DEPARTMENT OF HEALTH CARE SERVICES
BEHAVIORAL HEALTH STAKEHOLDER ADVISORY COMMITTEE
February 12, 2020

MEETING SUMMARY

Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Sarah Arnquist, Beacon Health Options; Catherine Blakemore, Disability Rights CA; Michelle Cabrera, County Behavioral Health Directors Association of California; MJ Diaz, SEIU; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Britta Guerrero, Sacramento Native American Health Center; Veronica Kelley, San Bernardino County; 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; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Jevon Wilkes, California Coalition for Youth.

Members Attending by Phone: Ken Berrick, Seneca Family of Agencies.

Members Not Attending: Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI California; Steve Fields, Progress Foundation; Andrew Herring, California Bridge Program; Robert McCarron, California Psychiatric Association; Maggie Merritt, Steinberg Institute; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Jonathan Sherin, Department of Mental Health, County of Los Angeles; Chris Stoner-Mertz, California Alliance of Child and Family Services; Stephanie Welch, Department of Corrections and Rehabilitation.

DHCS Attending: Richard Figueroa, Kelly Pfeifer, Jacey Cooper, Brenda Grealish, Marlies Perez, Janelle Ito-Orille, Erica Bonnifield, Karen Mark, Anastasia Dodson, Jim Kooler, Norman Williams, Morgan Clair.

Public in Attendance: There were 33 members of the public in attendance.

Welcome, Introduction of BH-SAC Members
Richard Figueroa, Acting Director, DHCS and Kelly Pfeifer, MD, Deputy Director for Behavioral Health, DHCS

Acting Director Richard Figueroa welcomed BH-SAC members and introduced several new members, including Jei Africa, Hector Ramirez, Britta Guerrero, Sarah-Michael Gaston, and Jevon Wilkes. Kelly Pfeifer also welcomed the new members, acknowledging a new consumer representative and asked each new member to offer information about themselves during introductions. Acting Director Figueroa let the group know this is his last meeting and announced several new appointments at the Department, including Dr. Brad Gilbert, new DHCS Director, who will be at the next meeting. In addition, Jacey Cooper is the new Chief Deputy Director for Health care Programs and State Medicaid Director, and Jim Kooler is DHCS' Behavioral Health Assistant Deputy Director.

In opening comments, Acting Director Figueroa spoke to the newly released public charge implementation date (February 24, 2020) and federal instructions. The Administration is reviewing the information and working through the implications. For individuals or groups trying to understand how this will impact California, the California Health and Human Services Agency (CHHS) website information is being updated and serves as the main referral for information and resources (https://www.chhs.ca.gov/blog/2020/02/24/update-chhs-public-charge-guide-2/. We are reviewing to identify and clarify information, however the implications are specific to each person and family and they will need to get legal help to answer many of their questions.

Follow-Up Items from January 6, 2020, BH-SAC Meeting
Norman Williams, DHCS

There was public comment at the previous meeting requesting that cultural competency be on the agenda for an upcoming meeting and DHCS is working on that.

Kelly Pfeifer, DHCS: We are also working internally to respond to questions raised on licensing and certification.

State of California HHS Budget Review
Jacey Cooper, DHCS

Jacey Cooper reviewed the highlights of the budget. There is information posted on DHCS website (https://www.dhcs.ca.gov/Documents/Budget_Highlights/DHCS-FY-2020-21-Governor%27s-Budget-Highlights.pdf). For 2020-21, the administration proposed a $107.4 billion budget with a notable $695 million budget for California Advancing and Innovating Medi-Cal (CalAIM) from the General Fund to Medi-Cal; $1.4 billion annually thereafter.

The budget includes the following proposed General Fund expenditures:

- $450 million for Enhanced Care Management (ECM) services for high-risk individuals.
- $115 million for In Lieu Of Services (ILOS) for housing and wrap-around services.
- $600 million for incentive payments to expand ECM and ILOS statewide.
- $225 million for transition of the Dental Transformation Initiative to statewide.
- $45 million for Behavioral Health Quality Improvement Program for counties to make system changes, including payment reform.

- Full scope expansion for undocumented adults.
- Updated Medi-Cal Rx savings. There is trailer bill language to remove the six-prescription limit and eliminate the $1 copay.
- $105 million supplemental pool for non-hospital 340B clinic pharmacy claims.
- Trailer bill language to create flexibility to negotiate pharmacy rebates for Medi-Cal and savings for non-Medi-Cal state-only programs through other pharmacy rebates.
- Transition out of Dental Managed Care into fee-for-service (FFS) statewide.
- Nursing facility financing reform through value-based purchasing and quality reforms.
- Additions to cover all Medication Assistance Treatment (MAT) services to expand access.
- $10 million for hearing aids and services for non-Medi-Cal children under 600% of poverty.

Acting Director Figueroa highlighted that the budget included establishing the Behavioral Health Task Force to address urgent mental and behavioral health statewide. There was a press release following the budget release seeking applicants for the Task Force. The charge of the Task Force is broader than BH-SAC's focus, which is primarily Medi-Cal. The Task Force will include workforce, parity and private plans. There will be four meetings during 2020.

Questions and Comments

Linnea Koopmans, Local Health Plans of California: Do you have a sense of DHCS' role on the Task Force and how much they will focus on Medi-Cal?

Richard Figueroa, DHCS: The composition of the Task Force will be broad and include counties, health plans, family members and others. They are still working on the overall charge for the Task Force; it will cover both mental health and substance use. There will likely be involvement of DHCS as well as other agencies.

Michelle Cabrera, County Behavioral Health Directors Association of California: We appreciate the significant proposals on behavioral health in the budget. Lifting the cap of six prescriptions is very important to our consumers. We are excited about the Behavioral Health Quality Improvement Program and are ready to roll up our sleeves to make system improvements through these investments. In addition to changes at the county level on systems for billing and coding, we will need to transition how the money flows. Will DHCS be requesting additional staff to work with counties on the back years of unsettled claims?

Jacey Cooper, DHCS: We are looking at how DHCS can address the cost report reconciliation backlog and there will an upcoming CalAIM staffing recommendation.

Hector Ramirez, Consumer Los Angeles County: Last year, the Governor mentioned he was considering including peer certification in the budget and legislation. Is that included in the budget? If not, can we revisit this issue to ensure this moves forward?

Jacey Cooper, DHCS: It is not in the budget at this time. We have started internal and

external conversations with stakeholders interested in moving forward on this issue.

MJ Diaz, SEIU: There is pending legislation to address certification and licensing for peer support for both professional and facility. We want to discuss this here given that previous veto messages mention this as a venue to advance dialog on the issue.

Hector Ramirez, Consumer Los Angeles County: We are the only state in the nation without peer support. I hope this will be the year we get peer support done.

Master Plan on Aging and Behavioral Health
Anastasia Dodson, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/BH-SAC-MasterPlanforAging.pdf

Anastasia Dodson reported on the Master Plan on Aging and Behavioral Health. The Governor released an Executive Order in June 2019 to form a multi-agency Master Plan on Aging. This is an ambitious effort across agencies and with public and private partners. A website was launched (Together We EngAGE: https://www.engageca.org/) and it received more than 700 comments in the first two weeks. The mission is: *A person-centered, data-driven, ten-year California Master Plan for Aging by October 1, 2020, including a state plan, local blueprint, data dashboard, and best practice toolkit*. The Department of Aging is leading this effort in coordination with DHCS and many agencies across state government. The process includes a Cabinet workgroup, subcommittees (long-term services and supports; research; equity) and frequent webinars. This will cover both state and local topics, such as behavioral health and age-friendly communities.

There are four goal areas:
1. Long-term services and supports (LTSS) – Behavioral Health included in “core mix” of services stakeholders want statewide, including residential care.
2. Livable Communities and Purpose – February 26 webinar on isolation, inclusion, and respect.
3. Health and Well-Being – Webinars on healthy aging, geriatric medicine workforce, and integrated health systems.
4. Safety and Security – Income security, adult protective services.

Catherine Blakemore offered additional comments about the Master Plan on Aging and Behavioral Health. There is a particularly high level of engagement in this process from across the state and through many channels. She also spoke about the LTSS plan due to the Governor in March as an area of key focus for the group right now. The LTSS plan includes more than 75 detailed recommendations as well as six overarching topics, listed below:

Overarching Topics for LTSS Plan:
1. The need for strong leadership with a vision to improve LTSS in California.
2. Equity: California is the most diverse state in the nation and there is a need to remove systemic barriers and improve the capacity to serve everyone in California.

3. Navigation: Systems are complex, and most people struggle to navigate the system and get the services they need.
4. Access to care: There is a robust set of LTSS services, however demographics indicate that a more diverse population will need LTSS.
5. Workforce: Ensuring there is both an adequate workforce and that wages/compensation are fair to workers.
6. Financing: Addressing the financing for a more robust system.

To achieve this, we are looking for:

- A dedicated cross-department unit for LTSS to report to the Secretary of CHHS. The LTSS will be embedded in multiple departments and needs a point person.
- LTSS should be understandable to the users of the system regardless of the entry point.
- There should be a universal LTSS benefit. Currently this is focused on Medi-Cal funding and excludes large numbers of the population.
- California will have the best LTSS system in the country and this means it is systemically and programmatically sustainable, including for rural communities, culturally/linguistically appropriate and innovative.
- There will be 1 million high quality direct-care jobs.

The report will be released early March with the opportunity for input and comment.

Questions and Comments

Michelle Cabrera, County Behavioral Health Directors Association of California: We are involved in the Administration's work on homelessness through the Council of Regional Homeless Advisors. A major driver is the number of those experiencing homelessness for the first time after age 50. I see a link between the LTSS plan and preventing and addressing homelessness. Will there be efforts to weave together the Master Plan and homelessness?

Anastasia Dodson, DHCS: The webinar today addressed this exact topic, so it is being considered. The Master Plan acknowledges this as an important point and in the comments submitted via the website, this was the number one issue raised.

Catherine Blakemore, Disability Rights California: This is also raised within the LTSS report around how those experiencing homelessness can access LTSS.

Jei Africa, Marin County Health Services Agency: I am thinking about how the older population is highly impacted by climate change. During the recent fires we observed that those who did not leave their homes were often older adults without the support they needed. This is important to add to the discussion.

Medi-Cal for Healthier California for All Update and CalAIM
Jacey Cooper, DHCS

Jacey Cooper offered an update on CalAIM. There are continuing workgroups through February. There have been over 30 workgroups and 60 meetings for input. We will report back on changes and updates to the original proposal sometime in March/April. There will be a formal release of the waiver for public comment and hearings in Northern California and Southern California for both the 1115 and 1915(b) Medicaid waivers. Both waivers will be submitted in June. Following this, we will be in discussion with CMS to reach approval. There are a number of State Plan Amendments (SPAs) tied to the overall proposal and those will be submitted in July. There have been hundreds of letters we are reviewing. We appreciate the extensive and thoughtful input.

Questions and Comments

Kim Lewis, National Health Law Program: In the Population Health Management workgroup, there was a summary of comments received and proposed changes. Will there be a document to report back changes in the overall proposal? Will the comment period be included in the timeline?

Jacey Cooper, DHCS: Each workgroup has approached this differently. We are identifying how to report back on the final proposal and the changes before the end of May. We are still thinking about the best way to communicate the changes we have received – whether through an edit of the original document or a listing of the changes. There is a requirement to respond to all comments and we will do that.

Rosemary Veniegas, California Community Foundation: I was able to listen to the morning discussion of rate setting and the calculations that go into the algorithms for rate setting. Now, in this behavioral health session, I am reflecting on negative and affirmative utilization management. In primary care, we think of negative utilization as emergency room visits, using skilled nursing facilities or a psychiatric admission. In some instances, in the behavioral health environment, treatment seeking behavior results in higher utilization, just as was the case in the advent of the Medicaid expansion in Oregon where emergency room use increased due to pent up demand. As the algorithms that will feed into rate setting are developed, perhaps it would be helpful to have a discussion with actuaries about simulating negative and affirmative utilization because that would then affect what goes into the benefits for individuals and how plans would address the costs.

Jacey Cooper, DHCS: The team is working with actuaries and I will take that feedback to them.

Hector Ramirez, Consumer Los Angeles County: There are 39 million Californians and approximately 15 million Latinos. In the stakeholder engagement, what opportunities has the Latino community had to participate? Can we say we are engaging linguistically diverse communities? Can you share specifics on stakeholder outreach to Latinos?

Jacey Cooper, DHCS: We are working broadly to reach out to everyone. Given the depth of the proposal, there are five workgroups, each with a diverse membership. There has not been specific process for any single culture. We are open to comment letters from everyone. I would be happy to engage with you about how to ensure we are reaching all appropriate

groups.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver Planning
Marlies Perez and Brenda Grealish, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/DMC-ODS-presentation-BH-SAC.pdf

Brenda Grealish opened the discussion with background information on the DMC-ODS. The goal is to treat people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment. California was first in nation to apply for and receive an ODS waiver. Now there are 20 other states with similar waivers. DMC-ODS uses a continuum of care modeled from the American Society of Addiction Medicine (ASAM) criteria for placement, continued stay, and transfer/discharge of patients with addiction. It includes all standard SUD treatment services plus case management, multiple levels of residential SUD treatment, withdrawal management services, recovery services, physician consultation, additional medication assisted treatment (MAT), and partial hospitalization. It also includes authority for federal reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). DMC-ODS is not statewide. There are 30 counties participating and eight other counties working to implement an alternative model. The other 20 counties have fee-for-service delivery which is more limited.

DHCS proposes to move the DMC-ODS into a Section 1915(b) waiver that incorporates managed care plans, mental health plans, and DMC-ODS. Some aspects of the program will remain in the 1115 waiver. Participation will not be mandatory for counties; however, we want to encourage all counties to opt-in. The waiver will also incorporate changes based on lessons from DMC-ODS.

Marlies Perez reviewed the proposal to CMS in each of the following 10 policy areas to strengthen the waiver through changes to the Standard Terms and Conditions (STCs) in the waiver. There are other items proposed that do not require CMS approval and are not captured here.

1. Residential treatment length of stay requirements: Remove the limitation of two non-continuous stays and change to a maximum 90 days annually for adults and adolescents.
2. Residential treatment definition: Require that MAT is delivered or the facility has an effective referral process; require 20 hours/week of clinical services and activities.
3. Recovery services: Clarify allowable recovery services (i.e. group counseling, education sessions, alumni groups, assessment); allow access to recovery services for justice-involved individuals; clarify that ongoing medication assisted treatment beneficiaries to utilize this benefit.
4. Additional MAT: Require all providers to provide or have effective referral mechanisms for MAT.
5. Physician consultation services: Clarify how and who can claim this activity.
6. Evidence-based practices: Retain the current evidence-based practices (motivational interviewing, cognitive behavioral therapy, relapse prevention, trauma informed treatment and psycho-education). Add contingency management.

7. DHCS provider appeals process: Eliminate since this is now covered under the federal 438 requirements.
8. Treatment after incarceration: Clarify language about individuals leaving incarceration who have a SUD.
9. Billing for services prior to diagnosis: Clarify allowing reimbursement for SUD assessments before a diagnosis is determined.
10. Tribal services: Clarify policies to increase access to SUD treatment services for American Indians and Alaskan Natives and seek allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement for the workforce of Traditional Healers and Natural Helpers, and culturally specific evidence-based practices.

She posed questions to the BH-SAC for comment:

1. Are there other opportunities to improve the DMC-ODS program?
2. What are the opportunities to incentivize/encourage additional counties to participate?

Questions and Comments

Gary Tsai, MD, Los Angeles County: On residential care, when we implemented DMC-ODS and moved to medical necessity, we experienced challenges in the interface with the court system with judges requiring 6, 9, 12 months of care. As the system evolves, it would be helpful to have state guidance and education on these issues for our justice partners to make the necessary shift. Also, on the hour requirements, it is clear that residential treatment will need to evolve. As lengths of stay shorten, how we set standards about clinical services and structured activities will also need to evolve. We should keep in mind service intensity in the various levels of care. In particular, higher levels of care should have higher levels of intensity – especially as lengths of stay shorten.

Michelle Cabrera, County Behavioral Health Directors Association of California: In the long run, we want all counties to join the DMC-ODS waiver, however, to get there rural counties will need help to develop the infrastructure and treatment resources. It is not a matter of will - there are not services in these parts of the state. We ask the state to support counties in terms of workforce and regional models. This is not unique to behavioral health. There are workforce and provider challenges that make economies of scale difficult overall. We support the requirement to require providers to offer or refer MAT. We support the removal of the two-day limit and move to 90 days total. We would like to see peers able to provide services at all levels of care. Currently, it is only recovery services and peer support is appropriate for other levels, including outpatient that is not reimbursed.

Kim Lewis, National Health Law Program: In terms of ways to equalize the service delivery system statewide, my suggestion is to move it outside the waiver and make these state benefits. Then, rely on managed care overall to accomplish timely access and network adequacy statewide. On the 30-day average length of stay requirement, are you proposing to change that or is the 90-day maximum within a 30-day average?

Marlies Perez, DHCS: CMS requires states to have a 30-day average length of stay for residential services. California was around 40 days in 2017 . This requirement is currently in

our 1115 waiver and it is doubtful that CMS would remove the 30-day average benchmark. We are looking to request a total of 90 days maximum in a year and not limit it to two stays.

Catherine Teare, California Health Care Foundation: Can you clarify that only the IMD residential will remain in the 1115 waiver? Are there other residential elements?

Marlies Perez, DHCS: We are requesting expenditure authority for services provided in IMD facilities which must be in an 1115 waiver. The other services in the DMC-ODS will move to 1915(b) waiver.

Catherine Teare, California Health Care Foundation: How do you think about the opt-in model in this, while in other proposals there is statewide standardization to managed care?

Jacey Cooper, DHCS: We will not be mandating that counties move to DMC-ODS. We are looking at integration models statewide while encouraging counties to opt in.

Catherine Teare, California Health Care Foundation: It seems moving to more regional approaches would help achieve standardization.

Sara Gavin, CommuniCare Health Centers: I appreciate the changes in the DMC-ODS waiver and see huge benefits. Specifically, on perinatal programs, this service needs additional resources to be effective, such as childcare. There are many programs providing this service that are not reimbursed.

Kelly Pfeifer, DHCS: I hadn't thought about that and will look into it.

Vitka Eisen, HealthRIGHT 360: It is great to see so many of the discussions we have had over time show up in the proposal. Although few beneficiaries use all the days available, is it correct that this is a reduction in available days over a year?

Marlies Perez, DHCS: It is currently in a requirement in our 1115 to have an average length of stay of 30 days. Some beneficiaries receive more and some less.This does not impact perinatal length of stay.

Vitka Eisen, HealthRIGHT 360: There was language for a longer length of stay for justice-involved?

Marlies Perez, DHCS: We don't reimburse for this through Medi-Cal, but placed it in the initial 1115 to recognize there are often longer lengths of stay for this population and to encourage other county funding for this population.

Vitka Eisen, HealthRIGHT 360: Do all the things not mentioned here remain in the STCs? On the clinical hour and service intensity requirements, the hours proposed align to licensing requirements. I want to be careful about allowing counties to do more. It seems there is an assumption that more intensity is better. However, people in an acute setting may not be able to tolerate extensive hours in clinical services. Some counties promote extensive hour requirements and it is not based on evidence. Residential has become about stabilization

and the real clinical work happens in outpatient where relationships are built. More is not always better – structure is better, but intensity is not. On the county participation, one thing that has worked is to have counties case manage participants and we place the member for treatment somewhere else. The county works to link them back to care. It might be a solution to build in payment structures that would allow counties to participate and claim that service.

Veronica Kelley, San Bernardino County: On opportunities to improve, we need to shorten the time for providers to get certified and make it customer focused. I agree we need state help for courts to understand the shift to medical necessity from mandating treatment length. We also need to attend to workforce to get more counties to participate. The average age of Alcohol and Drug Counselor in our county is 46 years old. They are experienced but have difficulty working with Transition Age Youth. We need to increase the workforce. Regionalizing is important for large counties also. There are areas of geography where there are not economies of scale and there are no staff.

Kelly Pfeifer, DHCS: My colleagues in provider enrollment are working to shorten the certification process, but there are many federal requirements that can't be abbreviated. I want to encourage providers to reach out when there is a problem and work through the challenges.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: I have several topics in my comments both on STCs and other concerns.

- On ASAM 3.7 and 4.0, there are two aspects – one is withdrawal management; the other is not – both are hospital level of care. However, there is only recognition of withdrawal management. We ignore the fact that hospitalization for substance use disorder is appropriate under 3.7 and 4.0. People are not able to access this service. They don't qualify to go through the mental health system, and we need to look at this to ensure counties recognize it. We also have a FFS voluntary withdrawal management benefit accessed through general acute hospitals. It doesn't tie to the ASAM criteria; it has a separate set of criteria. Some counties are taking that criteria and layering it on to ASAM criteria, and people can't access the voluntary benefit because there are not acute beds available. The chemical dependency and free-standing psych facilities are IMDs and we have a waiver for those facilities, but we exclude them from the FFS system. This is a barrier that needs a hard look.
- With shorter lengths of stay in residential, we will increase the frequency of admissions and discharges and increase the burden on facilities to deal with that volume. We need to keep this in mind.
- The MAT requirement is a good one. It is required today based on bulletins from DHCS that residential programs can't refuse admission due to MAT, but it happens often. This is an enforcement issue. We have supported requests to the legislature to give DHCS more resources to do enforcement and enrollment for licensing and program certification that get stuck because of a lack of resources. This results in barriers and delays in care.
- I echo Vitka's comments about the hour requirements. We burn out the population through intensity – they can't handle it. We should recognize that just being in a 24 hour environment is therapeutic and has immeasurable value by itself.

- I believe DHCS can fix the county variation. We should talk outside of the STCs about contracting issues and include stakeholders to fix the issues.
- Workforce is a crisis. There may be services within recovery support that need a well trained workforce to provide services. There are many people who will not become certified providers but have high value as non-certified staff in the system. We must recognize them.
- Case management is not referenced. Where does it fit in the new waiver? It is reimbursable and there are counties that do not pay for it because it is not listed by DHCS.
- Physician consultation should be a reimbursable service. We should expand who is recognized, including staff such as certified MAs, LVNs, and others.

Kelly Pfeifer, DHCS: Please send specific recommendations on 1) ASAM 3.7 and 4.0 and 2) the county variation on case management.

Alex Dodd, Aegis Treatment Centers: The time delays for providers to enroll are long and impact access. Smaller providers give up because of the challenges. Where is DHCS related to Partnership Health Plan model and timing?

Jacey Cooper, DHCS: We absolutely want to get this up and running. Late in the game, CMS raised concerns and we have to issue a SPA. We are working on that and once approved, will roll out contracts. We asked CMS to expedite the approval given the timing and CMS has been responsive.

Jevon Wilkes, California Coalition for Youth: If someone has experienced homelessness and receives DMC-ODS services, does this impact their homeless status? What do we do about out of county support given the large number of counties without ODS – is there technical assistance on this? On justice involved transition age youth (TAY), what community services are available to them for effective recovery, considering their challenges related to transition and the 90-day limits?

Kelly Pfeifer, DHCS: We recognize there are many barriers for TAY to access services. We are launching a workgroup on foster youth to discuss this and see how we can improve services. The workgroup will start in April. We know it is hard for small counties to offer the full continuum of ODS services and we are looking at regional options, like Partnership Health Plan taking on services for multiple counties. This is a top priority. I think you are referencing the federal rule on homeless status, and we don't have any control over that.

Jevon Wilkes, California Coalition for Youth: Yes, it is federal policy, however there may be additional services that can be provided to overcome that barrier. For the workgroup, judges need to be involved because they have lots of discretion and authority for TAY.

Kelly Pfeifer, DHCS: Homelessness is a top priority for the administration.

Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation: Thank you to Sara for highlighting the need for childcare as part of

services. On the five evidence-based services listed, I encourage you to include community-defined best practices and not limit to evidence based practices. There are listings of effective community-defined practices. For example, peer support services are vital for LGBTQ. There are programs offering these services and they can't bill Medi-Cal. The California Reducing Disparities Project (CRDP) is funding and evaluating programs and even those can't transition away from grants to Medi-Cal because they don't qualify although they are doing great work. The regional model is a good one related to LGBTQ communities. Given the small numbers, counties can't fund a person solely to serve this population, but the regional model can help address this through economies of scale. We did a mental health survey in the LGBTQ community last year and 77% of those wanting ethnic/population services couldn't get them; 66% wanting nontraditional services couldn't get them. Forcing people into models of care that are not relevant will not be effective. Please include community-defined best practices.

Rosemary Veniegas, California Community Foundation: I want to echo Mandy's comments on community-defined practices. The ability to provide community-informed services has been found to be effective, for example for gay men using methamphetamine. How are we thinking across systems and resources, like Prop. 63, Prop. 64, Prop. 47, to blend or braid resources intended for behavioral health services? How might DHCS and Medi-Cal incentivize using other funding through questions, bonus points or technical assistance to encourage leverage?

Kelly Pfeifer, DHCS: County Behavioral Health Directors are masters in weaving together multiple local resources. Also, to Mandy's comment, counties can pay for services that are not listed on the evidence-based core list.

Jonathan Porteus, WellSpace Health: I support additional resources to DHCS for licensing and certification. Also, to previous comment, there are longstanding treatments already in Medi-Cal for multiple levels of care and specific approaches. Some of us are working on Behavioral Health Home and I encourage more attention to that. It is a no-wrong-door (approach) to total health; there should be entry to full health services regardless of where they appear.

Kelly Pfeifer, DHCS: As we think about behavioral health integration, we need to move to a better way to offer the full suite of health services.

Jei Africa, Marin County Health Services Agency: There should be technical assistance and resources to build infrastructure for small, especially culturally based service providers to participate and thrive.

Hector Ramirez, Consumer Los Angeles County: Looking at the 10 policy proposals, I recommend that culturally tailored services be added. We have a diverse state and we know a range of approaches is needed. As a consumer, I struggled because of the lack of culturally specific services. We all have intersecting issues and they all need to be addressed – culture, gender, homelessness, jail, etc. We don't have adequate community supports in place and we are risking a bigger crisis. We have to be careful we don't repeat the previous mistakes of those coming out of institutions who ended up on the street

because community services were not available.

Kelly Pfeifer, DHCS: We will be discussing this topic of cultural responsiveness in a future meeting. It's clear we don't have a workforce that matches our population.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Without a miracle with CMS, we will end up with a shorter length of stay. It is already difficult with the 45 days we have today. We need to strategize and beef up community supports, housing and other services to make this work.

Kelly Pfeifer, DHCS: Thank you. This has been a great discussion and we have detailed notes to take back for consideration and follow up.

Trauma Screening
Karen Mark, M.D., DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/Trauma-Screening-Update-BH-SAC.pdf

Karen Mark presented background on Adverse Childhood Experiences (ACEs) screening and an update on the implementation of ACEs screening in Medi-Cal. As required by AB 340, an Advisory Group was convened to recommend tools and protocols for screening children for trauma. That work is complete, and the group statutorily disbanded on December 31, 2019. The BH-SAC is the ongoing advisory group identified by DHCS to review and advise on trauma screening. There is also a joint DHCS/ Office of the California Surgeon General Trauma-Informed Primary Care Implementation Advisory Committee to advise on:

- Promising models; best practices; evolving science; and clinical expertise for the implementation of trauma-informed care systems.
- Prevention of and screening for ACEs in primary care and specialty care.
- Integrated response, including mental and behavioral health services, care coordination, and advancement of diagnostic tools and services to address toxic stress.

California is leading the nation to address the public health crisis related to ACEs through a $29 payment to Medi-Cal providers for screening using a certified tool, training for providers to conduct screening and encouraging trauma-informed care through protocols and provider education. By July 1, 2020, providers must complete the free online training to receive reimbursement. There is an RFP to fund training and awareness on www.ACEsAware.org. Provider reimbursement is available for screening no more than once per year for children and once per lifetime for adults. Screening is voluntary for providers and patients. There are multiple ongoing provider informational and quality improvement activities.

Questions and Comments

Michelle Cabrera, County Behavioral Health Directors Association of California: This is exciting. We want to recommend expanded thinking about where trauma-informed training

and attention could live. There are behavioral health providers, homeless providers, courts, jail staff, etc. These are places where trauma plays out and it would be beneficial to expand the thinking on who is screening.

Catherine Blakemore, Disability Rights CA: I like that framing and would add schools to the list.

Linnea Koopmans, Local Health Plans of California: We are excited to see resources for training in the budget because the success of screening will rely on the effectiveness of the training. What feedback have you received from providers about the training? What part of the training focuses on referral and steps to follow the screening?

Karen Mark, DHCS: Feedback from providers has been positive. There is a high percentage of providers saying this will change what they do every day. The training engages providers in cases. They pick cases relevant to their practice and all cases touch on what providers can do to improve trauma-informed care and refer if needed.

Frank Mecca, County Welfare Directors Association of California: In addition to the cross-system training that has come up through the Program for Infant/Toddler Care (PITC), there is a need to develop ways to build a network of care to easily get patients to services they need.

Jonathan Porteus, WellSpace Health: I was involved in how this rolled out in New York. We were able to offer treatment in primary care. I would like to differentiate between system awareness and competence, and offering services. There are workforce issues related to having sufficient services.

Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation: Assessment is vital for knowing what to do. Once assessed, what is the system for services? It needs to be built as a system; not dependent on individual physicians to identify the service system. Otherwise, it is heartbreaking for providers and patients. The LGBTQ community experience high rates, in particular poly-victimization (family and peers) due to their status. The screening needs to incorporate LGBTQ issues. Many LGBTQ are not transparent to providers about their status because they don't want it to impact their care. There should be an adjunct element of training specific to this population. I recommend the work of Dr. Caitlin Ryan/The Family Acceptance Project and Dr. Paul Sterzing, UC Berkeley.

Jevon Wilkes, California Coalition for Youth: I am excited to see how this rolls out and I want to make sure that resilience is put into play. When you know better, you do better and I am looking for a higher accountability based on this.

Britta Guerrero, Sacramento Native American Health Center: I have two concerns. One is about the person carrying a high ACE score for life – what is their response to that? Tribal communities are overrepresented in CPS. When we find a child has a high ACE score, do

we become another unit of policing? I have concerns about how this may be used in assisting a family or against a family, to break up families.

Kim Lewis, National Health Law Program: As a reminder, the impetus for the legislation was EPSDT. There is an obligation already to screen under EPSDT, so I am wondering about the language of "voluntary". It will be important to track the follow-up and carefully examine the data to understand what is happening as this rolls out. In particular, part of the next step should be to focus on foster care.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: I echo Michelle's comments about the narrow set of providers and systems that was included. I think it should be broader. Why is this voluntary? Why wouldn't we ensure screening for all?

Karen Mark, DHCS: There are many requirements in place for providers, many from national guidelines such as Bright Futures. Also, as a new service, it will take time for providers to adopt and for this to spread. We are doing outreach to educate providers about the importance.

Bill Walker, MD, Contra Costa Health Services: We run a large primary care operation – 500,000 visits per year. When ACEs came up years ago, the recognition of the benefit was coupled with what happens post-screening. Is there an adequate system of referrals? Now that we are talking about integrated systems, this is a timely way to offer ACEs screening and systems for follow up. Providers will be more inclined to get on board.

Karen Mark, DHCS: The requirement is that screening AND discussion with the patient/family occur.

Vitka Eisen, HealthRIGHT 360: When we began to offer primary care, I thought we would have a single assessment form across primary care and behavioral health. Behavioral health requires tons of information, but the primary care team was resistant. Their view was, if I assess, I have an obligation to do something about it. This was an obstacle. In thinking about making this work, are there lessons learned from other places, such as providers who got the X-waiver (buprenorphine waiver) and didn't use it; the lack of connection in linking MAT to MAT providers? What were the barriers in implementation there that can inform this, especially for adults? Where didn't it work, to learn from?

Sara Gavin, CommuniCare Health Centers: We have been doing ACEs screening for several years. I appreciate that there is training because an untrained provider can re-traumatize. We do this for everyone. It is important not to pick and choose and end up with certain populations becoming overrepresented. We don't want to leave it up to the provider to determine when it is needed. FQHCs are a perfect place for referral and care, but with same-day billing, there are barriers to services.

Sarah-Michael Gaston, Youth Forward: I want to underscore comments about who is doing

the screening and how it is used, so that it is not used against the family. Family dynamics are complex and we need empathy in our approaches.

Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation: We need to build in case management for post-screening as we do for asthma and other medical conditions. Screening is insufficient without a system of services to follow up.

Ken Berrick, Seneca Family of Agencies: I want to echo Frank's caution. The people doing screening are all mandatory reporters and I worry we will have disproportionate child abuse reporting because they won't know what else to do. It is urgent to provide access to a resource and referral line, so providers have a follow up.

Public Comment

Jeff Farber, Chair of LA County Youth Services Policy Group and Executive Director of Helpline Youth Counseling: The LA County Youth Services Policy Group is a 22-agency coalition of substance use disorder providers that advocates for a youth-centered substance use system of care. Helpline Youth Counseling is a provider contracted for youth substance use and mental health services. The coalition urges you to put youth first in designing and implementing an integrated system for mental health and substance use disorder treatment. Youth First recognizes that youth have complex needs and require services appropriate for their developmental life stage. Services need to be customized to their individualized experiences to ensure appropriate treatment. There needs to be an SUD system that is flexible and not a DMC system that is one size fits all. We need parity and we need to remove barriers to treatment offered at all levels of systems. For example, Department of Mental Health providers have 60 days to complete an assessment; SUD providers are allowed only 14 days to complete an ASAM assessment. There needs to be parity. Youth need to be seen in youth-friendly environments, community centers, schools and homes that allow us to evaluate the environmental factors that affect their lives. DMC outpatient providers are limited to designated locations, staff and times. Vulnerable populations can't always make it to offices. Youth don't always want to be identified as the kid going to a certain office at school to see the SUD provider. They get around on skateboards and bicycles. They do not always have a caregiver to transport them. Mental health providers can see youth in homes, where they are, when they need to be seen, in the best environment that works for youth. We need the same system of parity for youth drug services that we have for adults. Adults with Medicaid are eligible for transportation support and youth need the same opportunity. We need a client support service benefit for wellness oriented interventions that increase rapport, treatment, engagement, enrollment and continuing participation. Youth are our future. Their experiences today affect their development and influence how they raise the children of tomorrow. I commend you for the work done. I think there is more to do to ensure youth have the access and parity they need across all systems.

Tamara Jimenez, Anaheim Lighthouse: I want to hear more about sober living and recovery

residences. DMC does cover recovery residences, but in Orange and many counties where Boards of Supervisors and City Councils are making decisions about certifications, they are pushing them out. They do not have expertise to make decisions. We need DHCS to step in on certification for recovery residences. DMC is great but we don't have the beds. There is a homeless man in Anaheim who is dying in a park and wants to go to treatment, but we don't have the beds. He can't go to treatment in Los Angeles because the county to county transfer is not in place. Senator Bell introduced SB 854 on MAT; Senator Weiner introduced SB 855 on parity in private plans. Thank you for your hard work.

Steve Leoni, consumer mental health advocate: I commend the previous speaker for giving us the reality. I am concerned about CalAIM. It doesn't seem fully cooked and there is confusion. I don't see how the pieces fit together. For example, there was a discussion of medical necessity and eligibility for mild to moderate and yesterday there was a discussion of specialty mental health, but the two things were divorced from each other. The two worlds aren't connected yet. The ODS proposal is precise and it seems like it is all covered, but life is messy and we need to use the concept in the Mental Health Services Act of "do whatever it takes". I congratulate Al Senella for offering the on-the-ground perspective.

Dr. Donna Costello, School Psychologist: I want to compliment you for the CalAIM proposal. I spent my career working with kids with mental health issues to coordinate services. I am wondering why there is not an educator as part of your group. Education is a different world and insulated. It could be helpful to have them part of this discussion. On a personal level, I am here because I have experienced a nightmare dealing with the systems in trying to support a family member with heroin addiction. As a family member, I am not considered part of treatment, part of the team.

Kelly Pfeifer, DHCS: This administration is committed to listening; thank you for the real life information that you all bring to the discussion.

Richard Figueroa, DHCS: My thanks to all of you. Next time Dr. Brad Gilbert will be here. I commend you for the discussion of ensuring the work is effective and accomplishes what is intended.

2020 BH-SAC Meeting Dates:

- 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.