

California Behavioral Health Planning Council

Systems and Medicaid Committee Agenda

Thursday, October 22 2020

Zoom link: <https://zoom.us/j/95412140339?pwd=dTJadmhCSkhvckNMQnd5NmIKWHRzQT09>

Meeting ID: 954 1214 0339 **Passcode:** 046661

Join by phone: +1 669-900-6833 **Passcode:** 954 1214 0339#

10:30 a.m. – 12:00 p.m.

10:30 am	Welcome and Introductions <i>Liz Oseguera, Chairperson</i>	
10:35 am	Approve June 2020 Meeting Minutes <i>Liz Oseguera, Chairperson and All Members</i>	Tab 1
10:40 am	CBHPC Equity Statement Review <i>Liz Oseguera, Chairperson and All Members</i>	Tab 2
10:50 am	Public Comment	
10:55 am	Review Talking Points Re: CalAIM Recommendation Letter <i>Ashneek Nanua, Council Analyst, Liz Oseguera, Chairperson and All Members</i>	Tab 3
11:15 am	Public Comment	
11:20 am	DHCS Behavioral Health Stakeholder Advisory Committee & CHHS Behavioral Health Taskforce Meeting Highlights <i>Ashneek Nanua, Council Analyst</i>	Tab 4
11:30 am	BREAK	
11:35 am	Nominate SMC Chair-Elect for 2021 <i>Liz Oseguera, Chairperson and All Members</i>	Tab 5
11:45 am	Next Steps for 2021 <i>Veronica Kelley, DBH, San Bernardino County</i> <i>Tony Vartan, DBH, San Joaquin County</i> <i>Liz Oseguera, Chairperson and All Members</i>	Tab 6
11:55 am	Public Comment	
12:00 pm	Adjourn	

The scheduled times on the agenda are estimates and subject to change.

If reasonable accommodations are required, please contact the Council at (916) 701-8211, not less than 10 working days prior to the meeting date.

California Behavioral Health Planning Council

Systems and Medicaid Committee Members

Liz Oseguera, Chairperson Karen Baylor, Chair-Elect

Veronica Kelley

Tony Vartan

Noel O'Neill

Daphne Shaw

Celeste Hunter

Catherine Moore

Cheryl Treadwell

Walter Shwe

Kathi Mowers-Moore

Susan Wilson

Deborah Pitts

Hector Ramirez

Dale Mueller

Karen Hart

Marina Rangel

Committee Staff

Ashneek Nanua, Council Analyst

Jane Adcock, Executive Officer

**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 22, 2020**

Agenda Item: Approve June 2020 Draft Meeting Minutes

Enclosures: June 2020 Draft SMC Meeting Minutes

Background/Description:

Committee members will review the draft meeting minutes for the June 2020 Quarterly Meeting.

Motion: Accept and approve the June 2020 Systems and Medicaid Committee meeting minutes.

Members Present:

Liz Oseguera, Chairperson	Karen Baylor, Chair-elect	Karen Hart
Catherine Moore	Hector Ramirez	Cheryl Treadwell
Marina Rangel	Celeste Hunter	Dale Mueller
Noel O'Neill	Susan Wilson	Daphne Shaw
Veronica Kelley	Tony Vartan	Deborah Pitts

Staff Present:

Ashneek Nanua, Jane Adcock, and Jenny Bayardo

Public Attendees:

Poshi Walker, Mandy Taylor, Steve McNally, Theresa Comstock, Elia Gallardo

Meeting Commenced at 8:30 a.m.

Item #1 Approve April 2020 Draft Meeting Minutes

The Systems and Medicaid Committee (SMC) approved the April 2020 Meeting Minutes. Noel O'Neill motioned approval. Catherine Moore seconded the motion. Marina Rangel abstained.

Action/Resolution

The April 2020 SMC Meeting Minutes are approved.

Responsible for Action-Due Date

N/A

Item #2 Review Talking Points Re: CaAIM Recommendation Letter

SMC staff reviewed talking points created from the committee's CaAIM Recommendation Letter. Committee members requested the following edits:

- **Clarify that the No Wrong Door approach be applied to children and adults.**

- **Add a talking point to highlight the Council's concerns with limited workforce and request expanding the definition of licensed mental health professionals (LMHPs) to include peer specialists, occupational therapists, and other provider categories to increase workforce.**
 - Tony Vartan stated that California continues to experience a shortage of mental health providers and indicated that the Statewide Health Planning and Development (OSHPD) is working with the regional partnerships on this issue.
 - Hector Ramirez added that the current systems are overwhelmed by the COVID-19 pandemic and additional workforce is needed to reduce the pressure placed on the current workforce.
 - Deborah Pitts indicated that CBHPC's Workforce and Employment Committee has explored the topic of expanding the definition of LMHPs and compiled a summary of potential providers who could be recognized as LMHPs including occupational therapists.
- **Add a talking point requesting the Department of Health Care Services (DHCS) to support telehealth and telemedicine.**
 - Liz Oseguera explained the difference between telehealth and telemedicine, indicating that telehealth is conducted over video while telemedicine is a phone consultation that has not been reimbursable outside of the flexibilities provided during the COVID-19 pandemic. She stated that phone is a favorable way of communication to providers due to disparities in accessing technology and requested DHCS to add telemedicine can help reduce gaps in health care inequities.
 - Noel O'Neill added that telehealth has been an acceptable practice in county health systems but telemedicine has not.
 - Deborah Pitts posed that challenges include how patients feel around intimacy of the provider seeing their home in a telehealth visit.
 - Committee members expressed that telemedicine is beneficial by increasing participation and reducing missed appointments.
 - SMC staff indicated that DHCS is interested in seeing what is working and what is not working in telehealth to incorporate it into the health care system post COVID-19.
 - Jane Adcock, Executive Officer, indicated that the Assistant Deputy Director of Behavioral Health, Jim Kooler, joined the Performance Outcomes Committee (POC) meeting and notified committee members that DHCS is seeking input and data to validate a request to CMS to expand telehealth following the COVID-19 pandemic. DHCS believes continuing telehealth will expand access and improve retention. The POC will redirect the 2020 Data Notebook to address this topic and submit a report to DHCS in Fall 2020.

- **Include the importance of knowledgeable, culturally-relevant, and affirming providers as a critical component of ensuring continuity of care.**

Hector Ramirez motioned approval of the talking points with the requested edits. Catherine Moore seconded approval. The talking points were approved by the SMC. Committee members will review the talking points at the October Quarterly Meeting.

SMC staff notified committee members that DHCS is working with the Centers of Medicare and Medicaid Services to postpone the renewal of the Medi-Cal 1915(b) and 1115 waivers by one year.

Action/Resolution

SMC staff will update the talking points from the CalAIM Recommendation Letter with the requested changes.

Responsible for Action-Due Date

Ashneek Nanua, Jane Adcock, Liz Oseguera, Karen Baylor – October 2020

Item #3 Public Comment

Steve Leoni stated that it is helpful for individuals to have one provider as they transition from Specialty Mental Health Services to mild-to-moderate services and vice versa. Mr. Leoni indicated that the Substance Use Disorder system has no division in how individuals receive care while the mental health system has a division of care between individuals with SMI and those with mild-to-moderate conditions. He stated that modified legislation may be needed in this area.

Karen Baylor responded to Mr. Leoni, indicating that an individual is able to request the same provider up to 12 months under the Final Rule. Michelle Cabrera stated that there is an information notice regarding continuity of care requirements. Ms. Cabrera added that the CalAIM workgroups had discussions regarding a No Wrong Door policy.

Poshi Walker stated that LGBTQ constituencies across the state report difficulty in finding providers who are affirming and knowledgeable and expressed that clients should be able to seek out providers.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #4 CBHDA Update Re: COVID-19 Impact on County Behavioral Health Services

Michelle Cabrera, Executive Director of the County Behavioral Health Directors Association (CBHDA), delivered a presentation on the impacts of COVID-19 on the county behavioral health system. Ms. Cabrera presented the committee with a comparison of the Governor's January Budget proposal and May Revision for FY 2020-21 which reflects a \$19 billion dollar loss in the State General Fund (SGF), an unemployment rate at 18%, and a projected Medi-Cal caseload growth by an addition 2 million Californians.

Michelle reviewed financing for the county behavioral health system. Counties are reimbursed through Federal Financial Participation (FFP) which has extensive documentation requirements and cost-settlement process. Additionally, counties receive financing from volatile funding sources such as Mental Health Services Act (MHSA) and Realignment funds. Each revenue stream has different criteria associated with it. Ms. Cabrera expressed the need to maximize Medi-Cal billing considering the largest share of money counties receive is from FFP.

Prior to COVID-19, \$6 billion of the \$105 billion Medi-Cal budget was allocated to county behavioral health services for adults with SMI and SUD as well as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children. Post-COVID-19 projections indicate a \$1 billion loss in Medi-Cal funds. MHSA distributions for the current year dropped by 60% and is anticipated to drop by 20% overall in the coming years. Medi-Cal behavioral health funding is estimated to drop by 13% over the next 3 years compared to the Managed Care system which will face a 1.5% cut in the budget.

Michelle Cabrera indicated that the need for services typically increase during low budget years. However, county funds are also falling due to fewer Medi-Cal billable services that are eligible to receive federal funds as well as the decrease in service volume due to Shelter-in-Place orders, staffing challenges, and disparities in accessing telehealth. Ms. Cabrera stated that budget cuts for behavioral health are hidden in state-level conversations so county behavioral health representatives need representation in order for the Administration and Legislature to acknowledge that counties will experience major cuts outside of the State General Fund.

While the May Revision is proposing to redirect \$1.3 billion from state to counties in CARES Act funding, there is no guarantee on how this money will be distributed at the local level. CARES Act funding can only be used to address COVID-19 such as securing personal protective equipment (PPE), training staff, and improving sanitation

efforts. It cannot be used to support the non-federal share of Medi-Cal or backfill existing supportive services.

CBHDA has joined with the California State Association of Counties (CSAC), County Welfare Directors Association (CWDA), and several provider organizations to request that the state Legislature propose a backfill on Realignment losses. The initial request was \$3.3 billion. The state has allocated \$1 billion for all Health and Human Services programs funded under Realignment and \$230 million of this fund would go to counties as a best case scenario.

Michelle Cabrera described impact of COVID-19 on the service delivery aspect of the behavioral health system, indicating that the CalAIM Initiative and Medi-Cal 1915(b) and 1115 waivers are on hold. These proposals are intended to provide better integration, coordination, and payment to providers. The State estimates saving \$347 million SGF by postponing the CalAIM Initiative. Ms. Cabrera added that DHCS identified the Medical Necessity proposal as an essential component in the waiver negotiations.

Michelle expressed the following client concerns regarding changes to the public behavioral health system as a result of COVID-19:

- Individuals with SMI often have physical health comorbidities which make them a high-risk group for contracting the virus.
- There is heightened anxiety to go outside due to fear of COVID-19 exposure.
- The digital divide is evident as clients do not have technology, privacy, nor literacy in their homes to engage in appointments.
- The use of telehealth has contributed to fatigue.
- The diminished connection between therapist and client due to the need to wear masks.
- Fewer clients are seeking substance use disorder services.

Additionally, crisis calls have increased due to the anxiety around COVID-19 as well as societal impacts including the protests against racial injustice. Many counties responded by launching warm lines to take pressure off hospitals and emergency departments. Los Angeles County implemented the Crisis in Place Initiative where mobile teams meet people where they are to manage crisis in the community and reduce the number of psychiatric holds. Active conversations at the local level include shifting resources from law enforcement to social workers.

Michelle Cabrera described the impact of COVID-19 on the behavioral health workforce:

- Telehealth can protect psychiatrists from exposure because many are older and at high-risk of contracting the virus.
- 80-90% of providers are working from home while maintaining field services.
- Many providers have concerns around securing child care.

- Additional telehealth training is necessary in order to shift clinical practices.

CBHDA contacted the California Institute for Behavioral Health Solutions (CIBHS) to form a curriculum and requested funding from the California Health Care Foundation (CHCF) to provide trainings on transitions to telehealth modalities. These trainings will be held every Wednesday through July 2020. Topics include harm reduction, engagement and retention, implicit bias, and telehealth in communities of color.

California has not provided additional funds to transition individuals to telehealth services thus limiting the ability for county providers to deliver and be paid for services. Counties are still subject to network adequacy requirements despite disproportionate cuts to behavioral health. CBHDA has requested policy changes to facilitate telehealth modalities and support cost-based and fee-for-service providers, including:

- Prioritizing Medi-Cal billing and services because they are entitlements eligible to receive federal dollars that help support the safety net system.
- Moving contracted providers to “1/12th contracts” where providers can receive monthly payments based on actual costs.
- Asking the State to partner and revise how Medi-Cal services are paid for, such as allowing counties to claim higher cost-per-unit as volume drops with service delivery.

Michelle Cabrera highlighted gaps and stigma related to the COVID-19 response. Key points are summarized below:

- Acute psychiatric hospitals were left out from guidance that the State provided on policy changes.
- State hospitals refrained from admissions and discharges during early stages of the pandemic.
- Emergency departments asserted that they will not take a psychiatric emergency unless an individual has a co-occurring physical health condition.
- Inpatient providers are requiring negative COVID-19 results before admitting patients, creating challenges in moving patients to appropriate levels of care.
- Alternative care sites are refusing admission for COVID-positive individuals who also have a psychiatric condition.

Despite these challenges, county behavioral health departments were able to influence the design of Project Room Key sites. Some counties designated a specific room in sites for clients to engage in telehealth.

Tony Vartan provided an update on the COVID-19 impact in San Joaquin County. Behavioral health directors acted quickly to erect an emergency system. Telehealth equipment were brought to sites where patients connect with providers. Director Vartan indicated that the county took on a No Wrong Door approach to ensure service

availability and measures were put in place to ensure provider and client safety. Challenges exist at the inpatient level due to limited ability to social distance and to secure adequate PPE for behavioral health workers.

Veronica Kelley provided an update on the COVID-19 impact in San Bernardino County. The county is currently serving 40,000 individuals and 1,000 of these individuals receive medication. Individuals with access to cellphones may not have coverage so the county has used land lines and clinics are open. San Bernardino County has taken steps to ensure client safety such as delivering masks in the community and conducting testing at churches and community centers to reach individuals often overlooked such as the LGBTQ population and communities of color.

Director Kelley reinforced the notion that individuals served have medical issues due to disparities stemming from racism and discrimination. She stated that each county has varying cultural humility requirements. San Bernardino has been called to work with law enforcement on how to deal with racism and discrimination as it impacts physical health.

Hector Ramirez suggested initiating a conversation with county directors about race as a major contributor to health disparities and indicated that many individuals fear law enforcement, who often guard health office buildings. Hector asked how disabilities can be considered as individuals move to remote modalities. Michelle Cabrera stated that county behavioral health consumers are often individuals with disabilities and recognized the importance to help them find supports to make services accessible and effective. She indicated that Dr. Sherin, Los Angeles County Behavioral Health Director, implemented community teams in place of law enforcement to deal with crisis in the community. Michelle added that MHSA allows counties to invest in community-defined practices and fund services that are not Medi-Cal fundable.

Ms. Cabrera expressed that county behavioral health is at the forefront of prioritized equity and disparities in terms of how they engage individuals and think about programs and services. She acknowledged that improvements need to be made.

Karen Baylor asked if there is an estimation of how much the FMAP increase would help generate funds for counties. Michelle Cabrera indicated that CBHDA does not know how it will be applied to the state at this time.

Daphne Shaw asked how counties are coping with certification hearings and aspects of patient rights. Veronica Kelley indicated that counties have been using telehealth to do this.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #5 Public Comment

Poshi Walker stated that it is intimidating to approach county behavioral health buildings that are guarded by armed police. Unaddressed mental health issues will increase physical symptoms and shared findings from Canadian research on mental health in the workplace. The research shows that physical illnesses occur for people in toxic work situations. Poshi pointed out that we are now living in our workplaces which may lend itself to toxic stress.

Steve Leoni requested that Michelle Cabrera's presentation be posted on the Council's website as a resource. Mr. Leoni indicated that many consumers are dying from COVID-19 because of programs with congregate settings and there is a need to see how this impacts communities.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #6 Wrap Up/Next Steps for October Quarterly Meeting

SMC staff provided committee members with details for upcoming DHCS meetings including the CalAIM Foster Care Model of Care Workgroup as well as the Long Term Care at Home Workgroup. Staff will send additional information to committee members via email.

SMC members expressed interest in the following topics for the October Quarterly Meeting:

- Mitigate the impact of COVID-19 on the public behavioral health system and address disparities.
- Influence police roles to include a strong mental health input in efforts to reduce police brutality and trauma to individuals with SMI.

Liz Oseguera, Chairperson, requested that the following agenda items be added for the October SMC meeting:

- Provide updates for the Behavioral Health Stakeholder Advisory Committee meetings.
- Review the committee's revisions for the CalAIM talking points.

Action/Resolution

- SMC staff will update the talking points from the CalAIM Recommendation Letter for committee member review.
- Staff will attend the July 2020 BH-SAC meeting and provide an update to committee members.
- SMC officers will explore options for the committee to be proactive in addressing the COVID-19 impact on the public behavioral health system and influencing police roles to reduce brutality to individuals with SMI.

Responsible for Action-Due Date

Ashneek Nanua, Jane Adcock, Liz Oseguera, Karen Baylor – October 2020

Meeting Adjourned at 10:30 a.m.

**California Behavioral Health Planning Council
Systems and Medicaid Committee (SMC) Meeting
Thursday, October 22, 2020**

Agenda Item: Discussion of CBHPC Equity Statement

Enclosures: None

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

The establishment of an Equity Statement will enable the Council to publicly acknowledge historical systemic racism and racial inequities which have resulted in significant health disparities. Further, the statement will indicate the Council's commitment and our efforts to change such institutional inequalities.

Background/Information:

The Council Officer Team comprised of the Chairperson, Chair-Elect, Immediate Past-Chair, and Executive Officer are considering establishing an Equity Statement for the Council that reflects the Council's vision, values and efforts to promote racial equity, reduce disparities and improve health outcomes for all Californians.

They invited the Reducing Disparities Workgroup (RDW) to draft the statement. Below is the proposed Equity Statement for the member consideration. This statement is being discussed during the October meetings of the Housing and Homelessness Committee and Systems and Medicaid Committee for full membership review. Ultimately, the statement will be posted on the Council website.

Draft Council Equity Statement Version 3

The California Behavioral Health Planning Council members and staff are dedicated to supporting efforts, policies and programs that bring about necessary change to address longstanding systemic racism and inequities. The behavioral health community is directly impacted by social injustice leading to far-reaching health disparities and life expectancy.

The nation is experiencing a number of crises; crises which have indisputably highlighted the complex issues of race and inequality across our country. The Planning Council's vision is a behavioral health system that makes it possible for individuals to achieve full and purposeful lives. We are committed to attaining racial and social equity through action and advocacy for an inclusive society in which all community members can realize their full potential regardless of their race, age, gender identity, sexual orientation, diagnosis, ability or economic status. The Planning Council employs a number of [Guiding Principles](#) that are foundational to its visionary work

It must be recognized that certain communities and individuals benefit from systemic racism and inequities while other communities and individuals suffer greatly. Leaders must look inward to identify unconscious biases as well as understand historical policies and practices that drive inequities. The Planning Council commits to continuing and improving our policies and practices to support and encourage diversity in membership and staff perspectives, to value individual lived experience, and to promote opportunities for ongoing education and growth.

The Council believes we can establish public policies that honor and respect differing backgrounds and life experiences by normalizing conversations about racial and other inequities. By building partnerships among Council members, policy makers, and communities served, we can operationalize the true meaning of equity. Through this process, the Council supports California in achieving the goals to reduce disparities, rebuild the trust lost from communities that have been historically under/inappropriately served and eliminate social injustice and racial inequities.

**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 22, 2020**

Agenda Item: Review Talking Points Re: CalAIM Recommendation Letter

Enclosures: CalAIM Recommendation Letter Talking Points

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides committee members the opportunity to review and approve talking points derived from the SMC letter of recommendations for the CalAIM Initiative. The talking points will be used to promote policy considerations for CalAIM at upcoming meetings held by Department of Health Care Services.

Background/Description:

SMC staff developed talking points to present at upcoming public hearings and related meetings focused on the CalAIM Initiative as well as the renewal of the 1915(b) and 1115 Medical Cal waivers. The talking points are based on the committee's key recommendations provided in the CalAIM Recommendation Letter addressed to the Department of Health Care Services.

Committee members reviewed the talking points during the June 2020 Quarterly Meeting and provided feedback for staff to make edits. The SMC approved the talking points and decided to review the requested edits during the October Quarterly Meeting.

Additionally, the COVID-19 pandemic and escalation of police brutality towards communities of color has further highlighted and exacerbated health disparities and outcomes among ethnically diverse populations. In response, the SMC Chairperson and Chair-Elect requested staff to include language in the talking points that ensure that the CalAIM recommendations are culturally relevant and adaptive for ethnic groups who are unserved, underserved, and inappropriately served by California's public behavioral health system. The SMC will also discuss whether to include additional policy recommendations around behavioral health service delivery through telehealth modalities.

Talking Points for DHCS Public Hearing Re: Medi-Cal Waiver Renewals

Hello, my name is Ashneek Nanua representing the Behavioral Health Planning Council's System and Medicaid Committee.

This Committee collaborated with stakeholders across California to produce a letter of recommendations to DHCS regarding Medical Necessity and the Administrative Integration of Mental Health and Substance Use Disorder Services. Key points for Medical Necessity include: **(20 seconds)**

Medical Necessity

- Supporting a No Wrong Door approach that permits service delivery through multiple entities simultaneously to ensure that **all children and adults** have access to care wherever they present in the system **regardless of insurance status.** (12 sec)
- The No Wrong Door approach is tied to payment reform. The committee supports payment before diagnosis to incentivize value-based care and reduce the effect of clients moving back-and-forth between Managed Care Plans and county systems. (12 sec)
- We ask that DHCS create statewide standards to operationalize warm hand-offs and referrals to prevent individuals from getting lost in the system. **The process should include multilingual navigators to assist non-English speaking clients and families through the transition.** (15 sec)
- DHCS should mandate a universal tracking tool to monitor clients' transition from MCPs and SMHS. (8 sec)
- The SMC supports the use of a lean standardized assessment tool that has a section where providers can include additional elements as needed. We request that DHCS field and compliance staff be trained to the assessment tool and hold entities accountable solely on the core standards of the tool. **The assessment tool should be culturally-adaptive to reflect appropriate treatment plans for diverse cultures.** (22 sec)
- We recommend the ACES screening tool be administered to adults in addition to children. (5 sec)
- It can take 90 days for Medi-Cal to activate when transferring to a new county. We recommend the prior county of residence be financially responsible for the beneficiary until their Medi-Cal is initiated in the new county of service. (13 sec)
- Families should be considered as part of the treatment process to reduce potential feelings of isolation and trauma experienced when navigating multiple levels of care. **Additionally, education should be provided to families with a misunderstanding of mental illness to reduce stigma and strengthen social support to the client.** (17 sec)

Talking Points for DHCS Public Hearing Re: Medi-Cal Waiver Renewals

For the **administrative integration of mental health and substance use disorder services**, the Committee recommends... (6 sec)

- Removing the primary diagnosis requirement so providers can deliver both mental health and SUD services if they have education and training in both arenas. (9 sec)
- Streamlining the licensing review process for facilities that deliver mental health and substance use disorder services. (6 sec)

In regards to providers,

- We ask that DHCS simplify the provider enrollment process to reduce delays in enrolling and licensing providers. (7 sec)
- **California continues to experience a shortage of behavioral health providers which has been exacerbated in response to COVID-19. We recommend building capacity by expanding the definition of licensed mental health professionals and implementing statewide peer specialist certification and training.** (17 sec)
- **Clients should be able to seek out and have access to knowledgeable, culturally-relevant, and affirming providers to ensure continuity of care. We encourage DHCS to ensure that education programs include cultural competency, humility, and implicit bias training in order to appropriately serve communities of color. We also recommend that Medi-Cal reimburse services delivered by non-traditional providers such as cultural healers and that DHCS revise current policies and practices to ensure welcoming and culturally-relevant care.** (29 sec)

We also recommend the ongoing use of telehealth and telemedicine. This includes...

- **Medi-Cal reimbursement for telemedicine to reduce disparities in accessing care.**
- **Adequate funding to develop infrastructure and provide technology resources such as equipment and broadband for rural and underserved communities.**
- **Hiring multilingual providers to meet the needs of non-English speaking clients.**
- **Designating a private room for telehealth appointments for individuals residing in congregate settings to protect patient privacy.**
- **Providing technical assistance to counties and community-based organizations.**
- **Creating practices that improve digital literacy and care coordination for individuals with severe and comorbid conditions.** (41 sec)

Talking Points for DHCS Public Hearing Re: Medi-Cal Waiver Renewals

With these recommendations, we believe CalAIM has the potential to reduce complexities within the behavioral health system and lead to better treatment outcomes for individuals served. We thank you for the opportunity to speak today. Please reach out to our Executive Officer, Jane Adcock, if you have any questions. **(15 sec)**

Total Time: 4.2 minutes

**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 22, 2020**

Agenda Item: DHCS Behavioral Health Stakeholder Advisory Committee (BH-SAC) & CHHS Behavioral Health Taskforce Meeting Highlights

Enclosures: [BH-SAC July 2020 Meeting Summary](#)
[BH-SAC July 2020 Meeting PowerPoint Presentation](#)
CBHPC Overview of BH-SAC July 2020 Meeting Summary
[Behavioral Health Taskforce August 2020 Meeting Materials](#)
CBHPC Overview of Behavioral Health Taskforce August 2020 Meeting

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides committee members with information about the activities of advocates and stakeholders involved in developing behavioral health policies for California's most vulnerable populations. The SMC will use this information to plan future activities and advocate for policies that improve access to high-quality health care in California's public behavioral health system.

Background/Description:

The Behavioral Health Stakeholder Advisory Committee (BH-SAC) was created by DHCS as part of the ongoing effort to integrate behavioral health with the rest of the health care system, and incorporates existing groups that have advised DHCS on behavioral health topics. Following the model of the Stakeholder Advisory Committee, the BH-SAC advises the DHCS Director on the behavioral health components of the Medi-Cal program as well as behavioral health policy.

The California Health and Human Services (HHS) Agency announced Governor Newsom's Behavioral Health Taskforce to address urgent mental health and substance use disorder needs across California. The Taskforce consists of stakeholders including individuals with lived experience, family members, advocates, providers, health plans, counties, and state agency leaders. The mission of the task force is to develop recommendations for the Governor about how California can provide timely access to high-quality behavioral health care for all.

Council staff will provide key updates from the July 2020 BH-SAC meeting as well as the August 2020 Behavioral Health Taskforce meeting.

Details for upcoming Behavioral Health Taskforce and BH-SAC meetings are provided on the following page:

Behavioral Health Taskforce Meeting:

Date: Thursday, December 3, 2020 – Time and web location TBD

BH-SAC Meeting:

Date: Wednesday, October 28, 2020

Time: 9:30 a.m.-12:30 p.m.

Web location TBD

California Behavioral Health Planning Council Overview of DHCS Behavioral Health Stakeholder Advisory Committee: July 2020 Meeting

The Behavioral Health Stakeholder Advisory Committee (BH-SAC) was created as part of the ongoing effort to integrate behavioral health with the rest of the health care system. The BH-SAC provides the Department of Health Care Services (DHCS) with coordinated input regarding behavioral health activities at a system-wide level. The intent of the BH-SAC is to build policies that will improve the behavioral health system.

This document includes a high-level summary of the July 2020 BH-SAC Meeting.

State Budget Update

State Medicaid Director, Jacey Cooper, provided an update on the state budget and indicated the following areas of focus for DHCS:

- COVID-19 response
- Skilled Nursing Facility (SNF) payment reform
- Increasing eligibility categories for age, blind, and disabled populations
- Supplemental payment pool (Proposition 56 funds) for providers who meet quality incentives
- Proposal to expand children's Medicaid coverage for hearing aids

Ms. Cooper indicated that the Behavioral Health Quality Improvement Project (QIP) will not move forward, however, the Behavioral Health Integration Project funded by Prop 56 will move forward.

COVID-19 Update

The Department of Health Care Services provided an update regarding their response to COVID-19 in the categories of telehealth services and the 24 hour Medi-Nurse Line.

Telehealth Update:

Service Delivery Flexibilities: Licensed providers have the flexibility to determine if service delivery is appropriate over telehealth. Beneficiaries also have the choice of service modality and are able to use their home as the originating site of visit, however, new patients require a video visit. E-consultations are now allowed for licensed providers but not available for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian 638 clinics due to their reimbursement structure.

DHCS indicated that they will review the flexibilities to determine which ones will be permanent and whether federal approval is required.

Financing: DHCS will pay the same rate for telephonic services as face-to-face services as long as the encounter meets the requirements of billed in-person visit, the service is clinically appropriate for the modality used, and the service meets all procedural and technical components of the service. Providers will also need to indicate how the service was delivered when filing claims. This applies to all provider types including FQHCs, RHCs, and Tribal 638 clinics.

California Behavioral Health Planning Council Overview of DHCS Behavioral Health Stakeholder Advisory Committee: July 2020 Meeting

Flexibility for FQHC, RHC, and Tribal 638 clinics include the following:

- Associate MFTs and Associate LCSWs can bill for services.
- Tribal 638 can claim reimbursement for providing services outside of a traditional clinic setting.
- Clinics can receive their Prospective Payment System rate or all-inclusive rate for telephonic services that meet billed visit requirements.

DHCS submitted several waiver flexibilities in response to COVID-19. Most requests approved by the Centers of Medicare and Medicaid Services (CMS). Outstanding items include the following:

- Receiving approval for the Disaster 1115 Waiver request from CMS.
- Exploring lessons learned from COVID-19 response to evaluate what should continue after the public health crisis period.
- Analyzing encounter data to review the early months of the public health emergency to explore how to continue service utilization moving forward.

BH-SAC members expressed interest in looking at data from health plans on utilization of telehealth services. Michelle Cabrera, CBHDA Executive Director, stated that it would be helpful to know how Managed Care Plans (MCPs) are conducting telehealth services to better inform policy. DHCS indicated that payment parity for telephonic services has changed and there will be evaluation for the use of telehealth to determine which services move forward via telehealth and which services must be delivered in-person.

Medi-Nurse Line Update:

Medi-Nurse is a 24-hour advice line for uninsured individuals or beneficiaries in the fee-for-service system to address COVID-19. Nurses provide direction on whether the caller should self-isolate, where to get tested, and how to seek treatment. Uninsured individuals will receive referrals to a provider to receive presumptive eligibility (PE) to receive temporary Medi-Cal coverage for COVID-19 related testing and treatment services. The service is available in multiple languages.

DHCS provided statistics on the Medi-Nurse Line thus far. Key statistics include the following:

- Over 11,000 calls have been made since May 2020 from 90% of counties.
- 36% of callers sheltered in place and 45% were referred to a provider for PE.
- 78% of callers spoke English, 21% Spanish, and 1% were defined as “other.”

Medi-Cal 1115 and 1915(b) Waiver Update

State Medicaid Director, Jacey Cooper, provided an update on the status of Medi-Cal waiver renewals. She indicated that DHCS is working with CMS to extend the current 1115 and 1915(b) waivers to December 31, 2021. The extension will provide federal

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authority and Medicaid matching funds to support the financial viability of the delivery system for COVID-19.

Key items from the [Medicaid Section 1115 Waiver Demonstration Extension Request](#) include the following:

- The Public Hospital Re-Design and Incentives in Medi-Cal (PRIME) program will not move forward in the extension request but will instead be transitioned to Medi-Cal Managed Care Quality Incentive Payment program (QIP).
- Whole Person Care (WPC) pilots will include a new target population for individuals affected by COVID-19.
 - Requesting \$300 million in federal match and ability to roll-over funds for an additional 12 months.
- Changes to the Drug Medi-Cal Organized Delivery System (DMC-ODS) include:
 - Removing the limit of residential treatment stays from 2 visits to unlimited visits with a 30 day average length of stay.
 - Reimbursing SUD services prior to diagnosis.
 - Expand Medication Assisted Treatment (MAT) by requiring all levels of care to provide or refer individuals to MAT services and adding Naltrexone to MAT services.
 - Increasing access for Indians and Alaskan Natives by allowing reimbursement and defining scope of practice for cultural healers. Indian providers must use two evidence-based practices (EBPs) from DMC-ODS.
- Tribal uncompensated care amendment will require California Rural Indian Health Boards (CRIHB) to contract with any willing tribal health program enrolled in Medi-Cal to provide uncompensated care payments for optional services.
- Addition of a new Program of All-Inclusive Care for the Elderly (PACE) program in Orange County.
- Other programs included in the waiver extension request include low-income pregnant women, former foster care youth, Community-Based Adult Services (CBAS), Coordinated Care Initiative (CCI), Health Homes Program, Global Payment Program (GPP), and Dental Transformation Initiative (DTI).

Programs that are not subject to budget neutrality include CBAS, DMC-ODS, Health Homes, ACA new adult expansion under MCPs, and out of state former foster youth. DHCS indicated that the MCP pharmacy carve out will achieve a savings of \$5.5-6 billion which will fund WPC, DMC-ODS, GPP, DTI, and QIP. Therefore, federal expenditures are anticipated to decrease during the 12-month extension period.

CalHOPE: Crisis Counseling Program Update

The Federal Emergency Management Agency (FEMA) awarded \$1.6 million to launch CalHOPE, a media campaign and website, to normalize feelings of stress, anxiety, and depression during the pandemic. DHCS has applied for an additional \$82 million to

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continue the program, reach target populations who may be otherwise missed, and connect individuals through schools.

Key outcomes from the CalHOPE program thus far include the following:

- 92% of individuals who clicked on the CalHOPE video watched the entire video.
- Spanish language response was twice the general market rate.
- Chinese display ad generated over 5,000 visitors.
- 26,300 website visits and 16,000+ new users.
- Average time spent on the site was 2 minutes.
- Warm line received 334 calls that were less than 15 minutes and 110 calls over 15 minutes.

Children and Youth Access to Behavioral Health Services Discussion

The Department of Health Care Services defined the goals for children and youth services were to 1) ensure that every child with behavioral health needs has timely access to high quality care and 2) ensure coordinated, cross-system, and trauma-informed care (TIC) for children in child welfare and foster care system.

Opportunities to improve the children and youth system of care include:

- **CalAIM:** payment reform, integration for co-occurring disorders, modifying medical necessity to allow treatment prior to diagnosis, and improve coordination among MCPs and Specialty Mental Health Services (SMHS).
- **Telehealth:** maximum flexibility to provide access to telehealth and leverage lessons learned to continue telehealth practices that were successful during the pandemic.

County behavioral health and MCPs will be held accountable to access and quality standards through metrics such as time and distance, timeliness of appointments, provider ratios, penetration rates, grievance and appeals, and CMS Core Set and quality measures. A public mental health and SUD dashboard are in development to assist with tracking metrics.

The Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC) are tools used to assess baseline and determine treatment response. DHCS is currently developing a report and oversight infrastructure which can include 1) analysis of functional assessments and utilization data to assess effectiveness of treatment by county and statewide broken down by age, race, gender, language, etc. and 2) comparative analyses of counties to work with counties on improvement projects.

DHCS discussed avenues to meet the needs of foster youth such as AB 2083 to promote better coordination between county and state agencies on trauma-informed practices, the implementation of a model for therapeutic foster care, the Pathways to Well-Being Program for coordinated and intensive home-based treatment services, and

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Family Urgent Response System to implement a hotline and county mobile response statewide. The CalAIM Foster Care Model of Care Workgroup is another avenue to evaluate options for health care delivery to children and youth in child welfare and the foster care system.

Key items from BH-SAC member discussion include the following:

- It is challenging to meet capacity for children who need acute, high-levels of care. It will help to define the continuum of care in each county and determine how counties can access high level services. This includes identifying what counties are currently doing and determining the capacity of MCPs and FQHCs to meet the needs of children and youth.
- Medical Necessity is an important factor to increase early detection in schools. Director Lightbourne indicated that medical necessity is one of the most important items to get clarity on and how it impacts foster care penetration rates.
- Engaging youth in leadership would allow opportunities to provide feedback and perspective on what youth would like to see in a system of care. Incentives and building relationships should be considered in this process.
- To address barriers in engaging children in SUD services, it would help to think about how to increase partnerships and referrals from systems outside of behavioral health.
- Inadequate funding remains to be an issue. It is beneficial to look at how MHSA dollars have been used and find ways to leverage these dollars in Medi-Cal, utilize every dollar available to receive Federal Financial Participation (FFP), and obtain more funding for behavioral health in the next legislative budget cycle.
- Data is needed to get an understanding of where children and youth are currently seeking and receiving care. Deputy Director of Behavioral Health, Kelly Pfeiffer, stated that there is a lack of quantitative data but qualitative data can be obtained from talking to youth and providers.
- Relationships help children who have experienced trauma so efforts to find families and ensure that children have someone they can go to is crucial.
- Members expressed the importance of looking at how racial bias is constructed in the current system and address this with solutions, potentially through CalAIM.

Director Lightbourne closed the discussion by stating that DHCS will do the necessary work to improve the children and youth system of care through the lens of equity and a fair and just society.

CBHPC Overview of CHHS Behavioral Health Taskforce: August 2020 Meeting

The Behavioral Health Taskforce was created under the California Health and Human Services Agency (CHHS) to advise the Administration's efforts to advance statewide behavioral health services, prevention, and early intervention to stabilize conditions before they become severe. The mission of the Taskforce is to develop recommendations for the Governor about how California can provide timely access to high-quality behavioral health care for all of its residents.

This document provides a high-level summary of the August 2020 Taskforce Meeting.

Discussion of Behavioral Health Impacts of COVID-19, Recession, and Community Action on Anti-Racism

Taskforce members addressed a series of questions regarding the COVID-19 impact on their organizations as well as their efforts to address racial disparities. Member feedback for each topic is provided below.

COVID-19:

*What behavioral health impacts has your organization seen as a result of COVID-19?
How has your organization's work changed as a result of COVID-19?*

- Telehealth
 - Health plans increased their resources and many entities reported reduced no-show rates through telehealth appointments.
 - The needs of SMI populations who rely on in-person services or have limited access to virtual care are not addressed in telehealth.
 - Broadband issues and lack of technology limits access to care.
 - 80% of providers intend to continue telehealth after pandemic.
- In-patient settings
 - Psychiatric facilities are not accepting COVID-19 patients.
 - Efforts have been made to move individuals out of congregate spaces.
- Effects on behavioral health include:
 - Higher overdose rates, fewer outpatient services, and challenges in managing safety for SUD clients despite higher need for services.
 - Higher rates of depression and anxiety escalating suicide rates.
 - NAMI calls have increased by 60% from family seeking resources.
 - Disrupted routines and isolation are concerns for individuals with intellectual disabilities and older adults.
 - Frontline workers are facing burnout and reduced behavioral health.
- Social determinants of health must be addressed as COVID-19 aligns with poverty and low socio-economic status indicators.
- Education and outreach efforts are addressing where to access services and resources in multiple languages as well as confusion around testing costs.
- Efforts within criminal justice system focus on reentry with few supports or advanced notification to counties to transition individuals to the community.

CBHPC Overview of CHHS Behavioral Health Taskforce: August 2020 Meeting

- Many entities engaged in advocacy efforts to secure PPE for county systems and organizations.

Racial Equity:

How have racial justice and equity been discussed or addressed in your work? How have racial disparities been highlight in your organizations? How can we address racial equity, justice, and disparities in our work on the Taskforce?

- COVID-19 highlights racial disparities in health outcomes:
 - There is an overrepresentation of cases in Black and Latino communities.
 - BIPOC are often essential workers who interact with the public.
- Entities identified their efforts as well as the continued need for education and outreach to engage individuals in care.
- Workgroup members stated the need to address the digital divide and social determinants of health.
- Health policies at state and federal level contribute to inequitable health outcomes (structural racism), highlighting the need to revise policies.
- Organizations should acknowledge and address implicit bias and expand provider diversity and trainings.
- Overrepresentation of POC in criminal justice system highlights the need to revise police standards and protocols.
 - Trauma that BIPOC experience from interactions with police contribute to negative health outcomes.
- Many organizations conducted listening sessions and are forming racial equity workgroups and advisory boards to mitigate disparities.
- Several members expressed the desire to continue CalAIM work and promote health equity.

Reassessment of Taskforce Mission and Objectives

Members reviewed the Taskforce mission and objectives and requested the following changes:

- Include language that embeds racial equity, inclusion, justice, and diversity.
- Broaden the focus to include models of care and services that are not typically delivered through insurance.
- Include client rights, dignity, and choice in the objectives.
- Add an objective to highlight data that is not currently collected and find avenues to collect that data.
- Add an objective to increase and maintain meaningful stakeholder engagement.
- Address causes of poverty, racism, and oppression beyond the three focus populations (homeless, criminal justice, and foster care/youth).

CBHPC Overview of CHHS Behavioral Health Taskforce: August 2020 Meeting

Work Plan Development and Timelines

The Taskforce will be composed of three committees focused on each population group. Each Taskforce member will participate in one committee. Each committee will develop recommendations for the entire Taskforce to review and adopt. Committees will meet a total of six times between October 2020 and May 2021 in three phases:

PHASE 1: Environmental scan of delivery systems, financing, and models of care. Establish target outcomes for 2025

Committee members will bring recommendations to the Taskforce in December 2020. Phase 1 will include a town hall for public comment to verify the goals of the group.

PHASE 2: Prevention and timely access to services

Committee members will bring recommendations to the Taskforce in March 2021. The Taskforce will then begin creating draft recommendations.

PHASE 3: Recommendations for quality, outcomes, and multi-system integration

Committees will bring their recommendations to the Taskforce in June 2021. The Taskforce will draft a report for feedback at the September 2021 meeting. Once feedback is collected, the Taskforce will create town halls for public comment by December 2021. The final draft will be completed in February or March of 2022.

Members indicated that the Taskforce should think about how CalAIM will feed into committees and how they can bring recommendations to the Department of Health Care Services. Deputy Secretary of Behavioral Health, John Connolly, stated that Taskforce is a roadmap to insert the work of similar groups into the Taskforce because it addresses a broad range of issues. He indicated that CalAIM will be included.

**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 22, 2020**

Agenda Item: Nominate SMC Chair-Elect for 2021

Enclosures: None

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the opportunity for committee members to nominate the next Systems and Medicaid Committee (SMC) Chair-Elect. The Chair-Elect is responsible for supporting the Chairperson with leading committee activities.

Background/Description:

Each standing committee shall have a Chairperson and Chair-Elect. The Chairperson serves a term of 1 year with the option for re-nomination for one additional year.

Karen Baylor is slated to become the Chairperson for the Systems and Medicaid Committee at the January 2021 meeting. The committee members shall nominate a Chair-Elect to be submitted to the Officer Team for appointment.

The role of the Chair-Elect is outlined below:

- Facilitate the committee meetings as needed, in the absence of the Chairperson
- Assist the Chairperson and staff with setting the committee meeting agendas and other committee planning
- Participate in the Executive Committee Meetings on Wednesday of every quarterly meeting from 8:30 am – 10:00 am
- Participate in the Mentorship Forums when the Council resumes meeting in person.

Motion: Nomination of a committee member as the SMC Chair-Elect.

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 22, 2020

Agenda Item: Next Steps for 2021

Enclosures: [CCJBH Workgroup PowerPoint Slides 8.27.20](#)
[Behavioral Health Care and Justice-Involved Fact Sheet](#)
[Reduce Preventable Emergency and Inpatient Utilization Fact Sheet](#)
[Medi-Cal Utilization Report Executive Summary](#)

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the System and Medicaid Committee the opportunity to plan areas of focus and committee activities for 2021.

Background/Description:

Since October 2018, the Systems and Medicaid Committee has focused its efforts towards developing policy recommendations to advise the Department of Health Care Services (DHCS) on the renewal of the Medi-Cal 1915(b) and 1115 waivers through the California Advancing and Innovating Medi-Cal (CalAIM) Initiative. Earlier this year, DHCS placed the CalAIM Initiative on hold due to the immediate demand to shift resources to respond to the COVID-19 pandemic.

Therefore, the SMC will determine an area of focus and plan next steps for the 2021 calendar year until CalAIM moves forward.

The pandemic has exacerbated behavioral health issues and suicide rates for many Californians. Factors include experiences of isolation and loneliness during Shelter-In-Place orders, job loss, balancing childcare with work responsibilities, grief from losing loved ones, as well as the impact of systemic racism. In response, the SMC officers have requested two behavioral health directors to present lessons learned and innovative practices applied in their counties to mitigate the COVID-19 impact on behavioral health. ***The county updates will initiate a discussion on advocating best practices around the public health emergency to DHCS.***

Additionally, SMC staff will provide an update on current activities from the Council of Criminal Justice and Behavioral Health (CCJBH) as individuals with SMI are overrepresented in the Criminal Justice System. In response to COVID-19, the California Department of Corrections and Rehabilitation (CDCR) initiated a mass release of inmates from jails and prisons with little to no services and supports as these individuals transition back to their communities. ***The SMC will discuss whether they will focus their efforts on this topic considering its large impact on the SMI population who intersect with the Criminal Justice System.***