SACRAMENTO STATE
COLLEGE OF CONTINUING EDUCATION

CALHHS BEHAVIORAL HEALTH AND TASK FORCE MEETING

# MEETING SUMMARY

WEDNESDAY, APRIL 10, 2024, 10 AM – 3 PM

## MEETING SUMMARY PURPOSE

This document provides a summary of the Behavioral Health Task Force (BHTF) quarterly meeting held on April 4, 2024. This summary is an accompaniment to the presentation slide deck and meeting recordings, both available for review on the BHTF webpage along with other meeting materials.

Appendix A of this summary lists meeting attendees.

Appendix B of this summary contains BHTF and public breakout notes and individual comments from an exercise on improving behavioral health outcomes for those with commercial health coverage.

## WELCOME & INTRODUCTIONS

Stephanie Welch, Deputy Secretary of Behavioral Health, CalHHS, welcomed participants joining in person and online. She emphasized the importance of BHTF member collaboration across diverse perspectives and areas of expertise to address common issues together.

Deputy Secretary Welch shared updates and additional resources regarding the January 17th meeting panel presentation on Justice Impacted Populations. She encouraged attendees to explore the Council on Criminal Justice and Behavioral Health's (CCJBH) published annual plan and highlighted recent activities of the Office of Youth and Community Restoration (OCYR) to support justice-involved youth through grants and partnerships.
Those resources included:

- CCJBH plan: Barriers to, and Strategies to Improve, Medi-Cal Behavioral Health Services Utilization: A Lived Experience Listening Session Report
- OYCR links:
    - Prop 47 Evaluation
    - Building Higher Education Pathways for Youth in Secure Treatment Facilities in California: A Call to Action
    - OYCR February Newsletter (ca.gov)
    - OYCR March Newsletter (ca.gov)

## IMPROVING BEHAVIORAL HEALTH ACCESS AND OUTCOMES FOR CALIFORNIANS WITH COMMERCIAL HEALTH PLANS – PANEL PRESENTATION

Deputy Secretary Welch introduced the panel by noting that the March 6, 2024, Lunch and Learn on Access to Behavioral Health Services for Commercial Enrollees generated so much interest that the topic warranted continued discussion and reflection today. She emphasized the variety of California's behavioral health systems and the need to support the success of all systems, including commercial insurance, which is the source of behavioral health coverage for many Californians. She explained that the panel includes state regulators, a representative of health plans, and a consumer, to incorporate the diverse perspectives of individuals striving to improve behavioral health care for all Californians.

## STATE DEPARTMENT PERSPECTIVE – DEPARTMENT OF MANAGED HEALTH CARE

Mary Watanabe, Director of the Department of Managed Health Care (DMHC), addressed the misconception that individuals with commercial coverage are immune to behavioral health challenges. She described the rapid spiral that can occur without proper treatment, leading to unemployment, homelessness, and other challenges. In addition, commercial insurance enrollees are often on their own when navigating the system. Director Watanabe described the challenges she herself experienced when navigating the commercial insurance system, despite her position and expertise.

She underscored DMHC's mission of protecting consumers and ensuring a stable healthcare delivery system, as it oversees 96% of regulated health care enrollment in California, including many commercial plans and most Medi-Cal Managed Care plans. DMHC regulates factors including timely care access, network adequacy, and cost-sharing.

Director Watanabe said the rising cost of health care is weighing heavily on her, with double-digit premium increases in 2024, and that DMHC is hearing concerns from consumers.

Director Watanabe reiterated the accessibility of the DMHC's Help Center and the critical role it plays in empowering consumers to advocate for their rights. She emphasized the importance of the independent medical review process as a safeguard against arbitrary denials of care by health plans. Director Watanabe encouraged attendees to leverage these resources and to spread awareness within their communities, particularly among those facing behavioral health challenges.

- DMHC Website

## PLAN PERSPECTIVE – CALIFORNIA ASSOCIATION OF HEALTH PLANS

Charles Bacchi, President and CEO of the California Association of Health Plans (CAHP), highlighted the benefits of managed care. He explained that managed care allows people to access care through an audited system; ensures that prevention and wellness programs, chronic care, and other services are provided; provides cost savings for consumers such as free services under the ACA and California law; and offers protections against large out-of-pocket costs if people experience catastrophic health conditions. Contracts and in-network care protect consumers by ensuring that spending and data can be tracked.

Mr. Bacchi shared 2022 data showing all but 7% of health plan spending was used to pay for medical costs. Mr. Bacchi said that, if the state Legislature requires health plans to cover more services as Essential Health Benefits (EHB's), commercial plans will face higher costs and thus likely need to raise premiums.

Regarding behavioral health, commercial health plans face two challenges. First, there is a shortage of behavioral health providers in California. And, second, many existing behavioral health providers decide not to contract with health plans, potentially due to plans' rules and regulations. Health plans are using telehealth and providing incentives such as educational loan assistance to expand the pool of providers.

Mr. Bacchi discussed common concerns raised by stakeholders. A key complaint is there are gaps in behavioral health outpatient and crisis care services coverage for the commercially insured. He acknowledged that public and private insurance systems have differing coverage because they are governed by different laws and regulations. He said commercial insurance plans should cover basic outpatient services as EHBs, and asked for attendees to share with him details and examples about coverage gaps so plan representatives can better understand areas where issues are arising. Mr. Bacchi also addressed a concern that private insurance does not reimburse counties for behavioral health costs. He believes the solution is to get more counties under contract with HMOs so they are in-network, and ensure that parties are using the correct billing codes.

Another concern is that counties are billing Medi-Cal for peer respite programs and other services and are not effective in billing commercial insurance. He acknowledged this is a problem area, due to the differing laws and regulations governing public and private insurance as well as differing institutional practices. The commercial sector is seeking to address this challenging area, including by educating providers about how to work with commercial

insurance. Mr. Bacchi also mentioned the concern that commercial plans do not cover transportation to "alternative destinations" (destinations other than an emergency department) for individuals in crisis, and, moreover, often do not cover community paramedicine. He asked attendees to provide him with more information on this topic, as he would like to look into this area.

## COMMUNITY PERSPECTIVE

Kiran Savage-Sangwan, Executive Director of the California Pan-Ethnic Health Network (CPEHN), offered a data-rich presentation on barriers and racial disparities in mental health care access. Ms. Savage-Sangwan said people of color make up a majority of the 14 million Californians with commercial healthcare but are disproportionately affected by health care access barriers. She showed data indicating that people of color see healthcare providers for mental health or substance use issues at lower rates than white individuals.

Cost is a major barrier to care access. 47% of adults overall—and 60% of Black adults and 65% of Latine adults—report it is difficult to afford health care. Almost a third of commercially insured people with moderate to severe depression who wanted to see a health professional did not because of cost. 15% of mental health care spending nationally is paid out of pocket, and it is six times more common for mental health care services to be out of network.

Ms. Savage-Sangwan also cited insufficient provider networks as a major contributor to racial disparities in behavioral health care access. California behavioral health providers are less diverse than the general population, with significant shortages in those who are Latine, multi-racial and American Indian. The behavioral health workforce lacks sufficient providers who speak Spanish and other languages. Commercially insured people of color report the greatest difficulty of any other group in finding a behavioral health provider, and one in five report a negative experience when they are able to do so.

In her recommendations for improvement, Ms. Savage-Sangwan called for expanding coverage of more culturally and linguistically competent providers, including peers and community health workers; ensuring provider directories reflect cultural and linguistic competencies; and rigorously enforcing existing laws such as those around language access.

- CPEHN Website

Deputy Secretary Welch thanked the speakers for their informative presentations. She echoed Mr. Bacchi's request that attendees share detailed examples of the issues they are aware of,

given how complicated it is to ensure that people with all coverage types receive the services they need.

## DISCUSSION ON COMMERCIAL PLANS AND BEHAVIORAL HEALTH

BHTF Members were invited to ask questions about and discuss the panel presentation verbally and in chat. Questions, answers, and comments follow.

- One member asked what the Department is doing proactively to engage plans around SB 855 regulations and to ensure their compliance, other than through independent medical reviews (IMRs).
    - Director Watanabe shared that DMHC conducts regular audits of plans' operations every 3 years to ensure plans are complying with filed policies. Additionally, her staff members investigate complaints, taking enforcement if needed, and have ongoing discussions with plans to clarify expectations, especially regarding out-of-network care. Their goal is to increase awareness among all stakeholders, including consumers, enrollees, and health plans.
- A BHTF member said the behavioral health sector needs to find ways to help Californians who may own their own businesses, but still cannot afford basic mental health services because they make too much money to qualify for Medi-Cal and cannot afford Covered California insurance.
    - Ms. Savage-Sangwan acknowledged this challenge, particularly for people who are not US citizens, and invited collaboration on advocating for solutions to this issue. She shared that an important policy issue is how the state could provide subsidized coverage, which it already offers citizens, to undocumented California residents.
- Another member stated that, while county behavioral health systems have had a greater tendency to serve people in need regardless of insurance status, they need to stand up systems that can more effectively capture commercial reimbursement in this post-payment-reform, post-Prop 1 world. The member explained that their county of 100,000 residents has billed close to 20 different insurance plans, which owe about $1 million the county has not recouped. The member said multiple participants in the behavioral health sector likely need capacity support to build a private insurance network effectively, and that their capacity to bill for crisis services is increasingly important, given the introduction of the 24/7 mobile crisis benefit. The member identified crisis system gaps as another major issue, offering as an example the story of

a teenager in crisis, who received thousands of dollars of bills after he took an ambulance ride, received a crisis assessment, and was hospitalized. The youth was suicidal because of the financial stress and will never use the crisis system again. The member expressed concern that the cost of using the crisis system is frightening for individuals who are under-insured, and the high costs could unintentionally limit care access.

  - Director Watanabe said DMHC is very interested in understanding and resolving the county reimbursement issue, and the simplest solution is bringing providers in-network to ensure oversight. She mentioned the need for legislation to waive cost-sharing and prior authorization and highlighted the challenge of reallocating costs when removing cost-sharing.
  - Mr. Bacchi acknowledged the complexity of trying to bridge the rules governing public and private insurance. It takes hard work and a few years to iron out. The health plans want to have relationships with the counties but understand the challenges counties face given the different records-keeping approaches the public and private sectors use. Plan representatives also struggle to manage data exchanges with the counties. Mr. Bacchi expressed optimism that parties will be able to address these issues through collaboration.
  - Deputy Secretary Welch emphasized the importance of understanding the impact on the underinsured, specifically regarding EHB's and preventative services in the mental health and substance use space. She suggested that this could be an area for further BHTF exploration and education.

- A BHTF member said the major driver in the behavioral health cost sharing issue is the fact that behavioral health treatments tend to have higher intensity and longer duration than physical health treatments. For example, weekly hour-long appointments with a behavioral health clinician far exceed 15-minute yearly visits to a primary care doctor. National data from a 2020 Milliman report indicates that those with significant behavioral health and co-occurring physical health needs are the subgroup with the highest spending, while the commercial plans pay only about $68 annually on those behavioral health conditions. Regulators need to conduct an analysis of behavioral health spending, broken down by number of services in the commercial market. What seems to be happening is that people fall back on the public system after commercial plans fail to meet their behavioral health needs. Commercial plans are not obligated to contract with counties. Self-pay providers also face incentives to remain outside of insurance contracts, including their current ease of payment and the limited

reimbursement they could receive from plans. Addressing this issue will take a lot of effort. Counties have reported difficulties getting reimbursed, most often when working with out-of-network providers, and have also reported that health plans tell enrollees to drop their commercial coverage to shift to county services. Health plans are having difficulties getting familiar enough with services to understand how to reimburse for them. The required benefits need to be prioritized.

  - Director Watanabe said she is very interested in using the rate review process to better understand plans' behavioral health investments. She acknowledged those investments likely need to increase, which will likely increase premiums as well. DMHC and the Department of Health Care Services (DHCS) are also looking closely at the differences between commercial insurance and Medi-Cal service coverage, and what the cost would be to align them.
  - Mr. Bacchi acknowledged the challenges in negotiating payment disputes, particularly in out-of-network situations. Dropping commercial coverage, he said, is a bad idea as cancer or other serious health conditions could arise. He emphasized that all the parties need to work with each other to look closely at what is and isn't covered, and what plans can afford. It may be worth revisiting the EHB's, which haven't been updated for 10 years.

- A BHTF member said many providers would be much more willing to participate in networks with higher reimbursement and with simpler and universal documentation requirements.
- Another member discussed access issues for parents, noting that in some cases health plans deny treatment or services that a provider has already recommended. The health plan may argue that, even though the treatment is a covered benefit, the health plan will not cover it because it does not deem the treatment medically necessary. In these situations, parents either go to the counties for assistance, or pay out of pocket in the range of $5,000-10,000 per child. Another unexplored area is the impact of mental health conditions on learning ability and the resulting need for special education services. These experiences impact multiple systems, not only the medical and health insurance systems. The member encouraged the group to consider the effects on county behavioral health or public education when systems fail to deliver in commercial health insurance. That is the more complete picture needed to really understand healthcare system cost.
- One member proposed what they described as a simple fix: both DHCS and commercial plans requiring network pharmacies to carry all FDA-approved medications for addiction

treatment. It is shocking how many pharmacies do not carry those medications and will not carry them even upon request. Provider workforce shortages also impact both public and commercial sectors. It would be beneficial if the commercial sector recognized the workforce needed to deliver services. The commercial side is very restrictive in who they will reimburse for, compounding the workforce constraints. Commercial reimbursement rates often barely cover the therapist or provider hourly rate, which is one of the reasons so many providers only take cash and won't contract with a health plan. In addition, plan benefits can be limited. In response to a request for outpatient or residential services, for example, a plan might authorize only 5-10 visits or 7 days, while the medical necessity based on ASAM assessments strongly indicates the needed intensity and duration of care is much more significant. Lastly, since most plans require preauthorization for all services, some individuals in crisis can't get the care they need because they don't have authorization.

- A member shared that the National Health Law Program has drafted its own version of the crosswalk between Medi-Cal and commercial coverage of behavioral health services, and program representatives are interested in when they can view and offer input on DMHC's version. Program representatives believe that coverage on both sides needs improvement and seek to learn more about the planned improvement process. The National Health Law Program also recommends that DMHC consider leveraging its authority to change California's EHB benchmark plan to improve access to behavioral health services. The National Health Law Program recommends the new plan cover services that plans are not covering now, such as methadone for opioid use disorders where there are gaps, over-the-counter Naloxone, TMS, mobile crisis services, and peer services. Not all changes to the EHB benchmark plan would need to go through the Legislature or benchmarking process.

    - Director Watanabe said there isn't a timeframe at this time, but she will share more as soon as she can. DMHC is conducting legal analysis on whether various proposed modifications would require changes to the state EHB plan. It would be helpful to see the NHLP crosswalk, if available, to make sure DMHC isn't missing something. There is a hearing today on SB 1290, which will begin the discussion around potentially setting a new benchmark plan. The public will have opportunities to provide input on priorities for the new benchmark plan.

Additional BHTF comments and questions for the panelists offered via chat:

- A BHTF member urged the state to go to high schools to encourage young people who speak other languages to pursue careers in behavioral health, to increase these young people's engagement and get to the root of the problem. The state should provide subsidies to support young people in pursuing these professions.
    - Another BHTF member said they agreed.
    - Elizabeth Landsberg, HCAI Director, responded via chat that this is an important suggestion, and that HCAI does fund pipeline programs including in high schools to introduce young people to behavioral health professions. It is especially important to do this in underserved communities.
        - The BHTF member responded that more needs to be done to share the information, then, because people don't know about these supports.
- A state BHTF member offered three questions for panelists:
    - What should the expectations be for individuals covered by commercial plans when they get diagnosed with a SMI (level of care management they should receive, health education services, SUD prevention, etc.)?
    - How should jail staff work with commercial plans when someone with a SMI and/or SUD who is covered by a commercial plan is arrested (particularly when the nexus for the arrest stemmed from psychosis)?
    - Has anyone given any thought to how individuals covered by commercial plans will receive care coordination upon release similar to DHCS' efforts in Medi-Cal regarding 90-day in-reach? Also open to any ideas on how the state, including the various relevant state councils, could be helpful in engaging and linking with the commercial system.

The following questions and comments were received from the public on this topic:

- What is the best way for stakeholders to engage DMHC on the implementation of SB 855 regulations?
- When will the DMHC/DHCS "crosswalk" be completed as discussed by Director Watanabe in the Lunch and Learn?
- [Regarding the BHTF member comment about parent's issues] That was a wonderful comment! Definitely more information for the educational system.

## FACILITATED DISCUSSIONS ACTIVITY

BHTF Members and Members of the Public were invited to participate in facilitated discussions in-person and online. In-person attendees gathered in small groups with designated notetakers, and online attendees brainstormed individually on a virtual whiteboard.

BHTF Members responded to the following questions:

1. A. What are the greatest **gaps and** unmet **needs** in the system for the constituents you represent or your community?
   B. What specific steps could we take to **help fill those gaps** and meet those needs?
2. How can we **help BH consumers access and navigate** the health care systems?
3. What are specific suggestions for how we can **help improve affordability and accessibility** of BH care for commercial health plan consumers?

Key themes from the breakout discussions and online brainstorm are summarized below. See Appendix B for the BHTF member and public verbal reports and detailed written comments.

## **QUESTION 1A:** WHAT ARE THE GREATEST GAPS AND UNMET NEEDS IN THE SYSTEM FOR THE CONSTIUENTS YOU REPRESENT OR YOUR COMMUNITY?

### ACCESS TO AND AFFORDABILITY OF BEHAVIORAL HEALTH SERVICES

Participants determined that one major gap is that some services, such as SUD treatment, specialty care services, non-ER crisis services, and stabilization medications, are inadequately supported or not reimbursed by commercial plans. Participants also discussed how consumers often lack comprehensive care, and how some consumers—especially those in rural areas—experience geographical service deserts. Consumers also face barriers finding service providers and therapists who are racially and ethnically diverse, LGBTQI+, culturally competent, have lived experience, or speak Spanish and other needed languages; participants pointed out that, if those providers exist, there are insufficient listing resources to help consumers identify them. Participants also highlighted the lack of in-network providers, specifically in SUD prevention/treatment for adults, children, and youth; trauma and violence prevention; cross-generational services for young children and their parents; and Medi-Cal mental health. Participants identified provider burnout and paperwork burdens as limiting factors. Affordability discussions echoed the plenary discussion about the specific needs of consumers who fall in the financial gap between Medi-Cal and commercial coverage.

### SYSTEM NAVIGATION SUPPORT

BHTF members and the public identified the need for health care system navigation support, both for consumers navigating in-network providers, and consumers with commercial coverage who need to find an out-of-network, specialty mental health, Medi-Cal, or county service. Participants identified navigation support as particularly important for individuals in crisis, youth in schools without school-based mental health services, and university students seeking combination mental health/SUD services or services outside of the university health care system. Participants also discussed the importance of involving culturally competent trusted messengers in navigation support. Some systems such as schools and universities would benefit from navigation support regarding services, funding and how to collect data.

### COORDINATION ACROSS SECTORS AND SYSTEMS

Participants identified a need for cross-sector coordination across all behavioral health care systems, including between the commercial sector, Medi-Cal, counties, specialty mental health care, and crisis lines. Participants identified a particular need for coordination regarding medication coverage and accounting systems. They mentioned a need for the behavioral health sector to coordinate with the education sphere, including gaining an understanding of university health systems. In addition, they identified a need for counties to coordinate with FQHCs, schools, and health information exchanges. Lastly, participants mentioned a need for greater data sharing and the development of data on key comparative statistics across sectors.

### PUBLIC AND CONSUMER KNOWLEDGE AND SKILLS

BHTF and public members saw a gap in educating communities and parents as consumers, including knowledge of essential services, care systems, grievance procedures, and rights. Participants identified skills training as a need for parents of neurodiverse children.

## **QUESTION 1B:** WHAT SPECIFIC STEPS COULD WE TAKE TO HELP FILL THOSE GAPS AND MEET THOSE NEEDS?

### CROSS-SECTOR COORDINATION AND PLANNING

One idea to improve health system alignment was to map out the differences between sectors, conduct a cost/benefit analysis, and then evaluate behavioral health service quality outcomes. BHTF members and the public also suggested making data exchange, billing, and documentation more standardized and accessible, to increase coordination and incentivize providers to join commercial networks. Other ideas included greater enforcement of Medi-Cal network accessibility requirements; helping the commercial sector understand the

effectiveness of FSPs; increasing education and navigation support; encouraging commercial plan membership on local advisory boards; and implementing 988 workgroup strategies to connect plans with local access lines.

### WORKFORCE EXPANSION

BHTF and public members identified several approaches to address workforce shortages, such as mapping out provider need across the public/private continuum and developing a strategic plan to recruit, train and fill those positions. Other ideas included increasing provider salaries and reimbursement; offering targeted incentives to attract newly trained providers to areas of need; providing state technical assistance to providers to build capacity for working within different delivery systems; easing training requirements for lived experience coaches; recruiting at high schools and colleges; and using creative recruitment and retention approaches to attract and keep BIPOC and multilingual providers.

### BEHAVIORAL HEALTH CARE AND MEDICATION PROVISION

To improve access to care in the commercial sector, BHTF members and the public suggested requiring commercial coverage of initial crisis care without preapproval; easing approval of referrals to licensed providers; increasing transparency around the reasons for service denials; and expanding the types of care providers commercial insurers authorize to be more comparable to public systems. Other ideas included requiring contracted pharmacies to carry addiction treatment medications; creating publicly reported SUD success metrics; and setting and enforcing required plan provider/member ratios and geography, time, and distance standards. Participants encouraged a more consumer-focused approach. Ideas beyond the commercial sector included expanding school-based health centers and confidential mental health visit spaces; providing mental health services and youth trauma/violence prevention services at the community level; utilizing community health workers; supporting creative arts for those with behavioral health needs; and building the capacity of CBOs to contract with MCPs.

## **QUESTION 2:** HOW CAN WE HELP BH CONSUMERS ACCESS AND NAVIGATE THE HEALTH CARE SYSTEMS?

### NAVIGATION AND ACCESS IMPROVEMENTS

BHTF and public members shared several suggestions, including providing navigators/case managers; reimbursing for call center services and expanding call-center capability, such as by

creating a simple universal call center that provides basic screening intake and a connection to a provider and appointment availability information; training access point teams to offer navigation support; reimbursing for care coordination; and increasing transportation access. Participants also discussed the opportunity to leverage digital tools and artificial intelligence.

### EDUCATION AND OUTREACH

Ideas here included conducting outreach on easy-to-understand information about navigation services, resources to help resolve issues, grievance procedures, and county behavioral health services. Participants highlighted the importance of information channels, including the BHTF network, wellness centers, club houses, and probation departments. Participants also suggested sending information campaigners into communities with the most concentrated problems.

### CULTURAL COMPETENCY

BHTF members and the public suggested training customer service personnel in cultural competency; providing information on available language access; supporting multilingual and culturally competent strategic community health outreach; and ensuring the availability of providers and navigators with lived experience, including individuals with experience in the juvenile justice system.

### ASSESSMENT

Ideas included utilizing secret shopper tactics to assess customer service and identify workflow gaps, and comparing the commercial sector and Medi-Cal using CAHPS or Press Ganey equivalent ratings.

## **QUESTION 3:** WHAT ARE SPECIFIC SUGGESTIONS FOR HOW WE CAN HELP IMPROVE AFFORDABILITY AND ACCESSIBILITY OF BH CARE FOR COMMERCIAL HEALTH PLAN CONSUMERS?

### SYSTEM-LEVEL IMPROVEMENTS

BHTF and public members suggested enforcing existing requirements on insurers; aligning commercial and Medi-Cal benefits; creating simple and universal mechanisms for documentation and reimbursement to incentivize providers to participate; and expanding the commercial care continuum to reduce out-of-pocket expenses and movement into the public sector. More generally, it was suggested plans treat behavioral health similarly to other chronic

conditions where the goal is consistent rather than episodic care, and that impacted systems consider "cost value" from approaches such as multi-payer fee schedules. A holistic approach would incorporate the added value to society and systems from Californians experiencing better behavioral health. For example, school wellness coaches for students and behavioral health treatment for parents can lead to better school attendance, thereby increasing school district budgets.

### WORKFORCE AND REIMBURSEMENT

BHTF and public members suggested ways to allow for more affordable provision of services, such as by reimbursing for care by associates, or by providers or students under the supervision of a licensed professional. Participants suggested that the commercially reimbursed behavioral health workforce be expanded to include certified professionals such as peer support specialists, CHW/P/R's, wellness coaches, and providers in specialty mental health systems and county alcohol and other drug service provider networks. Reimbursement rates may need to be changed to attract sufficient providers. Participants also suggested increasing support for behavioral health career paths and examining how work and studies in the creative arts may facilitate individuals toward a behavioral health career path.

### AFFORDABILITY

BHTF members and the public suggested prioritizing reimbursable services that help prevent costly hospitalizations, such as mobile crisis teams, peer support, and care coordinators. Participants also suggested that there be tighter control of plan coverage increases. The group also discussed how outreach to community members and trusted messengers may be needed to ensure members of marginalized communities are aware of financial assistance programs to help families access behavioral health care. Participants highlighted the Parent Project as a low-cost educational and support group that has been shown to successfully empower parents to help their children.

## 988-CRISIS CARE CONTINUUM UPDATE

Dr. Anh Thu Bui, Project Director of 988-Crisis Care Continuum, CalHHS, shared recent activities of the 988-Crisis Policy Advisory Group and its workgroups, which are developing a five-year implementation plan for a comprehensive 988 system by the end of the year. Dr. Bui thanked BHTF members for their involvement and help making connections to communities for interviews and focus groups.

Dr. Bui updated the group that the project team has made headway toward a state-based 988 platform. The 988 Policy Advisory Group has met twice. Three of the six 988 workgroups are finishing up their work, and the remaining three workgroups will meet from May through August to address communications, data/metrics, and funding/sustainability.

California has seen a steady increase in 988 call volume over the past year, with a 19% call volume increase between February 2023 and February 2024. In February 2024, California 988 centers received over 30,000 calls and achieved a roughly 90% in-state answer rate. 988 centers have also seen an increase in paid staff over the past two years. The plan is to build up capacity before launching a 988 media campaign.

The project team is now working to engage the project's populations of focus. The program has launched a Tribal consulting team to understand how best to reach and be responsive and accessible to Tribal communities. The project team is also launching a peer workgroup and focus groups that involve LGBTQ+ individuals, veterans, transition-aged youth, foster youth, older adults, families, and other populations to learn their needs. The project team aims to review the draft implementation plan with the BHTF and other groups in mid-September and to solicit public comments in October.

Dr. Bui invited all BHTF members to get involved by reviewing the team's work to date or participating in workgroups (to do so, fill out a statement of interest here).

- 988-Crisis Policy Advisory Group website.
- Sign up for updates and information about upcoming engagement opportunities by emailing AB988Info@chhs.ca.gov.

## BHTF MEMBER DISCUSSION

- One BHTF member asked whether the 988 project team is looking at the data on 988 callers' ages or ethnicities, as it would be helpful to identify whether these data reflect expectations in the behavioral health field.
    - Dr. Bui said the program is collecting callers' demographic data, including age, gender identity, sexual orientation, race, and ethnicity, with the caveat that these data are voluntarily provided. In the course of a crisis call, between 16% to over 40% of callers may not divulge that information. Whether and how that will be collected will need to be part of the plan. They will report on the available data.

- Another member asked if the standard 988 workflow requires call-takers to provide callers—such as youth calling in—with tools to help prevent another crisis, as individuals in crisis are at high risk of experiencing another crisis.
    - Dr. Bui said that, yes, the goal is for 988 to be interconnected with other services and resources via warm handoffs, and for transfers to and from 988 to work well bilaterally.
    - Dr. Sohil Sud, Director of CYBHI, highlighted the bi-directional nature of tools such as Soluna, a behavioral health app for youth. Soluna providers can refer youth to 988 in crisis situations, and 988 providers can refer callers to Soluna for ongoing support.

## UPDATES ON THE CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE (CYBHI)

Dr. Sohil Sud, MD, MA, described the Children and Youth Behavioral Health Initiative's (CYBHI) collaborative work to support individuals from childhood through their transition into adulthood. Dr. Sud and representatives of the Department of Public Health also unveiled the recently launched Never A Bother youth suicide prevention campaign.

Dr. Sud explained that CYBHI envisions a transformation of massive scale, which can only be achieved through system-wide collaboration. He conveyed the breadth of CYBHI's vision by narrating the story of a fictional child living in a future state with access to the resources and services CYBHI strives to implement. He described how the CYBHI programs and timely interventions—such as youth centers, online supports, and therapy—could support this child and their family through challenges throughout the child's youth. Dr. Sud emphasized that everyone can play a part in making this goal a reality, and urged any BHTF members who did not see a professional role for themselves in this process to contact him to explore ways that CYBHI needs to engage them.

Dr. Sud then described CYBHI's objectives in four settings: health care settings, homes and families, schools and colleges, and the digital environment. He emphasized that equity is a foundational part of the initiative. He also explained three campaigns CYBHI will launch in 2024 to reduce stigma around mental health, to inform on ways to heal from early adversities, and to prevent suicide.

Sarah Mann and Ashley Mills, from the Department of Public Health Office of Suicide Prevention, then joined Dr. Sud to discuss the Never A Bother youth suicide prevention campaign, which combines traditional media efforts, local outreach, and content co-created by

youth. They reviewed the Never a Bother website, www.neverabother.org, and elements of the campaign, which were co-created with more than 400 youth. The campaign validates youths' experiences, encourages youth to reach out for support, and provides resources on how to offer support to someone who might need it. They invited meeting participants to attend an April 11 webinar to learn more about the campaign and toolkit. Anyone with questions can reach Ms. Mann at sara.mann@cdph.ca.gov.

**Never a Bother resources:**

- Website: www.neverabother.org
- Related co-creation contests
- Social Media accounts:
  - Instagram
  - YouTube
  - Facebook
  - TikTok

## BHTF MEMBER DISCUSSION

BHTF members were invited to ask questions and offer comments on the CYBHI updates.

- One BHTF member expressed that they think the Never a Bother website is well done, since it is appealing to youth, simple, and easy to use.
  - Dr. Sud responded that that is a testament to keeping youth at the center of the initiative. There were concerns from adults about the color, look, and feel of the website, but the kids were all in, and they are the website's main audience.

## BHTF MEMBER UPDATES

Deputy Secretary Welch shared that state leaders have not completed internal planning regarding implementation of Proposition 1. DHCS will lead the cross-departmental work. She advised BHTF members who want to engage in Prop 1 implementation to become experts on the details of this very complex legislation, so they are ready with their questions and thoughts when DHCS begins its robust stakeholder engagement process. There will be more information available soon.

Regarding BHTF meetings and member participation, Deputy Secretary Welch is looking at creative ways to make meetings more accessible to members from outside Sacramento or

Northern California. She is planning to hold one BHTF meeting each year in Southern California, where roughly half of the BHTF members live.

- A BHTF member based in Los Angeles indicated strong support for this idea.

BHTF members were invited to share updates and announcements related to their work:

- Responding to a question about Prop 1 infrastructure funding and participation by other entities, Deputy Secretary Welch said that will be the first information they will share when they are able.
- Via chat, another BHTF member asked if there might be implications for Prop 1 from the recent state audit on funding for homelessness, sharing a CalMatters link.
- Department of Public Health Director Tomás Aragón said his department will issue a one-pager on its community engagement timeline. Also, regarding the CYBHI update, he shared that he recently learned an average middle school child who has a smartphone spends five to eight hours a day on social media, resulting in sleep and social deprivation. The average youth who brings a cell phone to class also receives over 250 notifications per day, which can lead to attention fragmentation and difficulty concentrating. Dr. Aragón emphasized that this emerging issue is wide-ranging and critically important.
- HCAI Director Elizabeth Landsberg asked attendees to spread the word about the department's new Certified Wellness Coach profession and the available scholarships of up to $35,000 a year to support young people in becoming Certified Wellness Coaches. She highlighted that this is an important opportunity to expand and diversify the behavioral health profession. See HCAI's workforce wellness coach page or the outward-facing wellness coach website. Applications are due by June 24.
- Some BHTF members discussed ways they can connect outside meetings to take action and resolve issues around SB 43, which affects both mental health and substance use disorder populations. Members of the behavioral health care community currently lack a platform to discuss this new initiative.
    - Kirsten Barlow from the California Hospital Association invited interested stakeholders to meet with her on SB 43. Hospital representatives are curious about what other sectors, such as drug and alcohol service providers, mental health directors, first responders/law enforcement, and others are thinking about ways to implement the initiative efficiently.

  - Robb Layne from CAADPE offered to co-host this conversation with the California Hospital Association and is looking forward to connecting outside of meetings. He emphasized that the group can make huge inroads by working together.
  - Deputy Secretary Welch said members of the CARE Act Working Group have asked to take up this issue, which has been top of mind for those working with people who are high utilizers of crisis systems. Stakeholders are considering how to have a more holistic planning process that accounts for the interconnectivity of crisis services.
  - Jenny Bayardo said the Planning Council will meet in mid-April, and that one committee will hold an hour-long public forum on SB 43 to hear from stakeholders, including the psychiatric associations that cosponsored it. Information from the forum will be provided to DHCS.
  - Dawan Utecht agreed about the need for broader coordination around SB 43. She would also appreciate any updates on SB 525, the health care minimum wage.
- Grant Boykin shared that his non-profit Shatterproof has a resource to help people find substance use disorder treatment, the Treatment Atlas. It is for everybody, but relevant to today's discussion as it may be particularly important for those with commercial insurance – Mr. Boykin was a commercial consumer himself and struggled to find appropriate care. Shatterproof partnered with DHCS to include California licensed and certified substance use disorder treatment providers on the site.
- One BHTF member noted that behavioral health discussions tend to focus on mental health. They proposed an SUD focus for an upcoming meeting, including a focused conversation about prevention. The member emphasized that groups such as the Alliance, CAADPE, and the National Council are doing important SUD prevention work such as screenings and suggested that a strong focus on prevention would inspire hope and help identify ways to prevent people from needing services.
  - Deputy Secretary Welch expressed interest in the SUD topic and also suggested they dedicate a meeting to discuss the behavioral health workforce.
    - A BHTF member said it will be important to address administrative issues in the workforce discussion.
- Another BHTF member raised concerns that developmental disabilities are often forgotten in these conversations, but that they are also under the behavioral health umbrella. As with mental health and SUD services, there are not enough providers supporting individuals with developmental disabilities. There is a high percentage of

individuals who have developmental disabilities who have co-occurring mental health conditions and might be getting applied behavior analysis or other services. The BHTF member asked the group what they can do collectively to make sure that the developmental disabilities workforce is included in their discussions.

  - Related to this topic, Deputy Secretary Welch suggested getting an update on the Master Plan for Developmental Services.

- A BHTF member said attendees are learning a lot at these meetings, and asked what the next steps are to build on today's work of identifying improvements for mild-to-moderate BH systems and managed care. They suggested that a library or other platform would be helpful, where information generated during the meeting could be stored and stay available for members.
  - In response, Deputy Secretary Welch said CHHS is a bit resource-strapped with the BHTF, but they are considering trying to improve the BHTF website or communications. She noted the impact the BHTF has had in informing policy, including the CCC-P, the essential crisis benefits that the state adopted, and the metrics for CYBHI. At minimum, CalHHS will take back what was shared today and share a summary of the discussion with members. Deputy Secretary Welch noted that the BHTF's main focus is on sharing knowledge and feedback, but that BHTF can connect offline and take action together.
- Steve Dilley shared that The Veterans Art Project's school of ceramics and glass is holding an open house and potluck, open to everyone, including veterans, active duty, spouses, dependents, and caregivers.

## PUBLIC COMMENT

Members of the public were invited to share comments and questions.

- A representative of Kooth, the creator of the Soluna mental health app for 13- to 25-year-olds, thanked presenters for their support and for giving a shout-out about the app. Kooth team members were available at the meeting to speak with attendees and answer any questions.

## NEXT STEPS & CLOSING

Immediately after lunch, Facilitator Ariel Ambruster informed BHTF members that, given how many people brought their lunches back to the meeting, they will shift to a working lunch – 30 minutes off to get food and 30 minutes meeting over lunch – at the next meeting unless there

were any significant member concerns. No BHTF member in the room or online indicated any opposition; four online members indicated support.

Deputy Secretary Welch said that, because of the long summer stretch until the next quarterly meeting, CalHHS may offer more than one Lunch and Learn presentation so that information continues to circulate between meetings. She thanked BHTF members and stakeholders for joining today and for their attention.

Remaining 2024 Quarterly Meeting Dates (all will be hybrid):

- August 28, 2024
- November 13, 2024

For more information, please visit the BHTF website.

## APPENDIX A. MEETING ATTENDEES

### STATE REPRESENTATIVES AND BHTF MEMBERS

Chair: Mark Ghaly, Secretary, CalHHS
Dr. Tomas Aragon, CDPH
Michelle Baass, DHCS
Elizabeth Basnett, EMSA
Jenny Bayardo, BHPC
Stephanie Clendenin, DSH
Susan DeMarois, Aging
Brenda Grealish, CCJBH
Christian Jacobs, UCOP
Elizabeth Landsberg, HCAI
Will Lightbourne, OYCR
Dr. Diana Ramos, Surgeon General
Kim Rutledge, DOR
Dr. Sohil Sud, CYBHI
Marjorie Swartz, Senate
Erika Torres, CDE
Mary Watanabe, DMHC
Jackie Wong, First 5
Alfredo Aguirre, LBHC
William Arroyo, MCHAP
Charles Bacchi, CAHP
Kirsten Barlow, CHA
Phebe Bell, Nevada County BH Dept
Grant Boyken, Shatterproof
Theresa Comstock, CALBHB/C
Steve Dilley, Veterans Art Project
Michelle Doty Cabrera, CBHDAC
Vitka Eisen, HealthRIGHT 360
Ruby Fierro, CPOC
Anita Fisher, NAMI California
Lisa Fortuna, Psy/Neuro, UC Riverside
Lishaun Francis, Children Now
Cynthia Jackson Kelartinian, Heritage Clinic
Carmen Katsarov, CalOptima Health
Karen Larsen, Steinberg Institute
Robb Layne, CAADP
Kim Lewis, NHeLP
Michael Lombardo, CalHHS Advisor
Stephanie Moon, LACDHS Housing/Health
Elizabeth Oseguera, CPCA
Justin Peglowski, Indian Health Services
Evangelina Ramirez, Promotoras con Alma
Allison Rodriguez, CommuniCare Health Cen
Albert M. Senella, Tarzana Treatment Cen
Miguel Serricchio, Didi Hirsch
Christine Stoner-Mertz, CACFS
Zofia Trexler, Disability Rights California
Gary Tsai, LAC DPH SA Prevention/Control
Dawan Utecht, Telecare Corporation
Astin Williams, CA LGBTQ HHSN
Shaina Zurlin, CCAH

## PANELISTS AND PRESENTERS

- Mary Watanabe*, Director, Department of Managed Health Care
- Charles Bacchi*, President, California Association of Health Plans
- Kiran Savage-Sangwan, Executive Director, California Pan-Ethnic Health Network
- Dr. Anh Thu Bui, Project Director of 988-Crisis Care Continuum, California Health and Human Services
- Dr. Sohil Sud*, MD, MA, Director, CYBHI
- Sara Mann, California Department of Public Health, CYBHI
- Ashley Mills, California Department of Public Health, CYBHI

## CALHHS AND FACILITATION TEAM

Stephanie Welch, MSW. Deputy Secretary of Behavioral Health, CalHHS
Josephine Baca, CalHHS
Hailey Shapiro, CalHHS
Ariel Ambruster, CSU Sacramento
Julia Csernansky, CSU Sacramento

* Also BHTF Member

## APPENDIX B. COMMERICAL HEALTH CARE AND BEHAVIORAL HEALTH: REPORT OUT AND DETAILED NOTES

BHTF Members and members of the public were invited to participate in focused brainstorming on Improving Behavioral Health Outcomes for Californians with Commercial Health Plans. In-person participants gathered in small groups. Online participants individually brainstormed using an online whiteboard (Google Jamboard). Below is the summary of the report-out session, followed by the detailed input provided by member and public small groups (via worksheets) and online BHTF members and members of the public (via an online whiteboard).

### REPORT OUT ON BREAKOUT DISCUSSIONS

#### BHTF MEMBER GROUP DISCUSSIONS

**Group 1** shared the following takeaways and suggestions:

**QUESTION 1A:** WHAT ARE THE GREATEST GAPS AND UNMET NEEDS IN THE SYSTEM FOR THE CONSTIUENTS YOU REPRESENT OR YOUR COMMUNITY?

- The crisis care continuum and limited access to alternative destinations, some of the most desirable crisis services or emerging newer interventions, because of reimbursement barriers. The EMS or ambulatory system has to take people to emergency departments in order to be reimbursed. Is there a way that they could take people home or somewhere else and still get reimbursed? There are a variety of other crisis services that may not be covered under commercial insurance. Examples are peer respite, in-home stabilization, peer providers, and sobering centers.
- The challenge of having a large workforce that is private pay only, that many providers will only take payment out of pocket and won't come in network. One of the biggest barriers to improving this, to meeting the needs in the system, is that it's harder or very hard to measure outcomes for people experiencing behavioral health conditions.

**QUESTION 1B:** WHAT SPECIFIC STEPS COULD WE TAKE TO HELP FILL THOSE GAPS AND MEET THOSE NEEDS?

- Follow a three-step process to help really understand if it's worth investing in an intervention, if it has the kinds of outcomes that we value.
    - Really mapping out the differences in the systems, what services are offered and what services are available in particular. For example, what is the whole array of crisis services? Which ones are covered and which ones are not? Knowing what the difference are across the systems.
    - Create a step-by-step cost-benefit analysis to better understand if the efficacy that's associated with the intervention is worth the cost, basing us in reality.
    - Really important in addition is understanding quality: do the people experiencing the intervention feel any better, do they get the outcomes they want from it?

- Assess whether there is a network of providers that can really deliver the benefit that we want. Consider what community health workers do, and some of the new benefits such as doula benefits.
    - Are we mapping out the process and the time that it takes to create the kinds of people who can work in the jobs that we would like them to work in, in order to deliver the intervention?
- The sustainability factor: is this the type of intervention that there's going to be demand for? Do we know what that demand is? Are we creating a provider network and people to work in those positions to meet that demand?

**QUESTION 2:** HOW CAN WE HELP BH CONSUMERS ACCESS AND NAVIGATE THE HEALTH CARE SYSTEMS?

- Are there ways in which we can use artificial intelligence responsibly to help people better understand how to navigate and access systems?

**QUESTION 3:** WHAT ARE SPECIFIC SUGGESTIONS FOR HOW WE CAN HELP IMPROVE AFFORDABILITY AND ACCESSIBILITY OF BH CARE FOR COMMERCIAL HEALTH PLAN CONSUMERS?

- We don't do a lot to really assess the kind of added value that may impact systems if people have better and improved behavioral health. An example: Chronic school absenteeism and attendance is a real problem now. If we have behavioral health wellness coaches that are able to help kids in school manage their mental health issues, that could lead to increased days of school attended, which then leads to an increase in the school's overall net budget, because they receive resources based on attendance. This is value added that the school may potentially be able to reap more resources if they have healthy kids because the kids are coming to school. If parents are getting access to substance use and mental health treatment, they are more equipped to make sure that their kid gets to school.

**Group 2** focused their conversation on gaps and shared out some of the major categories of takeaways.

**QUESTION 1A:** WHAT ARE THE GREATEST GAPS AND UNMET NEEDS IN THE SYSTEM FOR THE CONSTIUENTS YOU REPRESENT OR YOUR COMMUNITY?

- Individuals seeking services often may be in crisis, and it might be difficult for them to to navigate the system. There may need to be somebody who can assist them in navigating a complicated system.
- Workforce is another large issue, because in some regions and areas, there just isn't a provider. It's not that it's not covered, but there just might not be somebody available for what a person needs.
- The challenges in navigating between specialty mental health services and the commercial side. If services are unavailable through their commercial plan, people might end up at the county or at a certified clinic. Sometimes people end up there because they were unsuccessful in utilizing the services in the other system. It may be that not everybody knows how to direct them back to the right services.

**QUESTION 2:** HOW CAN WE HELP BH CONSUMERS ACCESS AND NAVIGATE THE HEALTH CARE SYSTEMS?

- Provide navigators and improve information about navigation services

- Maybe there is an opportunity to train people at the clinics to know how to direct someone who comes in back to the services.
- Improve available information. Many group members weren't aware of some of the information shared in the presentations regarding resources to help people resolve their issues. Is the information out there for consumers to easily access? How are we sharing that information? There may be opportunities for some of these other access points, for us to potentially be trained or be given resources so that we can also assist with that. The information needs to be easy to access and easy to understand, so that consumers can get the resources that they need.

**Group 3** did not report out.

**Group 4** shared the following takeaways and suggestions:

**QUESTION 1A:** WHAT ARE THE GREATEST GAPS AND UNMET NEEDS IN THE SYSTEM FOR THE CONSTIUENTS YOU REPRESENT OR YOUR COMMUNITY?

- For federally qualified health centers (FQHCs):
  - A need for more language access
  - Provider burnout, mostly in the behavioral health or specialty mental health space. Causes:
    - Administrative reporting and paperwork burden
    - Navigating between the managed care plan, their delegated health networks, or the plan between the county health centers – having a lot of different delivery systems to deal with
  - Uninsured paying existing funds. Because these individuals might not be associated with a health plan or other coverage, they're having to pay for the services. So money is not coming in then to cover that, and the revenue isn't matching.
  - Behavioral health silos: the difficulty in navigating between health centers responsible for mild to moderate services and county services
  - The inherent difficulty of coordinating around members moving across county
- Youth
  - A general lack of providers and facilities for substance use services for youth under age 26
  - Difficulty accessing services if attending schools without school-based mental health services
  - Workforce shortages result in shifting provider gaps – when professionals move into the schools arena, it can create a shortage in the county workforce
  - Parents not knowing what services are available to access. If you don't know it, you can't access it. Lack of knowledge about grievance processes, workflows. How do they do that, or what are their rights around youth and students aged 17+?
  - Youth who have coverage plans that are outside of managed care or county, such as through the school, such as UC SHIP (Student Health Insurance Plan), paid by students through tuition/school fees. This is a totally different system. Difficulties understanding the delivery systems and navigating between the primary payer (the school) and secondary payers.

- Challenges for the schools in understanding and navigating the delivery systems of managed care plans, county behavioral health services, and campus behavioral health services. Addressing needs for external substance use or mental health services unavailable on college campuses.
- Each campus has its own identity and operations
- Lack of an established memorandums of understanding or other mechanism around service coordination
- Difficulty navigating funders or funds and understanding how to get the funds and collect data

**QUESTION 1B:** WHAT SPECIFIC STEPS COULD WE TAKE TO HELP FILL THOSE GAPS AND MEET THOSE NEEDS?

- Increase coordination with the counties
- Better requirements or standardization around data in general, and how everyone should exchange data. Standardize processes to the extent possible.
- Technical assistance from the state to providers, helping them in any way possible at the front end, so they don't have the issues later in dealing with the different delivery systems
- Education and navigation: even though there is a lot now, there needs to be more of it
- Remove the burden from consumers. Anything that we can all do together so that it's not felt by our consumers, our members, our patients. And on the back end, we can do all of those administrative things.

**QUESTION 2:** HOW CAN WE HELP BH CONSUMERS ACCESS AND NAVIGATE THE HEALTH CARE SYSTEMS?

- Expand the care and the services
- Workforce: consider the different types of recognized professionals across the different delivery systems, in mental health or SUD

BHTF MEMBER BREAKOUT GROUPS

**IN-PERSON BHTF SMALL GROUP 1**

| 1. A. What are the greatest gaps and unmet needs in the system for the constituents you represent or your community? | 1. B. What specific steps could we take to help fill those gaps and meet those needs? |
|---|---|
| • Crisis Care Continuum and limited access to alternative destinations – not reimbursed anywhere but ERs<br>• Not all crisis services are covered under commercial insurance<br>  ○ Sober centers<br>  ○ Peer respite | 1. Need to map the differences between what crisis services are covered and what are not<br>2. Cost-benefit analysis of the effectiveness of the benefit/intervention<br>3. What is the quality of this? Do people feel or get better? Is the cost worth the outcome? |

**IN-PERSON BHTF SMALL GROUP 1**

| | |
|---|---|
| ○ In-home stabilization<br>○ Peer providers<br>• Workforce – private pay – people will pay out-of-pocket<br>• Outcomes are harder to measure in Behavioral Health | 4. Can we share FSP effectiveness with plans?<br>5. Is there a network of providers to deliver the benefit?<br>• CHW<br>• Doula services<br>6. What is the sustainability of the intervention with the provider, e.g., ECM? |
| **2. How can we help BH consumers access and navigate the health care systems?** | **3. What are specific suggestions for how we can help improve affordability and accessibility of BH care for commercial health plan consumers?** |
| • Can we use AI? | • Systems impacted – can they see the "cost value"? Example: multi-payer fee schedule<br>• BH Coach helps child MH and number of school days attended goes up and school gets more funding |

**IN-PERSON BHTF SMALL GROUP 2**

| **1. A. What are the greatest gaps and unmet needs in the system for the constituents you represent or your community?** | **1. B. What specific steps could we take to help fill those gaps and meet those needs?** |
|---|---|
| 1. Individuals seeking behavioral health services are generally in crisis and need help with navigation. Navigators/case managers are needed.<br>2. Workforce shortages are contributing to access issues – Medi-Cal mental health<br>3. Gaps between specialty care services and commercial plans force individuals who need higher level services to stay well to choose public versus commercial. | • No answers for this question |

**IN-PERSON BHTF SMALL GROUP 2**

| 2. How can we help BH consumers access and navigate the health care systems? | 3. What are specific suggestions for how we can help improve affordability and accessibility of BH care for commercial health plan consumers? |
|---|---|
| • Provide navigators/case managers<br>• Information needs to be easy access/understandable – that helps consumers understand rights/services and how to access<br>• Training for access points teams on how to provide support to assist individuals in accessing services. | • No answers for this question |

**IN-PERSON BHTF SMALL GROUP 3**

No worksheet submitted.

**IN-PERSON BHTF SMALL GROUP 4**

| 1. A. What are the greatest gaps and unmet needs in the system for the constituents you represent or your community? | 1. B. What specific steps could we take to help fill those gaps and meet those needs? |
|---|---|
| • FQHC<br>1. Language access<br>2. Provider burnout<br>  ○ BH space/SMI<br>  ○ (reporting/paperwork burnout)<br>  ▪ MCP (HN/direct) county health centers<br>3. Uninsured – paying existing funds – money isn't coming in<br>4. BH silos – health center mild/moderate FQHC ,←→SMI/County = hard to navigate<br>5. Members moving across county<br>• Youth – students 17 and up, primary/secondary payer | 1. Increase coordination with counties<br>2. Requirements Data – data exchange<br>3. Standardize processes<br>4. Technical assistance from state to providers<br>5. Education and Navigation<br>6. Removing burden from consumers |

## IN-PERSON BHTF SMALL GROUP 4

| | |
|---|---|
| 1. Coverage plans – comes out of tuition – UC SHIP (Student Health Insurance Plan)<br>2. Understanding delivery system<br>3. County BH and campus BH services getting students to SUD etc. for services that can't be done on school campus – –> no established MOU, etc.<br>• Youth<br>o Parents not knowing what's available (grievance process, etc.)<br>1. SUD under 26 RTC/partial (LOC)<br>2. Lack of providers/lack of facility<br>• School MH<br>1. If school doesn't have school-based mental health services, hard to access<br>2. Increased workforce but at expense of County workforce, shortage of professional | |
| **2. How can we help BH consumers access and navigate the health care systems?** | **3. What are specific suggestions for how we can help improve affordability and accessibility of BH care for commercial health plan consumers?** |
| 1. Improve affordability health plans<br>2. Expand care and service<br>3. Workforce | 1. Quality + outcomes<br>2. Other BH professionals reimbursement ability |

## IN-PERSON BHTF INDIVIDUAL WORKSHEET ANSWERS

| **1. A. What are the greatest gaps and unmet needs in the system for the constituents you represent or your community?** | **1. B. What specific steps could we take to help fill those gaps and meet those needs?** |
|---|---|
| Individual 1:<br>• County BH + HIE collaboration | |

## IN-PERSON BHTF INDIVIDUAL WORKSHEET ANSWERS

| | |
|---|---|
| • State's understanding of the UC behavioral health delivery system UC SHIP –> Medi-Cal –> commercial HP<br>• Dedicated space for SUD's and CRP services<br>• Collection of data from under-represented students<br>• Access to on-campus services MH plus SUD's<br><br>Individual 2:<br><br>• Comprehensive and coordinated care<br>• Specialty care – EPI + FSP et al wraparound etc. | |
| **2. How can we help BH consumers access and navigate the health care systems?** | **3. What are specific suggestions for how we can help improve affordability and accessibility of BH care for commercial health plan consumers?** |
| | |

## ONLINE BHTF MEMBER BRAINSTORM

| **1. A. What are the greatest gaps and unmet needs in the system for the constituents you represent or your community?** | **1. B. What specific steps could we take to help fill those gaps and meet those needs?** |
|---|---|
| • Access to facility where arts are supported, facilitated, for Veterans, spouses, dependents active duty.<br>• Affordability of services.<br>• Timeliness of access to services in rural areas.<br>• Lack of Spanish speaking therapists<br>• Inadequate BH networks across Medi-Cal and commercial plans | • 1. Increase reimbursement rates for providers. 2. Make it easier to navigate documentation and billing requirements<br>• Require all contracted pharmacies to carry all FDA approved addiction treatment medications |

## ONLINE BHTF MEMBER BRAINSTORM

- Significant mental health needs for those who do not qualify for Medi-Cal and cannot afford other insurance options.
- Access to methadone treatment for OUD
- BH workforce doesn't represent CA's diversity and isn't in all geographic areas.
- It is challenging to discuss unmet needs in terms of healthcare exclusively because individuals and families have various categories of costs, e.g., health, rent etc. to manage
- Professional capacity: many newly trained professionals are reticent to stay in the area in which they trained due to disparities in salaries and living expenses.
- Need for FQHC's to be better represented on Health Plan networks
- Falta de informacion en las comunidades que no tienen acceso a una escuela o centro comunitario. Necesitamos hacer llegar la voz. [Lack of information in communities that don't have access to a school or community center. We need to get the word out]
- Lack of consistent connection between County Access and Crisis lines to commercial health plans (note 988 workgroup should address this)
- The HMO-to-IPA-to beneficiary complexity is highly confusing for many folx.
- Data gap (unless I missed it in on presentations this am), penetration rates (for both MH and AOD) comparison between Medi-Cal system and commercial health
- Lack of Therapists who are culturally congruent with communities (language & BIPOC)
- Medication that was covered in custody to stabilize an individual may not be the same one covered when they are released from custody by medical or private insurance.
- Lack of multi-generational MH services for young children & their parents.
- Basic access to mental health services. There are not enough available appointments/providers.
- Require commercial plans to allow crisis care for mental health and SUD, be it outpatient, residential or inpatient for some limited amount of time before requiring pre approved services
- Support creative/arts orgs to develop and build out facilities through collaboration or stand-alone locations where art making is encouraged, for Veterans
- Create an easy-to-use universal billing and documentation system to reduce barriers for providers to provide services
- Debemos de ir a las comunidades, puerta a puerta. Y programas en salud mental dentro de las comunidades. [We must go to the communities, door by door. And mental health programs inside the communities.]
- Expand incentives for newly trained professionals to remain in areas where they trained or where there is a dire shortage of professionals, e.g., housing subsidies
- Re local access line connection to commercial health plans, 988 workgroup strategies would be important
- Usar las promotoras/community health workers para llevar la voz a las comunidades porque ellas conocen la communidad.[Use promotoras/community health workers to get the word out to the communities because they know the community.]
- Health plans need to better represented on local BH/MH Advisory Boards to foster collaboration
- Expand recognized care providers in commercial plans to align with public side of who can provide care

## ONLINE BHTF MEMBER BRAINSTORM

| | |
|---|---|
| • Access to mental health services for students that do not have private insurance or Medi-Cal<br>• There is no parity, in terms of quality and dosage, between commercial insurance SUD treatment and public-funded treatment for Medi-Cal. Better quality on public side over com | • Set specific network requirements in terms of numbers of each provider type to member ratios and better enforcement of violations (geographic/time and distance standards)<br>• Para la falta de profesionales en estas carreras debemos ir a las high schools y colegios y ofrecer oportunidades a los jovenes [To address the lack of professionals in these careers, we should go to the high schools and colleges and offer opportunities to the young people.]<br>• Single payer<br>• Create an easy-to-use universal billing and documentation system which would reduce barriers for providers and incentivize them to participate in the commercial plans.<br>• Creative recruitment and retention strategies that target BIPOC and multi-lingual providers.<br>• Professional capacity shortages may be curbed through competitive salaries.<br>• No wrong door referrals, streamlined coverage, ensuring that families do not have to figure out who is the payer for services; similar to single payer.<br>• Cost of health care may be lowered through a unified financing model of healthcare of which single payer is one of several types<br>• More enforcement of Medi-Cal network access/adequacy problems by DHCS where clear violations exist (Medi-Cal in particular)<br>• Drug pricing is a major source of healthcare costs increases accounting for nearly 10% of total healthcare costs. These costs must be reined in.<br>• State and counties more proactively develop workforce plans to address need across the spectrum of public-private |

**ONLINE BHTF MEMBER BRAINSTORM**

| | |
|---|---|
| | • State and counties more proactively develop workforce plans to address gap through the public-private continuum |
| **2. How can we help BH consumers access and navigate the health care systems?** | **3. What are specific suggestions for how we can help improve affordability and accessibility of BH care for commercial health plan consumers?** |
| • Education is continuously needed especially for Veterans who may not know of, be aware of county level behavioral health assets that may support them with services.<br>• Necesitamos hacer campanas de informacion de los diferentes programas que existen e ir a las areas donde se concentran los problemas y ayudarles a entender las difere [We need to have information campaigns from the different programs that exist and go out to the areas where the problems are concentrated and help them to understand the differences]<br>• Reimburse for care coordination pre treatment admission<br>• Expand call center capability and reimburse for call center services<br>• Increase transportation services and easy access to same<br>• More involvement in County funded wellness centers and consumer run clubhouses in providing education on overall health care system<br>• Support/funding for strategic community health outreach that are culturally congruent and offered in multiple languages.<br>• Simple, universal call center that provides a basic screening intake and makes an actual connection to a provider, potentially with actual appointment availability.<br>• Probation is a support and connector to resources for many people. Keeping probation informed helps transfer info to those often vulnerable to difficulties navigating systems. | • Support the development of certified BH professionals such as peer support specialists, CHWPRs and wellness coaches.<br>• Reimburse for providers of care below licensed professionals who may be under the supervision of a licensed person<br>• Increase in network providers of the specialty MH systems and County AOD provider network in the commercial health plans<br>• Commercial plans need to fairly reimburse for care and expand care continuum to reduce out of pocket care and movement into the public sector<br>• Tighter control of plan coverage increases<br>• Create simple and universal mechanisms for documentation and reimbursement which would incentivize providers to participate.<br>• Clear and simple mechanism for reimbursing services provided by a supervised student.<br>• Increase support for career paths in this space to have more providers available.<br>• Prioritize reimbursable services that avoid costly hospitalizations, like mobile teams; peer support; care coordinators for those with more serious BH issues<br>• El expandir la voz si existen programas de ayuda economica que puedan ayudar a las familias a beneficiarse para tener acceso a la |

### ONLINE BHTF MEMBER BRAINSTORM

| | |
|---|---|
| • Y ayudarles a entender las diferentes opciones que existen para en diferentes idiomas para que estos puedan ayudarse.[And help them understand the different options that exist for different languages so that they can help themselves.]<br>• Better use of technology, when appropriate.<br>• Ademas capacitar a los del servicio al cliente sobre maneras de atender a estas personas para que no se sientan atacadas o vulneradas. [In addition, train customer service personnel on how to assist these people so that they do not feel attacked or vulnerable.] | ayuda. Ir a las comunidades, puerta a puerta [Spreading the word if there are financial assistance programs that can help families benefit from accessing help. Go to the communities, door to door]<br>• Tenemos familias que no tienen ninos en la escuela sus jovenes estan perdidos y no saben a donde ir para buscar la ayuda. Sugiero llevarle esa informacion a sus hogares. [We have families who don't have children in school their youth are lost and don't know where to go to look for help. I suggest taking this information to their homes]<br>• O sus trabajos, iglesias es ir hacia ellos para poder realmente hacer que haya acceso y alcance [Or their jobs, churches. going to them so that we can really make sure that there is access and outreach.]<br>• I do believe that through creative arts development we may find individuals who may choose a behavioral health degree and job path. |

## PUBLIC PARTICIPANTS

### IN-PERSON PUBLIC SMALL GROUP

| 1. A. What are the greatest gaps and unmet needs in the system for the constituents you represent or your community? | 1. B. What specific steps could we take to help fill those gaps and meet those needs? |
|---|---|
| • Diverse workforce –> lack of language access<br>• Bridging the education space and BH space<br>• Lack of clarity around navigation | • More transparency on why services are denied by the plans<br>• Decisions about what's medically necessary<br>• Automatic approvals of referral of services based on a licensed BH professional<br>• Championing lived-experienced coaches and reducing the length of training |

**IN-PERSON PUBLIC SMALL GROUP**

| 2. How can we help BH consumers access and navigate the health care systems? | 3. What are specific suggestions for how we can help improve affordability and accessibility of BH care for commercial health plan consumers? |
|---|---|
| • Using digital access to BH care | • No answers to this question |

**ONLINE PUBLIC PARTICIPANT BRAINSTORM**

| 1. A. What are the greatest gaps and unmet needs in the system for the constituents you represent or your community? | 1. B. What specific steps could we take to help fill those gaps and meet those needs? |
|---|---|
| • Availability of and access to youth substance use services from prevention through care and treatment<br>• Availability of LGBTQ+ culturally competent providers that are covered by insurance.<br>• LGBTQ+ community members not being able to clearly know which providers are culturally competent and having a not having a clear resource to find providers.<br>• Integrated trauma and violence prevention with other pediatric or youth-focused behavioral health.<br>• Treatment and healing services provided by people with lived experience, and navigation by trusted messengers.<br>• Parents need to learn skills to address the needs of the neurodiverse children, see Parent Project for a low cost approach. The work and knowledge being applied through Early | • Add and publicly report on SUD (substance use disorder) to the metrics for success in annual quality reports; work with the education systems to integrate these as well<br>• Capacity-building for trusted CBOs to contract with MCPs.<br>• Create pathways for organizations addressing trauma and violence to participate as care extenders in the ecosystem of pediatric/youth behavioral health |
| **2. How can we help BH consumers access and navigate the health care systems?** | **3. What are specific suggestions for how we can help improve affordability and accessibility of BH care for commercial health plan consumers?** |

| ONLINE PUBLIC PARTICIPANT BRAINSTORM | |
|---|---|
| • Conduct smart/secret shopper activities to look at customer service and access areas of improvement or gaps in workflows<br>• Lived experience providers (juvenile justice-involved) and navigators.<br>• Show comparisons between CAHPS or Press Ganey equivalent ratings between Medi-Cal and commercial health plan beneficiaries<br>• Support groups to have parents with lived experience transfer the valuable information they learned by successfully navigating and addressing their children | • Allow BH services to be performed by associates.<br>• Enforcement of existing requirements. Align benefits between commercial and Medi-Cal.<br>• Parent Project is a low cost educational and support group setting that has proven tremendous results for helping parents feel empowered to help their children rather than relying on<br>• Treat behavioral health like other chronic conditions, i.e., consistent care is the goal rather than episodic care |

In addition, members of the public offered the following comments via online Q&A during the afternoon report-out session:

- Carmen - great comments. Please also include space for school based health centers and confidential working space for mental health visits inside the school setting. Not sure how this task force can assist.
- We need to talk about the barrier of data sharing as well.