they were to go into FFS, we would lose them in care.

Rene Mollow, DHCS: We want to look at what has worked. There are counties operating with policies for warm hand-offs and we want to look at that and bring together policy that work for this population.

Stephanie Welch, Department of Corrections and Rehabilitation: Do we have a sense of timing for the federal guidance related to using Medicaid 30-days prior to release? How do we define pre-release; is it at booking, is it post adjudication, is it 30-days pre-release? Is this determination going to be statewide or happen by county?

Jacey Cooper, DHCS: We are watching the Support Act guidance on the 30-day in-reach policy. New York has submitted a waiver for this, and we are looking closely at that for our waiver submission. On the second question, this is one of the key policies we need to work on. We want to learn from those already doing this, including California counties, and have discussions with the workgroup to help us determine what the parameters should be for this policy. There may be a need to have a state standard with discussion of county flexibility. If you have recommendations on this, we are interested in hearing from you.

Rene Mollow, DHCS: We greatly appreciate all the input and welcome the thoughts. Some of those identified today to include for this workgroup, we have also identified, so we appreciate that.

Kim Lewis, National Health Law Program: Washington, D.C. requested a waiver for coverage for inmates and it was not approved. The Support Act is broader than substance abuse and we should be clear about that limitation.

Mari Cantwell, DHCS: Yes, when we first did Whole Person Care, we tried to get authority to go in prior to release and we did not get that approval. If someone is going to be released and is not suspended, does not have a previous health plan or were not enrolled previously, what are your thoughts about enrolling them into a plan pre-release?

Kim Lewis, National Health Law Program: It is quite different to be on a plan and keep them on vs not enrolled. Keeping them on FFS while incarcerated helps with reimbursement for hospitalization during incarceration. That's why it's important to be narrow about the suspension. However, if they are enrolled pre-released, we would want them to be in FFS and have a choice of plans.

Kelly Pfeifer, DHCS: Are there different perspectives around the table about enrolling people into a plan and preserving their choice?

Stephanie Welch, Department of Corrections and Rehabilitation: We do have a transient population. When released, you are required to return to the county where you are convicted and people may not stay there. We hear that it can take longer to get enrolled in a plan if you move to a new county and were already enrolled in a plan somewhere else.

Sara Gavin, CommuniCare Health Centers: I would add the Transition Clinic Network, who specialize in this area to the group of individuals considered for the workgroup. We have provided services in the jail and want to underscore how important relationships are for

engaging the population in care. We build a system with multiple agencies and different agencies for various services. It is difficult to establish those relationships when there are multiple agencies and staff. On the issue of health plans, it is difficult to serve those who are auto-assigned somewhere and need to change plans to receive services.

Linnea Koopmans, Local Health Plans of California: I understand the desire for beneficiary choice pre-release; however, it does seem more seamless to have a warm handoff if they are pre-enrolled in a plan before release both from data sharing and coordination point of view. Given the proposal for annual enrollment, this may need to be a population with an exception to those limits.

Rene Mollow, DHCS: We appreciate the comments. This policy area will need the input from many stakeholders. One question that didn't come up is on data sharing. Do people have comments or experience challenges related to data sharing?

Vitka Eisen, HealthRIGHT 360: On the previous topic, it is not clear that the process described doesn't include choice. When people are enrolled, they choose a plan.

Rene Mollow, DHCS: There may be thoughts about those individuals going back into the plan they were previously enrolled in without a new discussion of a plan choice.

Vitka Eisen, HealthRIGHT 360: Can't we develop a process that would include choice? It seems that going to jail is a "qualifying event" and would give them the option to make a new choice of a plan that accommodates their plans to go back to a different county. On data sharing, is this about enrollment or is it about the care they receive while incarcerated? It is complex for data sharing related to their care, but it shouldn't be as difficult on enrollment. It took five years to get data sharing agreements under AB 109, however perhaps looking to AB 109 agreements will help.

Rene Mollow, DHCS: It is on both the enrollment and the health care services side – their diagnoses and treatment. It is likely to involve each county, with 58 county counsels, and different ways the data sharing is working.

Farrah McDaid Ting, California State Association of Counties: To this point, bringing in the Sheriff and bringing them along related to data sharing is critical, in addition to County Counsel and perhaps Probation. Medications, treatment and health care data can all be a challenge.

Jacey Cooper, DHCS: We agree. We know this will be difficult and we want to learn from existing practices.

Veronica Kelley, San Bernardino County: The data issue is huge for counties. Even with an awesome Sherriff and great access in the jail, it is still difficult. There are also challenges with the DA and PD because information in the chart can impact a legal proceeding. We need the medical chart of their treatment while in custody and need to be able to exchange information with the jail.

Kim Lewis, National Health Law Program: The data sharing issue is huge and crosses workgroups, especially for mental health and substance use. In terms of this population, there may be claims data that can be shared but it is often not timely. In this case, it may not be only Medi-Cal data and it differs across facilities - state and county. Perhaps there are ways to share data agency to agency more easily.

Gary Tsai, MD, Los Angeles County: My comment is about the nuance on 42 CFR Part 2 (federal confidentiality law), because that is the challenge. It's important to establish clearly what is and is not allowable. It is not clear to me that criminal justice settings fall under 42 CFR Part 2 because they do not hold themselves out as substance abuse treatment centers. It would be helpful to have something from State Counsel as guidance to County Counsel, similar to the Manatt, Phelps & Phillips paper, *Fine Print: Rules for Exchanging Behavioral Health Information in California*. Also, it's important that, with consent, information can be shared, and it would be important to incorporate consent into each step of the process to facilitate data sharing.

Kelly Pfeifer, DHCS: This has been extremely helpful.

Rene Mollow, DHCS: Thank you all.

Behavioral Health Payment Reform
Lindy Harrington, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

Lindy Harrington reviewed slides on behavioral health payment reform. The CalAIM initiative aims to reformat the Medi-Cal behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. She described the specifics of two phases to shift from the current cost-based reimbursement structure to a rate-based system. She reviewed questions developed by staff and opened up for discussion with members.

Questions from DHCS

1. How would set rates for services best be established? What geographic groupings might be appropriate, and how many should there be? Would there be a need to differentiate payment rate by provider type (e.g., county owned vs private provider; clinic vs individual provider)?
2. In addition to payments for services, what flexibilities would counties want in order to allow for value-based payments or quality payments?
3. Should DHCS transition all three delivery systems on the same schedule or should the systems be transitioned via a phase-in schedule?
4. Counties and providers are in different states of readiness for transition to HCPCS Level I Coding submission to DHCS. What steps should DHCS take to ensure counties are prepared for transition?

Questions and Comments

*Chris Stoner- Mertz, California Alliance of Child and Family Service*s: Has there been a crosswalk developed between the Healthcare Common Procedure Coding Systems (HCPC) to Current Procedural Terminology (CPT) codes? It's difficult to understand the impact without having that.

Lindy Harrington, DHCS: Both the financial and benefits teams are currently working on that.

Michelle Cabrera, County Behavioral Health Directors Association of California: On the rate groupings that might be appropriate from an efficiency point of view and to get the right rates, we believe it's important to look at peer groupings in addition to geographic proximity. We could get some misalignment without this. Also, on setting rates, it's important to look at rate setting in light of the work happening on medical necessity. There has been impact on how counties deliver services based on financial resources, Medi-Cal or not. There is information that counties use Mental Health Services Act (MHSA) and other county funds that do not draw federal match. It is difficult to do but important to include this information to make sure rates account for services previously not matched.

Lindy Harrington, DHCS: Yes, we acknowledge that some counties have made the choice to use non-Medi-Cal resources. We would need actual claims and other data to use in the rate process, so it's important for counties to begin to look at what information they have on those resources.

Farrah McDaid Ting, California State Association of Counties: On the question posed about what technical assistance (TA) is needed; yes, there will a high level of TA required for the transition for counties and providers, but also TA on the overall issues of payment reform, switching from Certified Public Expenditures (CPEs) to Intergovernmental Transfers (IGTs). There is currently a seven-year tail on getting final costs settled so we will be operating under the new system while still maintaining financial accounting for the old system. Having both systems operating simultaneously while we settle the tail is an issue for both county and DHCS workforce. We want to work with you to identify the issues and make that work.

Vitka Eisen, HealthRIGHT 360: In reference to Question #4, does this mean we will unbundle current services? For example, currently a residential stay is bundled. Does this mean that each activity in a residential stay needs to be entered and coded?

Lindy Harrington, DHCS: This is where the cross walk will help. Most of Level 1 coding is "physician services" and some will continue in a bundled rate. If we know all the components of a bundle, we can also look at how to set a rate that incorporates all of the components and costs.

Vitka Eisen, HealthRIGHT 360: if you want more granular data from what is historically a bundled service, is there is a tradeoff in what currently requires significant narrative charting? Currently, there is a subjective review that may result in a challenge to whether the charting justifies a service. It could be a valuable trade-off to providers to simplify this charting and provide more detailed data.

Mari Cantwell, DHCS: That is part of the plan in general. It is likely that residential services

will remain fairly bundled in a similar way to now and the way inpatient services are handled elsewhere.

Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy: The National Speech Therapy, Physical Therapy and Occupational Therapy Associations collaborate and negotiate with the American Medical Association on specific CPT rehabilitation codes for those providers. Which codes are you cross walking? For example, occupational therapists are non-licensed but can bill for some CPT codes. Will that be included in the crosswalk and will the crosswalk be available for review?

Lindy Harrington, DHCS: Yes, it is included, although this is technical and goes beyond my specific knowledge. Yes, the crosswalk will be available.

Veronica Kelley, San Bernardino County: For rate setting groupings, we ask you remember that like-size counties such as Kern and San Bernardino are more like small counties such as Mono in their frontier areas. Counties need flexibility in determining the performance outcomes details. For example, if the performance outcome is for increased access, in small counties this is not about increased calls to the access line because they tend to meet in person and that would be a better access measure for them. Finally, although a longshot, I want to be on record that if the state would take a lead in setting a single statewide EHR and billing system, it would be useful for transition.

Kim Lewis, National Health Law Program: We want to ensure that in rehabilitative specialty mental health services for children under EPSDT, often provided by non-clinical, non-licensed staff, that there is adequacy of those rates statewide and that they are not time limited. This needs its own evaluation because unlike adults, they are unlimited. Looking at behavioral health integration, how do we ensure the rates are comparable across plans so providers can work across networks and plans and when beneficiaries change plans or needs change, they don't have to change providers.

Rosemary Veniegas, California Community Foundation: On the issue of crosswalks, there is an additional layer of complexity with CPS. Substance use is only picked up under a general neglect code and this means that in order to get services to foster youth, it is necessary to expand what gets coded and captured in the other involved system. It's important to consider the data and reporting and what limitations exist from other systems when coming into the DHCS side of it. Would there be incentives for entities to take on the multiple systems or identify data to provide better services?

Sarah Arnquist, Beacon Health Options: It is a good move to go to standard CPT codes. This allows for braided funding by tying the codes more precisely to various sources available. To Kim's point on the rate comparisons, the 2019 county maximum allowable rate for medication management translates to $364/hour. If you look at the 99205 E&M visit code, the Medicare rate is $225/hour and the Medi-Cal rate is $82 for adults and $100 for kids. There will be little overlap in networks, unless we can address the huge disparity in what the county and other systems pay.

Michelle Cabrera, County Behavioral Health Directors Association of California: It is

important to restate that payment reform is about building out new FFS rates and we are having a conversation of driving to incentive and value payments. FFS is the rate paid to the plan and they will be expected to develop a system of value payments and incentives through provider contracts to ensure adequate services. What the plan is paid is different from how we engage with contracted providers.

Lindy Harrington, DHCS: correct. This is the rate for County Behavioral Health Plans. They have the opportunity to negotiate rates with providers.

Ken Berrick, Seneca Family of Agencies: My comment is on standardization around EHRs. As we move to clearer rate structures, unless the documentation standards are clear, we will have a new mess. We need minimum standards for documentation and systems to translate those efficiently.

Vitka Eisen, HealthRIGHT 360: It's a complex topic and we get lost in rates and coding discussions. I'm not clear where the value conversation is happening and when? Is this at the state level? If this is only at the county, that could be problematic.

Lindy Harrington, DHCS: We need a payment methodology established first at the state level and get experience with that to drive change at the county level. We can put other things in place to incentivize change at the county. For example, the work on incentive payments on in lieu services will require providers, counties and plans to work together to achieve those dollars. By changing to this payment methodology, we are creating the opportunity for the county to participate. We are looking at all the levers we can pull over time. Payment is the first step in long-term incentives.

Vitka Eisen, HealthRIGHT 360: I think some of this work can be done in parallel. The behavioral health system is not prepared for the quality discussion. We don't have to wait to have educated partners to shape this. Yes, the specifics have to wait but we can begin the discussion.

Steve Fields, Progress Foundation: Going back to the old rate structures of Statewide Maximum Allowances (SMA) and it was a blunt instrument that prevented innovation because cost was so embedded. The definitional consistency are important. What is the value in a 40 bed crisis facility that doesn't operate in a community system? How do we account for innovation and change? We are currently promoting recovery, but we don't define things similarly. Rates are linked into this discussion. Outpatient is easier to define; residential services are more difficult. I'm hoping the effort defines things in a way that innovation and change; a value system that promotes recovery over stabilization are clear in the taxonomy of what we want to do.

Mari Cantwell, DHCS: We have experience in Whole Person Care where counties built in intensive payments. We aren't limited to HCPCS, although they are a baseline part of this. How we think about that and move faster to incentives is a good point.

Michelle Cabrera, County Behavioral Health Directors Association of California: In order to move to value, we need to finalize the outstanding carryover cost issues. Counties are

carrying huge amounts on their books in order to deal with any audit issues. We aren't going to get to a value discussion until this is solved. We will need a massive retraining effort at both county and state level on the auditing process. We will need a different approach and philosophy to move away from the CPE system. On the value proposition, some clients will be in care for very long periods of their life and value won't look like getting them out of services. It means that continuing care to maintain stability and seeing providers will help avoid other, higher costs. It may be a different value proposition.

Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services
Brenda Grealish, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

Brenda Grealish offered a review of slides on the proposed medical necessity criteria. This will ensure beneficiary behavioral health needs are addressed in the most appropriate delivery system and provide appropriate reimbursement to counties. DHCS is proposing to separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services and allow counties to provide and be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the provider determining whether the beneficiary has a covered diagnosis.

Kelly Pfeifer offered additional comment. This proposal has evolved significantly following the last Behavioral Health Workgroup meeting. For example, what problem are we trying to solve in having a universal clinical assessment? The first task is to determine which delivery system they belong in for initial care. The no wrong door approach means ensuring treatment starts in whatever system they show up in, and we aim to avoid disrupting continuity when beneficiaries need different levels of care. Perhaps we don't need a standardized assessment tool for all situations, but do need a screening tool for a new intake to decide whether a beneficiary should start care in the managed care or specialty mental health delivery system.

Questions from DHCS

1. Does DHCS' proposal to amend medical necessity criteria for outpatient and inpatient specialty mental health services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of CalAIM? If not, what changes are needed to address identified gaps? What else should DHCS consider?
2. Does DHCS' proposal to amend medical necessity criteria for substance use disorder services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of CalAIM? If not, what changes are needed to address identified gaps? What else should DHCS consider?
3. How should DHCS operationalize the "no wrong door" approach for children/youth for accessing mental health services?
4. What are your recommendations to strengthen care coordination between the counties and Medi-Cal managed care plans?

Questions and Comments

Gary Tsai, MD, Los Angeles County: A question on distinguishing between medical necessity and eligibility: does this only apply to specialty mental health systems?

Kelly Pfeifer, DHCS: Yes.

Gary Tsai, MD, Los Angeles County: If we move to standard assessments, we need to pay attention to workforce and training. It is clear to me that the workforce doesn't have skill sets for comprehensive assessment on both the mental health and substance use disorders. Also, the diagnosis for substance use disorder needs clarification. The DSM V criteria extend out to 12 months. There is confusion with providers that if someone is not actively using after 12 months, they are ineligible for Drug Medi-Cal services. Given that this is a chronic condition, we need to use modifiers.

Kelly Pfeifer, DHCS: We agree with you.

Ken Berrick, Seneca Family of Agencies: The combination of no wrong door and the decoupling of diagnosis, while building in opportunity for research, can be a game changer.

Linnea Koopmans, Local Health Plans of California: I understand that the proposal is moving away from the proposed standard assessment toward criteria for how individuals move between systems?

Kelly Pfeifer, DHCS: This is evolving. What we heard is concern in the workgroup about a long standardized assessment. We heard it could be useful to have a standard screen for whether someone is better served in specialty mental health or Medi-Cal managed care plan, such as is being used in Sacramento right now. In addition, some will need services in two systems – specialty mental health services and substance use services or mild to moderate and other services. Also, we need to solve for when individuals need higher levels of care. How do we have standards across the state that move us away from focusing on chart documentation to get paid?

Kim Lewis, National Health Law Program: I want to raise what I think is the confusion of three issues: 1) waiver structure of MCO, BH plans, ODS; 2) the screen/assessment discussion; and, 3) the legal entitlements and laws around medical necessity that are different for children vs adults. We are lumping them together. In assessment, are we talking about screening for what care, what system? The various systems have different networks and are paid for a different menu of services. We don't have a no wrong door in that sense. I think we have to have conversations separately, then put them together – not have them all together.

Jacey Cooper, DHCS: We agree and are working on a document to clarify definitions. In looking at the waiver, this is a key piece we need to clarify to submit the combined 1915 b waiver. There will be some components that stay in the 1115 waiver and other elements that go into the 1915 b waiver.

Michelle Cabrera, County Behavioral Health Directors Association of California: One issue we are concerned about is the idea that one tool will do it all. It seems we have common understanding there are different purposes on the table. I want to give DHCS credit for this aspirational proposal. There are tools for screening into specialty mental health services and some work better than others. The level of care and assessment screening is more challenging. We are not yet at the point of having fully integrated clinical settings to understand the whole person's needs. We have to take one step at a time to make progress and do better. Progress right now includes making sure we aren't doing artificial gate keeping – most people are not exploiting these services. If we can parse this to screening vs other functions, we can make progress.

Chris Stoner- Mertz, California Alliance of Child and Family Services: We submitted comments. Are you saying the goal is for MCOs and mental health plans (MHPs) is to both provide and pay for the full array of EPSDT services?

Jacey Cooper, DHCS: No. It is what is within the parameters of their contract. There are some lower level services that overlap. We don't want a ping pong effect. We want to ensure they are in the right system or transition from one system to another, if that is best for the child.

Brenda Grealish, DHCS: Making sure that kids are anchored in one system that is best for them.

Chris Stoner- Mertz, California Alliance of Child and Family Services: In our comments, we proposed that, essentially a child presenting to a provider should be able to get the service, then have a regional ASO or other function built to determine on the back end.

Jacey Cooper, DHCS: We will look at what you are proposing. There would be implications for county systems to consider.

Vitka Eisen, HealthRIGHT 360: For counties that have gone to a more medical necessity model under ODS-Medi-Cal, I'm not sure there is increased access in every county, but statewide access does look better. A two-hour assessment will just send people away from care. We need to balance administrative complexity and access to care.

Rosemary Veniegas, California Community Foundation: On question 2, yes, medical necessity for substance use disorders is a good thing. However, there is more to do on the no wrong door approach on the substance use side.

Jonathan Porteus, WellSpace Health: I am lost in the complexity here. We see many children for medication who are not interested in EPSDT services. How does a health center see those who exceed the mild to moderate?

Jacey Cooper, DHCS: Any child can receive mild-to-moderate without medical necessity or authorizations and they wouldn't be forced to go to a particular system. EPSDT is a protection, not a service. If a child is getting medication management through primary care

and don't need higher levels of care, they can stay there. This doesn't change that. If they need a higher level of care that aren't available in that setting or plan, this allows referral to county for higher level of care. There should be no barriers for children.

Jonathan Porteus, WellSpace Health: If a provider has services for higher level of care but is not in the county system, how would that work?

Jacey Cooper, DHCS: Our hope is that FQHCs will contract with county mental health plans so services can be offered there. We are not changing the mild-to-moderate split with this proposal.

Jonathan Porteus, WellSpace Health: We would be able to provide those services while waiting for them to transition into a specialty mental health system?

Jacey Cooper, DHCS: We have to look at that. There is authorization of services for higher level of care mental health services, similar to what happens on the physical health side.

Ken Berrick, Seneca Family of Agencies: On operationalizing no wrong door, I hope there is consideration for how to structure LEA Medi-Cal. Currently, it operates as a reimbursement for certain services. It could be and is used in other states as an entrance and way to integrate with other systems.

Sara Gavin, CommuniCare Health Centers: We have a workforce challenge in mental health and substance use services. With this proposal, will it alleviate the challenge of waiting for a master's level clinician to do the assessment and instead have a qualified substance use clinician assess necessity and get into care?

Kelly Pfeifer, DHCS: We will look at that.

Frank Mecca, County Welfare Directors Association of California: Is the expectation that for children, the child will ultimately have a covered diagnosis? Is it pre-what?

Kelly Pfeifer, DHCS: The way we see it, the "pre" for kids it is irrelevant. If you have a mental health or substance use symptom, it can be treated without requiring an immediate diagnosis.

Steve Fields, Progress Foundation: As a community based residential provider serving those coming out of the emergency room, the need is clear. Programs like ours serve dual substance use AND mental health – not either or. One thing driving confusion is the need to separate and prioritize mental health or substance use. We have both most of time. We need to be able to assess and serve for medical necessity of dual needs – not obsess on whether it is primarily substance use disorder or mental health disorder.

Kelly Pfeifer, DHCS: And people often carry these labels of diagnoses for life, so especially for kids, we want to remove the financial pressure for a label in order to be reimbursed.

Administrative Integration of Specialty Mental Health and Substance Use Disorder

Services
Brenda Grealish, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

Brenda Grealish provided an overview of the proposal for administrative integration of specialty mental health and substance use disorder services into one behavioral health managed care program. The goals are to improve outcomes for beneficiaries through coordinated treatment across the continuum of care and reduce administrative and fiscal burdens for counties, providers, and the State. The result would be, by 2026, a single prepaid inpatient health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder treatment services for all Medi-Cal beneficiaries in that county or region.

Questions from DHCS:
1. What are the benefits for counties and beneficiaries?
2. What elements are not included in the proposal that should be considered?
3. What advice do you have about timelines and phasing for implementation?
4. What would integration look like in counties not participating in DMCODS?

Questions and Comments

Veronica Kelley, San Bernardino County: A good place to start is to talk to behavioral health counties already doing this. The artificial boundaries are created by regulation and policy and we spend time working on a seamless approach.

Kim Lewis, National Health Law Program: We strongly support integration of systems. The timeline is too far out and I hope we can do this more quickly. Many counties already have this integration or some elements of it. The fragmented system keeps people from getting services so we need to expedite efforts to remove the barriers.

Steve Fields, Progress Foundation: There have been so many attempts at this kind of integration. At a clinical level, we need integration of services. We primarily see “attached” not integrated care where someone is primarily in a mental health program that seeks consultation from substance use recovery program and vice versa. They are not synergistically integrated to actively provide both interventions in a whole person approach. Residential tends to operate in a more integrated structure. There is a third way that is compatible with both severe mental health needs and substance use disorders. The administrative integration needs to drive a vision of treatment integration with both approaches in one setting.

Kelly Pfeifer, DHCS: We agree with you and see this as a steppingstone toward that goal.

Linnea Koopmans, Local Health Plans of California: How does this interact with the full integration pilots?

Brenda Grealish, DHCS: This is part of that, and we want to think about full integration as we do this piece.

Jacey Cooper, DHCS: In addition, the full integration pilots are not statewide.

Kelly Pfeifer, DHCS: We are taking an incremental approach, a step-by-step process that acknowledges the different stages in different parts of the state and moves everyone forward.

Michelle Cabrera, County Behavioral Health Directors Association of California: We really agree with removing regulatory barriers to integration of clinical integration in County Behavioral Health. At the provider level, we have some evolving to do. Sometimes specializing is appropriate and sometimes it has been a barrier. On the timeline, it is important to figure out how quickly can we get the infrastructure aligned to this concept? We are taking two disparate regulatory structures and integrating them. We hope this will lead to federal financial reimbursement we don't currently have.

Sara Gavin, CommuniCare Health Centers: Currently, our DMC license is through the state and our specialty mental health license is through the county. Does this change that?

Kelly Pfeifer, DHCS: We need your input on that to know what makes sense. Licensing and certification haven't been involved to date in CalAIM. We do want to think about how the principles of streamlined, seamless systems for providers apply to this division. We welcome your thoughts.

Janelle Ito-Orille, DHCS: Our goal is to streamline systems and CalAIM is a good opportunity. I am Interested in meeting with you to hear more.

Vitka Eisen, HealthRIGHT 360: I would want to consider how we can use CalAIM to realign the certification process to the counties given they are doing this for specialty mental health because this would allow outpatient programs to come on line more quickly and potentially leave residential licensure with the state. Residential is higher risk than outpatient and need more oversight. I would be happy to join a separate discussion.

Veronica Kelley, San Bernardino County: We can learn from Behavioral Health Counties about how we get creative. We serve co-occurring disorders and doing the treatment but using other resources and not getting paid for the other co-occurring disorder.

Chris Stoner- Mertz, California Alliance of Child and Family Services: I support looking at certification. Schools have to obtain individual site certification, even if they don't keep records there. Looking at the administrative burdens would serve us well.

Jacey Cooper, DHCS: There are federal requirements for provider enrollment and for credentialing managed care plans we can't get around.

Kelly Pfeifer, DHCS: I can't promise all things but there is a place between perfect and where we are now.

Gary Tsai, MD, Los Angeles County: Counties certify specialty mental health clinics; we are

not allowed to certify specialty Drug Medi-Cal. As I understand this, allowing counties to certify both would streamline things because currently the timeline at the state extends out to more than a year.

Institutions for Mental Disease (IMD) Expenditure Waiver
Brenda Grealish, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

CMS issued guidance that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness and children with serious emotional disturbance who are enrolled in Medicaid. It allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD). California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries. There is an extensive process to apply for this exclusion and we are seeking input about this option.

Questions from DHCS:
1. Depending on county interest, what is a realistic timeframe in which to apply to CMS, particularly given the extensive application requirements?
2. What are we trying to achieve through this waiver that will strengthen the public mental health delivery system (other than increased federal funding)?
3. What should be the parameters or expectations for counties to participate?
4. What protections should DHCS include in this demonstration to ensure that care is being appropriately delivered along the lower level of the continuum in order to prevent inappropriate use of IMDs?
5. How do we leverage all aspects of CalAIM to build the expectation for the waiver (e.g., Enhanced Care Management, In Lieu of Services, jail diversion)?

Questions and Comments

Catherine Blakemore, Disability Rights California: I want to start from the place of, do we have enough data to know if this is a good idea? People are in IMD far beyond 30 days; will this bring more people in to IMDs to stay for long periods? What are the community supports for them to go to? What are some other models? Some sister agencies have developed step-down models, so people have places to go when there is a crisis – as opposed to an IMD. IMDs aren't always very good at facilitating people back to community. There isn't an incentive to work with other agencies to transition back to community. From our perspective, absent some thoughtful reason about why to have new places to institutionalize people, we believe this will result in more people institutionalized at high cost and is not well thought out.

Kim Lewis, National Health Law Program: We have written on our opposition to this. There is a new MACPAC report out on IMDs. One concern is that we haven't had a consistent, statewide approach to a system of community services that is adequate and funded. We are looking at this to fund more institutional care, but this won't change anything if there are no

services for them in the community. We should not fixate on this as the solution despite the need for short-term institutional care. In order to be approved, we must show an ability to track the system, and that we are not retracting from the current system. We don't even have adequate data about what people are getting now. We need to do better with what we have; we need a better and more consistent system across the state.

Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy: Institutional practices are dangerous to people. It is disturbing to have a conversation about finding mechanisms for more institutionalization. I understand there is a different point of view that we don't have sufficient beds. The crisis is not beds, it is insufficient community services. There is plenty of evidence on this. We should not try to sustain institutional practices.

Gary Tsai, MD, Los Angeles County: I represent the substance use system and work in a county implementing the ODS waiver, so we have an IMD waiver in place. We are providing IMD and not being reimbursed for it. This is an issue of parity. There is a spectrum of acuity for psychiatric conditions and there are people who do not receive the short-term hospital services they need because of the lack of reimbursement. The IMD exclusion served a purpose in the past, however we have advocates and voices to prevent abuses now. This is an important opportunity for people on the serious side of the spectrum who need short-term hospitalizations to get the care they need.

Sarah Arnquist, Beacon Health Options: If we think of IMDs as free-standing psychiatric facilities or hospitals; even Medicare pays for inpatient hospitalization for short term and Medicaid does not. If we were able to confine the waiver to acute inpatient hospitals, it could produce significant additional revenue to invest in community services. The opportunity in this waiver is the required building of community systems. We allow a system where Medi-Cal beneficiaries don't have access to the same continuum of treatment. This would be setting a high bar and compel the system forward, as long as it is confined in a way that doesn't lead to long-term re-institutionalization.

Michelle Cabrera, County Behavioral Health Directors Association of California: This is not a black and white - either-or proposal. We don't want the status quo. There are serious concerns about not being able to build out a robust system of services. We can design a waiver in a way that requires that. Building out the community systems is infrastructure that doesn't go away. That is an important value proposition here. The scarcity of beds means it is difficult to require higher quality within those IMD institutions. If we are going to turn this around, we need to start, and this waiver is a balanced way to do that.

Jessica Cruz, NAMI California: This is a parity issue. I have 180 responses from members on this issue. We understand the old ways of institutionalization are not the way to go. It is an opportunity to create standards and there are people on the most serious end of the spectrum who need this level of care. This is an opportunity to get help for 30 days with the hope we build infrastructure for community support for those with severe mental illness.

Steve Fields, Progress Foundation: in 1970s, there was money to build a treatment system and every county had the opportunity to build community services. What happened post-

state hospital closures, was IMDs and re-institutionalization. It took a court to reverse the trend. This was another opportunity for California to build community system of rehabilitation and they didn't. We know how to help people who need intensive services in community. But most counties do not have the services in place to avoid institutionalization. When all we have is the option to institutionalize people, we will trend to abuse. What I support on this is to go forward by leveraging a continuum of 24-hour services. I strongly support the carrot of additional funding to say you don't get this opportunity until you invest in a community continuum to prevent institutionalization. Prop 63 could fund this kind of 24-hour alternative to institutions right now and almost none have done that. IMD is the ultimate last resort – show us your action in building that system before you have this tool.

Kelly Pfeifer, DHCS: I appreciate the detailed input on this.

Rosemary Veniegas, California Community Foundation: in lieu of IMD, we put people in jail which is not what we want. IMDs offer an alternative with advocates at the table.

Vitka Eisen, HealthRIGHT 360: Part of the problem is that you can be classified as an IMD when you operate three small programs that are, collectively, over the bed limit. We need more community-based, treatment oriented programs. Is there a way to do this in the way it is done for SUD so that they are not considered an IMD?

Jonathan Porteus, WellSpace Health: There is a perverse reliance on the IMD level and paucity of care on the subacute side. Saying no to this would be a missed opportunity for those with serious mental illness. If we imagine adequate services through the continuum up to the IMD level, what might we do with this waiver? For example, can we tie funding to require follow up?

Steve Fields, Progress Foundation: I want to clarify that we have 138 beds and we are not an IMD. There are programs across the state that provide residential services and add up to more than 16 beds and they are not IMDs.

Vitka Eisen, HealthRIGHT 360: Substance use providers at the federal level have researched this and SUD providers have advocated to be outside IMD rules. They may not be enforced.

Mari Cantwell, DHCS: We need to follow up on this to understand and clarify this.

Catherine Blakemore, Disability Rights California: It seems very hard to have a discussion without knowing the community capacity needs; how many people are in IMDs; how long have they been there; what prohibits them from getting out?

Substance Use Disorder Managed Care Program Renewal and Policy Improvements
Brenda Grealish, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

Ms. Grealish reported that there will be discussion of these changes during the next BH Stakeholder meeting in February. Today, it would be useful to hear input on what your

questions are and what we should cover in that meeting. You can also email us following this meeting if you have ideas.

Questions from DHCS:

1. Given that this proposal will be discussed in greater detail during the February BH SAC, what topics/components do members most want to focus on?
2. Do these proposed clarifications align with county priorities based on implementation experience?
3. What would incentivize/encourage non-ODS counties to participate?

Questions and Comments

Gary Tsai, MD, Los Angeles County: Two Suggestions: 1) recovery support services are underutilized and part of this is about justifying the ongoing medical necessity when someone is doing better per my comments about justifying via DSM V diagnosis how to continue care when individuals are doing better; 2) how discussions are going with CMS about residential length of stay.

Stephanie Welch, Department of Corrections and Rehabilitation: A challenge we hear about is that individuals have been abstinent while incarcerated but have a serious addiction. They have unique needs and don't meet normal medical necessity.

Kelly Pfeifer, DHCS: This should be fixed over time as the American Society of Addiction Medicine is considering changes to the ASAM criteria to resolve these problems.

Behavioral Health Regional Contracting
Brenda Grealish, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

Brenda Grealish provided an overview to regional contracting. There is recognition that some counties have resource limitations and the Cal-AIM proposal offers options for counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries.

Questions from DHCS:

1. What prevents counties from doing regional contracting now? What are the challenges?
2. Are there any lessons learned from the current regional contracts that should be considered?
3. In the proposal, DHCS mentioned several strategies for establishing regional contracts (a Joint Powers Authority, an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program). Are there any other recommended strategies that should be considered when seeking to establish regional contracts or any advice regarding the opportunities/challenges with those identified by DHCS?

Questions and Comments

Veronica Kelley, San Bernardino County: Kern and Inyo are currently using this contracting arrangement, and this may offer an example of how to implement this. Part of that is working with the boards.

Sarah Arnquist, Beacon Health Options: We have spoken to counties and heard that data sharing and reporting to DHCS may be challenges. Could the data be rolled up or would it have to be individualized for each county. In order to make it cost effective, rolling it up would be important. Also, moving to standard 834 files (standard format for information exchange).

Kim Lewis, National Health Law Program: One of challenges is that data is by plan, not by county. It makes it hard to make comparisons across health plan and mental health plan without data at a county level. We need to understand how this regional approach would impact the data.

Sarah Arnquist, Beacon Health Options: It is possible to track the data back via zip codes for a provider or a patient and create county-level data. The plans do this now and the state could do it.

Linnea Koopmans, Local Health Plans of California: It will be important to clarify plan vs county data related to HEDIS and quality outcomes.

Full Integration Plans
Michelle Retke and Brenda Grealish, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-1-6-20.pdf

Brenda Grealish and Michelle Retke are co-leading this. It is intended only for a few sites across the state to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. There is a workgroup on this topic and this will not go live until 2024.

Questions from DHCS:

1. What policy discussions/decisions need to occur before moving forward with a fully integrated delivery system?
2. What topics/discussion items would be helpful to tackle during the workgroup process?
3. What advice do you have about timelines for implementation?

Questions and Comments

Kim Lewis, National Health Law Program: we offered comments, including safeguards on this topic and are supportive of moving forward to a more integrated system. The timeline is too far out to allow for work in places trying to do this now to meet their challenges. Can we develop a list of barriers that keep this from moving forward and start now with a staged

process?

Gary Tsai, MD, Los Angeles County: In the past, we worked on a universal consent form across plans. What held it up was the consent revocation process that would require a platform for us to share this across all the parties. It would help to have state level guidance and a template for several of the topics we have discussed today.

Linnea Koopmans, Local Health Plans of California: It would be useful to have presentations from counties and plans trying to do this type of integration.

Veronica Kelley, San Bernardino County: I am happy to share our experience working with Inland Empire Health Plan on integration. One of the biggest challenges is dental. The way we paid for the model in the past is through funding by the plan. On integration and performance, we have a strong model that won't work for everyone, but may be of interest.

Sara Gavin, CommuniCare Health Centers: This will require special consideration for FQHCs. Integration is in conflict with existing requirement for separating staff. We can co-locate but not integrate.

Mari Cantwell, DHCS: The reason that happens is because the payment structures are separated. Under an integrated plan, those requirements would change, and it will help overcome that.

Kelly Pfeifer, DHCS: In closing, I want to say this has been very helpful and thoughtful input, and given concisely. We are taking away very helpful information. We heard from you at the last meeting about topics you want to discuss in depth. The next meeting will focus on SUD DMC-ODS. We also heard an interest in discussing children and youth. Jim Kooler will be joining us and has a passion for this topic.

Frank Mecca, County Welfare Directors Association of California: It feels like it is a risk to delay the foster care discussion to June. There are suggestions from stakeholders that require a waiver to move forward. Is there is an alternative way to construct the dialog or engage stakeholders? Absent the ability to talk to you, the current process is fraught.

Public Comment

Steve Leoni, Mental Health Consumer and Advocate: I want to repeat my previous comment that there is no representation on this workgroup by consumers. There is lots of discussion about the impact on how the system works and consumers but are missing the discussion about what it is like on the ground. The first waiver had strong representation by consumers, but only after advocacy. There is an assumption that you are making improvements and automatically the consumer will fit it but there are many wrinkles to that. In any medical setting, if you need a service beyond primary care, you get referred to a specialist. Instead of integrating, we are splitting apart again. In a CalAIM presentation by Beacon, I thought I heard that when people step down from county, they get less of a benefit package. I'm not hearing that providers are contracting to both health and mental health plans. It bothers me that we aren't talking about MHSA here. There is a planning process for

MHSA that is a big deal for the consumer and family community. I know my community and consumers can seem to talk endlessly about peer services and don't lock us up. I think you can find people who offer good feedback.

Lilyane Glamben, On Track Program Resources: We are a technical assistance provider to the California Reducing Disparities Project. I want to commend you on this thoughtful process and am learning a lot about the complexity of the system. I am struck by the lack of representation by individuals in the public mental health system – the most diverse state in the country. The decision making process is not reflecting the diversity and those with tremendous disproportionality. I hope it is not too late to do something about that. In upcoming meetings, I would ask you to consider consumers, families, caregivers and community providers. I'm not seeing anything in CalAIM about this issue to heart of disparities. ACA took care of a lot, but we need to take on institutional racism and the ways it plays out. If we don't take that on, it is a chink in an otherwise thoughtful process. We have providers along the spectrum from prevention to treatment and they can offer insights. I would love to have conversations include this discussion of disproportionality.

Lorraine Zeller, Ambassador for ACCESS CA: We are not feeling empowered and ask to be invited to the table. As a consumer, I was put in an unlicensed board and care and I became an expert in the differences between licensed and unlicensed. Our county will fund $500K of MHSA for someone to come in and provide benefit to the licensed board and cares. We are losing licensed board and care homes and people are going into unlicensed board and care homes. I bring this up because consumers have lots of expertise to bring to this table. It would be an honor to be part of the conversation. It would be helpful to know how peer support are included in CalAIM? Alameda County had a Mentors on Discharge program to meet people at the hospital. The return on investment was $800K. We can show our peers how to engage in service to keep them out of IMDs and in the community because there is no power dynamic. In Santa Clara County, we have a peer respite in operation where people can stay up to 2 weeks and that is keeping them out of the hospital. Peer support works.

Jane Adcock, California Behavioral Health Planning Council: I want to give a huge thank you to DHCS staff for this meeting and for the questions you are pondering. We hope you will continue to bring those questions as you get input and will continue to drill down further as you go along. I echo the value of including those with lived experience and we stand ready to help.

Kelly Pfeifer, DHCS: Thanks for your leadership on the Planning Council. Jim Kooler and I look forward to attending the Council.

Carolyn Caton, CDSS: Thank you for the discussion. The materials very helpful. I want to echo the comments by Frank Mecca about children in foster care. Our kids are impacted by the decisions made here. We encourage you to have the conversation sooner and we are ready and eager to participate.

Carolina Valle, CPEHN: We ask DHCS to agendize the topic of cultural competence plans for a future meeting to achieve our shared goals. It is a good time to do that with the focus

on integration of cultural competence plans. we know cultural competency plans have not been updated in quite some time although California is undergoing change through CalAIM. We want to ensure we don't leave cultural competency behind. In the new quality strategy report, DHCS reported they had conducted an analysis of mental health cultural competence plans and want to ask DHCS to share that analysis with this committee and get input to see what we can do to update those plans.

Karen Vicari: ACCESS CA: I want to echo my colleagues and am saddened when I saw the list of this group. There is a hole without the consumer voice. We have comments we will submit. We need to keep our focus on recovery oriented systems. Please don't forget the big picture that we are here to help those with mental illness.

Mari Cantwell, DHCS: This is my last BH SAC. I am leaving DHCS at the end of the month. I want to appreciate the work this group is doing and thank the team that will be here to carry on. I will always have Medi-Cal in my heart.

Kelly Pfeifer, DHCS: We are all grateful to Mari. Many of the great ideas in the proposal came from Mari and we will miss her.

Next Steps and Final Comments

Behavioral Health Deputy Director Kelly Pfeifer reviewed the schedule of meetings and topics. In February, the BH SAC will discuss ODS; in May the discussion will be on children and youth. I will take the issue of cultural competency back to the team and figure out how to integrate that.

2020 BH-SAC Meeting Dates:

- February 12, 2020 1:30 p.m. – 4:30 p.m.
- May 27, 2020 9:30 a.m. – 12:30 p.m.
- July 16, 2020 1:30 p.m. – 4:30 p.m.
- October 28, 2020 9:30 a.m. – 12:30 p.m.