February 4, 2020

Via Email: Jacey.cooper@dhcs.ca.gov
Attention: Jacey Cooper, Chief Deputy Director - Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899

**RE: Behavioral Health Integration**

The California Children's Trust (CCT), the California Alliance of Child and Family Services (Alliance), the California Council of Community Behavioral Health Agencies (CBHA), and the Association of Community Human Services Agencies (ACHSA) are pleased to submit comments in response to the Medi-Cal Healthier California for All initiative (MHCA) led by the Department of Health Care Services (DHCS). The CCT represents a broad statewide coalition of stakeholders committed to addressing the children's behavioral health crisis in California. The Alliance is a statewide association of more than 146 accredited, private nonprofit agencies dedicated to achieving progressively better outcomes for vulnerable children, youth and families in public human services systems. CBHA is a statewide association of over 70 mental health and substance use disorder non-profit community agencies. ACHSA is a county organization of more than 90 private nonprofit community mental health and foster care agencies serving Los Angeles County residents. We believe that Californians deserve a comprehensive community-based behavioral health system that is adequately funded. We value outcome based, data driven, and culturally responsive approaches to providing services.

Our comments in this letter will be focused on Behavioral Health Integration and based on questions and issues raised in the Behavioral Health Workgroup held on January 23, 2020.

**Proposal for Administrative Integration**

CCT and the Alliance support the proposed integration of specialty mental health services (SMHS) and substance use disorder services (SUDS) in concept. As revealed during the BH Workgroup focused on this integration, there are many systems-related structures to be addressed in order to make this integration result in more effective seamless service access and delivery and overall client care. It is also important to separate discussions regarding the administrative integration of adult services versus child/youth services (up to age 21). The financing mechanisms and structures, as well as the Medi-Cal EPSDT entitlement, require that these populations be considered differently. Questions posed at the workgroup are:

1. **Does DHCS' proposal to administratively integrate SMHS and SUD services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of Medi-Cal Healthier California for All? If not, what changes are needed to address identified gaps? What else should DHCS consider?**
2. **Does DHCS' proposal to administratively integrate SMHS and SUD services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of Medi-Cal Healthier California for All? If not, what changes are needed to address identified gaps? What else should DHCS consider?**
3. **What concerns, if any, do you have about integrating SMHS and SUD service delivery systems? How can DHCS best address your concerns?**
4. **What would integration look like in counties not participating in DMC-ODS?**
5. **What are your recommendations about phasing and/or timelines for implementation?**

**Adult System**

As described in the MHCA proposal, CCT and the Alliance support the move to administratively integrate SMHS and SUDS. Specifically, the concept of one contract that covers both SMHS and SUDS services, is a significant positive component of the proposal. As described in the proposal, the inconsistent access and service delivery that results from having some counties under the DMC-ODS and others using fee-for-service systems creates regional inequities. And even within counties that have the DMC-ODS, those with co-occurring disorders must navigate two separate systems within one mental health plan (MHP).

One of the first items for DHCS to tackle is the expectation for all counties regarding access and service continuum to SUDS. **If there are differences in what is available in DMC-ODS counties versus fee-for-service counties, then it is essential to provide clarity about the minimum SUDS services provided across all counties and the network adequacy expectations that exist**.

The goal of an integrated access line, integrated intake, screening and referrals, assessment and treatment planning and one set of beneficiary informing materials is a great aspiration. Similarly, the plan to create one contract across SMHS and SUDS is excellent if done in a

manner that supports best practices within both systems. More complicated are the data sharing and privacy issues that exist as a result of 42CFR Part 2, as well as electronic health records that are programmed based on federal privacy requirements. The integration of other administrative components such as cultural competency plans, quality improvement, EQRO, compliance reviews and network adequacy seem less onerous to integrate, and we fully support this integration.

**Children and Youth System**

The MHCA proposal does not truly address the system for integrated care for children and youth. As noted at the January 23rd BH Workgroup, California's State Plan currently does not allow SUD services to be provided using Medi-Cal EPSDT, despite the federal regulations allowing for access to these services. According to a 2015 joint guidance by CMS and SAMHSA:

> "Many of the services that are essential to the implementation of a full continuum of care for youth with SUDs may be covered through Title XIX, 1905(a) authority. Identification and treatment for mental health and substance use issues and conditions is available under a number of Medicaid service categories, including hospital and clinic services, physician services, and services provided by a licensed such as a psychologist. States should also make use of rehabilitative services. While rehabilitative services can meet a range of children's treatment needs, they can be particularly critical for children with mental health and substance use issues."

**There is not a SUDS system of care for youth in California, and this is an urgent issue**. According to a 2018 report by the California Healthcare Foundation, thirteen percent (13%) of youth ages 12-17 reported using marijuana in the past month (for ages 18-15, 34%), and 9.1% report using alcohol (for ages 18-25, 54%). Given DHCS' and the Governor's desire to reduce the prevalence of behavioral health disorders, intervening earlier and ensuring access to the full range of SUDS and SMHS services is essential. According to NIMH, "The likelihood of developing a substance use disorder is greatest for those who begin use in their early teens. For example, 15.2 percent of people who start drinking by age 14 eventually develop alcohol abuse or dependence (as compared to just 2.1 percent of those who wait until they are 21 or older)."

As DHCS moves to integrate SMHS and SUDS at the county level, it is critical that the EPSDT benefit is utilized to develop and ensure access to SMHS and SUDS services based on the medical necessity definitions developed through the MHCA process. Any barriers to a child or youth accessing the full array of services to meet the EPSDT entitlement must be addressed through this process of integrating services under one system.

**Specifically, we recommend the following:**

1) **Substance use treatment should be formally integrated into the EPSDT benefit and new resources should be provided by the State for the non-federal share of the expenses.**

2) **DHCS should concurrently revisit the availability of confidential services under the minor consent Medi-Cal program. The historic neglect of this critical mechanism serves as a functional impairment for children to access care in most safety net systems.**

**Behavioral Health Workforce Considerations**

In light of California's behavioral health workforce shortage crisis, expanding our supply of behavioral health workers must be a top priority. We urge DHCS to keep this goal in mind when developing integrated mental health and SUD licensing and certification requirements. Medi-Cal's non-clinical mental health provider categories such as Mental Health Rehabilitation Specialists and Other Qualified Providers, for example, offer effective mechanisms for expanding California's behavioral health workforce**.** New integrated certification requirements should expand in particular the roles of peer support specialists. Studies demonstrate that the use of peer support specialists in comprehensive mental health or substance abuse treatment programs helps reduce client hospitalization, improve client functioning, increase client satisfaction, alleviate depression, and diversify the workforce. **SB 803 (Beall) offers CA the opportunity to certify peer providers in the behavioral health system, and we recommend that DHCS support this legislation.**

An additional workforce development strategy that would better align licensed staff functions to those tasks for which they are required (by statute, regulation, and/or training) **would be to change the language in the State Plan from "under the direction" to "as recommended by" a Licensed Practitioner of the Healing Arts (LPHA).** Interestingly, the "recommended by" is the actual federal language. It is also the actual language from the 10-016 (May 21, 2011) SPA. For some reason it was changed to 'under the direction' in the TN No. 12-025 (Dec 2012). We support the change back to "as recommended by" which we believe would greatly ease the burden on providers and address the shortage of LPHAs at the same time.

**Lastly, we support expanding the definition of the Mental Health Rehabilitation Specialist to include an individual who has a Certified Psychiatric Rehabilitation Practitioner (CPRP**) **certification**. The CPRP is a nationally recognized certification. Individuals of all backgrounds can achieve the CPRP credential. Currently, CPRPs vary from MDs, PhDs to GEDs, occupational therapists to peer specialists, social workers to caseworkers – all sharing a commitment to the fundamental principle that recovery from serious mental illness is possible. Because the credential is competency based, it allows persons who have not traditionally had access to graduate school to qualify to provide specialty mental health services as Rehabilitation Practitioners.

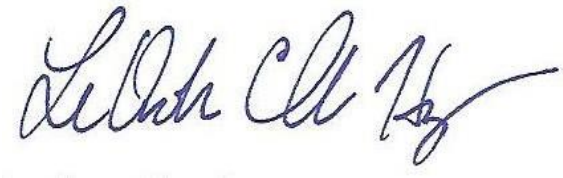
The shortage of licensed personnel in the behavioral health workforce and an even greater scarcity of licensed individuals from ethnic communities has opened the gateway to evaluate which services and functions should be provided by licensed personnel and which should be provided by experts in the psychiatric rehabilitation field. These three workforce recommendations we are making here would expand the use of non-licensed professionals and then we as a State can strategically utilize licensed staff within our systems of care across both mental health and substance use services.

Thank you for the opportunity to provide input and recommendations into the MCHA process.

Respectfully submitted,

Christine Stoner-Mertz, CEO
California Alliance of Child and Family Services
chris@cacfs.org | 916-956-0693

Alex Briscoe, Principal
California Children's Trust
alex@cachildrenstrust.org | 415-629-8142



Bruce Saltzer, Executive Director
Association of Community Human Services Agencies
bsaltzer@achsa.net| (213) 250-5030

Le Ondra Clark Harvey, Ph.D.,
Director of Policy and Legislative Affairs
California Council of Community Behavioral Health Agencies
lclarkharvey@cccbha.org| (916) 557-1166

CC: Richard Figueroa, Department of Health Care Services
Brenda Grealish, Department of Health Care Services
Kelly Pfeifer, MD, Department of Health Care Services
Lindy Harrington, Department of Health Care Services
Autumn Boylan, Department of Health Care Services
Erika Cristo, Department of Health Care Services
Marlies Perez, Department of Health Care Services
John Connolly, Health and Human Services Agency
Secretary Mark Ghaly, MD, Health and Human Services Agency
Tom Insel, MD, Governor's Special Advisor on Mental Health
Diane Cummins, Department of Finance