December 16, 2019

Via Email: jacey.cooper@dhcs.ca.gov
Attention: Jacey Cooper
Senior Advisor - Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95899-7413

Re: Joint CBHA/CBHDA Feedback Regarding California Advancing and Innovating Medi-Cal (CalAIM) Proposal – Integration of Mental Health and Substance Use Disorder Care

Dear Ms. Cooper:

On behalf of the members of the California Council of Community Behavioral Health Agencies (CBHA) and the County Behavioral Health Directors Association (CBHDA), we write to share preliminary feedback on the CalAIM proposal. First, we laud the Governor and his appointed leaders of DHCS for the inclusion of several concepts, including integrated behavioral health care for clients with co-occurring mental health and substance use disorders. Our members have advocated for policy changes that will help to remove barriers to clinical mental health and substance use disorder services over the past several years. It is clear to us that the Department has heard our feedback and has designed a plan that is thoughtful and responsive. Overall, we share the Department's excitement about the potential of the CalAIM proposal and seek to be partners in the process. Additionally, we appreciate the inclusion of several of our members in the workgroups.

Below, please find joint comments that are primarily focused on DHCS' proposal for the "Administrative Integration of Specialty Mental Health and Drug Medi-Cal", and that we hope can inform the dialogue on this topic that will take place in the Behavioral Health Workgroup. We also speak to other, interconnected CalAIM proposals that promote more integrated and effective care across Medi-Cal delivery systems.

Access to Integrated Care Across Delivery Systems

Both of our organizations prioritize ensuring timely, accessible and quality care for clients. We recognize that there are multiple barriers that impact the ability of clients to access appropriate

treatment and an array of services regardless of their diagnosis. We note that one overarching goal of CalAIM is to support better care coordination and a "No Wrong Door" approach for Medi-Cal clients. As such, we encourage the workgroups to carefully consider specific implementation strategies that can promote more integrated care within our mental health (MH) and substance use disorder (SUD) systems for clients with co-occurring mental health and substance use conditions, as well as enhanced coordination and alignment with physical health systems.

We commend the inclusion of proposals for Population Health Management, Enhanced Care Management, and In Lieu of Services, and would suggest that the needs of clients with mental health conditions and substance use disorders continue to be prioritized in the development of these proposals. The population health management efforts led by Medi-Cal Managed Care Plans should be carried out in close collaboration with behavioral health delivery systems, as our programs are frequently the primary point of contact within Medi-Cal for Californians with behavioral health conditions and other complex, whole-person needs.

Clinical Integration of Mental Health and Substance Use Disorder Services

It is essential that the CalAIM proposal for the "Administrative Integration of Specialty Mental Health and Substance Use Disorder Services" include policy changes that promote integrated care delivery at the clinical/service level (in addition to changes that advance administrative integration). As DHCS moves forward with implementing an integration plan and developing new requirements for the two programs, practice level goals for better care should drive and inform administrative changes.

Accordingly, we recommend that during the workgroup process, DHCS solicit stakeholder input on changes to existing program requirements for Specialty Mental Health (SMH) and Drug Medi-Cal (DMC) that would be most impactful from a clinical perspective. The resulting goals for more integrated care at the client level can serve as a "north star" to help guide and prioritize the work of aligning administrative policies and procedures for the two programs.

From our perspective, the following are important considerations and recommendations for a successful SMH and DMC integration initiative:

- **Screening, Assessment, and Establishing Medical Necessity**

One goal for the integration effort should be to develop more uniform, standardized screening and assessment tools for use across the behavioral health delivery system. We recommend exploring a modular approach to assessment and intake. For example, an initial module for clients with either mental health or substance use conditions could be used to collect demographic data. Additional modules could be completed as needed for co-occurring disorders, based on the results of a universal screening or triage tool that can help identify whether clients should be further assessed for mental health conditions, SUDs, or both.

Our members would also appreciate the opportunity to work with DHCS to develop a new, client-centered approach to behavioral health treatment planning, and to standardize treatment plan requirements across the Specialty Mental Health and Drug Medi-Cal delivery systems.

Treatment plans should be strengths-based and oriented toward resiliency and recovery, rather than shaped by fraud/compliance concerns that are disconnected from the provision of care. While ensuring program integrity is clearly an important goal for the Medi-Cal program, it should not be the primary driver behind how care is structured if we are to attempt to achieve better outcomes for our beneficiaries.

We would also suggest that the Behavioral Health Workgroup, which will consider changes to behavioral health Medical Necessity criteria as well as MH and SUD integration, may be a good forum to explore concerns about the timing associated with establishing an initial diagnosis and carrying out a full assessment. Current requirements to establish a diagnosis prior to providing most billable services can hamper engagement and progress for clinicians and clients. The pressure that clinicians feel to provide a diagnosis means that multiple assessments and other paperwork must be completed in early sessions. This can be burdensome for clinicians and off-putting to clients, many of whom struggle to even make it to an initial session.

DHCS in its CalAIM proposals has indicated that it may be time to move away from emphasizing specific diagnoses as a pre-condition for receiving behavioral health services. We support this concept and believe clients that are experiencing functional impairment from a behavioral health condition – be it mental health or substance use – should be able to begin receiving care even as a clinician works over the course of a few encounters to engage the client and to unpack the client's symptoms to establish a diagnosis. This could be accomplished by allowing for provisional diagnoses for the first several sessions, and/or by specifying a set of services that can be provided without a diagnosis.

We further recommend that DHCS approach all potential changes to medical necessity, assessment, and treatment planning requirements in a manner that prioritizes the clinical needs of Californians with co-occurring mental health and substance use disorders. In other words, changes to requirements for one behavioral health delivery system should not be considered in isolation from the other. We recognize that the distinction between mild-to-moderate and Specialty Mental Health Benefits raises some specific considerations that differ from those for the Drug Medi-Cal program. But ultimately, we want to see screening, assessment, and medical necessity protocols that enable people with co-occurring conditions to promptly and readily receive the MH and SUD treatment they need without encountering artificial barriers to care that result from disparate policies for the two delivery systems. We would suggest the Behavioral Health workgroup explore options for making this vision a reality.

- **Standardization**

Our organizations have long engaged in discussions about the need to standardize various operational aspects of our behavioral health system. We are hopeful that the CalAIM workgroups will serve as a forum for considering changes that can simplify and clarify Drug Medi-Cal and Specialty Mental Health program requirements to improve standardization across counties and among providers. These changes can help ensure that providers are able to focus on providing high-quality care rather than struggling to succeed within an overly complex, compliance-driven system.

- *Documentation*
  To incentivize more behavioral health providers to offer effective, evidence-informed models of integrated behavioral health care, the state must reduce duplicative documentation requirements that frustrate clients and providers while serving no clinical purpose. We propose that DHCS consistently consider options for revising burdensome documentation requirements in relation to the CalAIM proposals for Medical Necessity, MH and SUD Integration, and Behavioral Health Payment Reform. Providers and counties stand ready to assist in developing new documentation requirements that are grounded in clinical best practices rather than compliance concerns.

- *Case Management and Integrated, Team-based Care*
  DHCS' proposals acknowledge that various clinicians and case managers will often be brought together to assist an individual client with complex needs who requires services from multiple systems of care. In relation to both the ECM/ILOS and MH/SUD Integration proposals, we look forward to further dialogue about how providers should identify the primary case manager within integrated models of care, and how members of multi-system care teams can best work together.

- *Terminology*
  We also recommend that the terminology about clinical processes, names of reports etc. endemic to each service system be reviewed and clarified in order to reduce redundancies and confusion as providers work together to serve clients.

❖ Training the Workforce

CalAIM proposes many changes within Medi-Cal's delivery systems that, if enacted, must be successfully implemented by clinicians and health care workers on the ground. These changes will result in broad and deep impacts on clinicians and the settings they work within. Historically, many providers have chosen to work in only the SMH or DMC system (rather than both). The ability of publicly-funded delivery systems to offer clinically integrated behavioral health care will depend on providers' ability to develop new clinical and administrative skills. We recommend that the workgroups discuss the robust training that will be needed to equip providers to offer accessible and quality clinical services across integrated care settings.

❖ 42 CFR Compliance

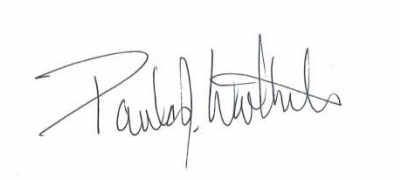
Both providers and health care administrators are concerned that compliance with 42 CFR protections for substance use disorder records will continue to pose obstacles to successful implementation of the changes proposed by CalAIM. Specifically, members have raised questions about how health information can be shared more effectively between providers and delivery systems to facilitate integrated care. They also are curious about how to make 42 CFR-compliant changes to electronic health records for more integrated clinical records.

While we recognize DHCS has limited ability to issue definitive legal guidance in these areas, we believe challenges related to 42 CFR should be promptly acknowledged during the workgroup process. It is imperative to recognize the persistent stigma and challenges that individuals with SUDs encounter, and we urge the state to take strides to ensure that information sharing not be at the expense of the safety and protections of clients.

We welcome continued dialogue with DHCS about the work counties and providers must undertake to develop electronic records and data exchange protocols that support clinically integrated care for clients with substance use disorders.

In closing, we reiterate that our members are tremendously excited about the potential of the CalAIM proposals to improve integrated care for clients with co-occurring mental health and substance use disorders, who frequently have complex physical health needs as well. Thank you for your consideration of our comments and recommendations. Please feel welcome to contact us at pwilhelm@cbhda.org or lclarkharvey@cccbha.org if we can answer questions or provide any additional information.

Sincerely,



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