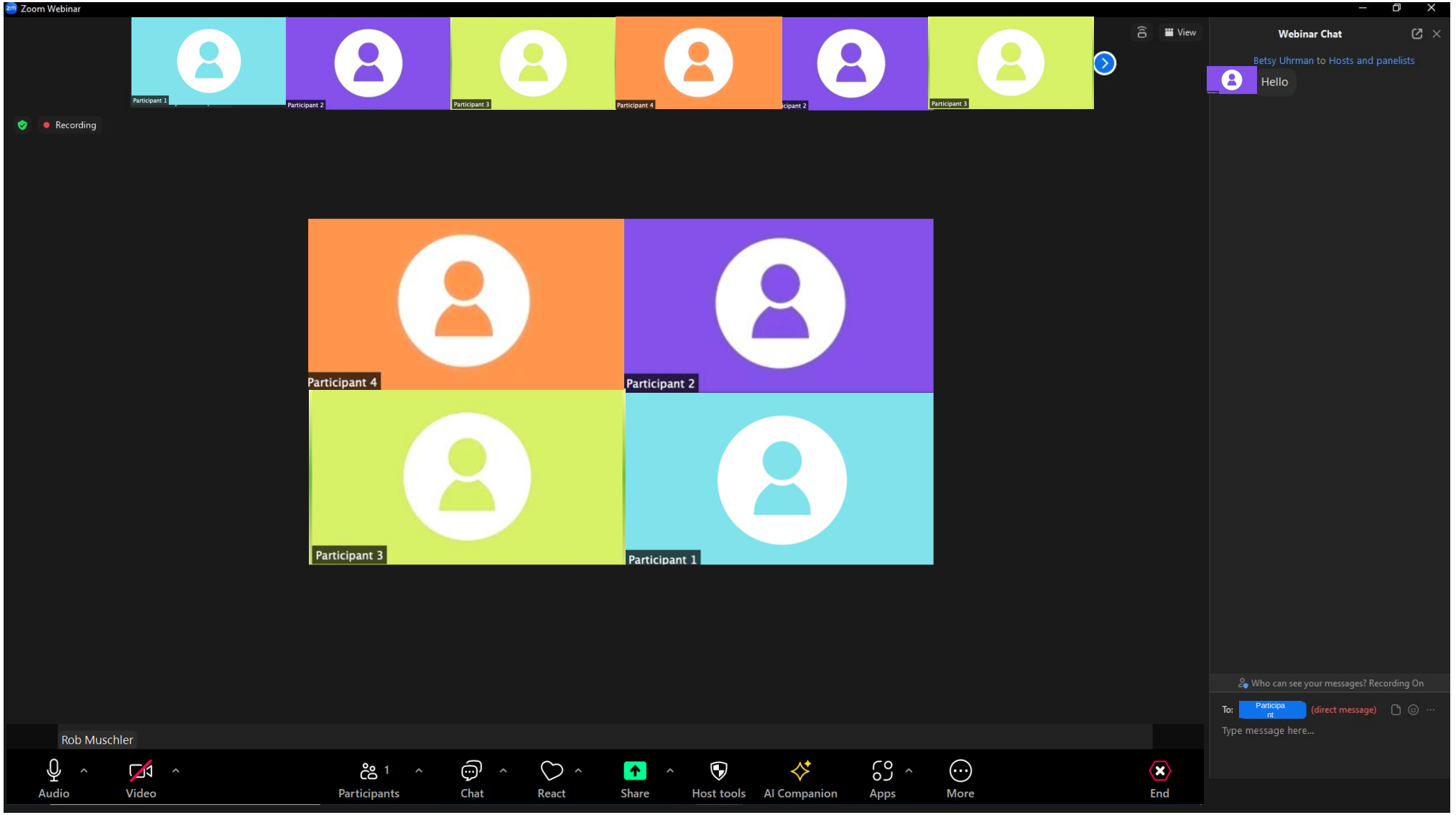
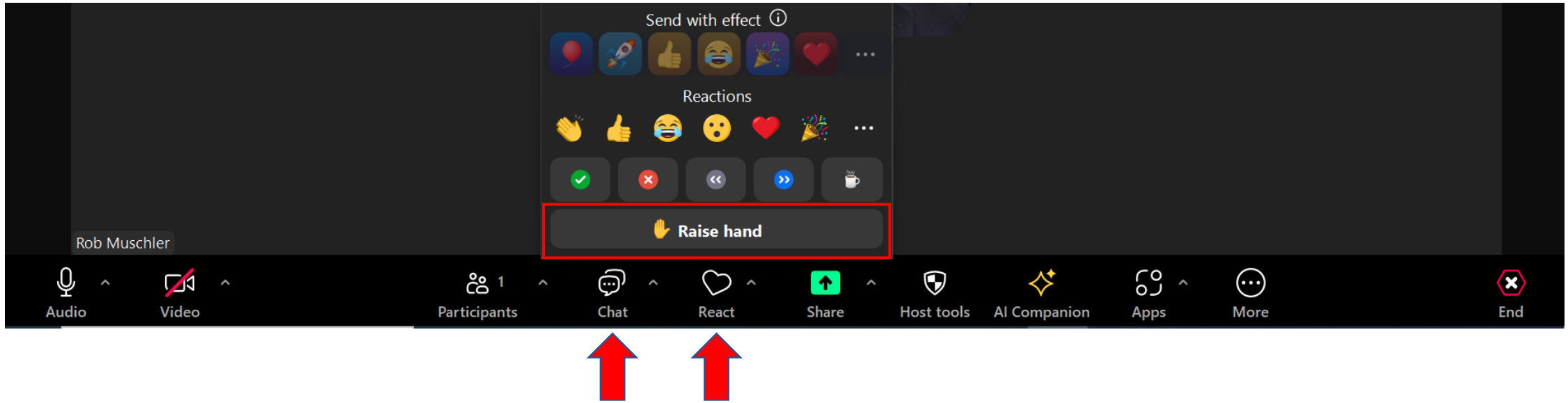
Workgroup 6: Funding and Sustainability

Meeting 3
September 3, 2024

Webinar: Panelist View



Webinar View: Attendee



- Workgroup members will be able to utilize the chat function throughout the meeting. Chat messages cannot be seen by non-workgroup members, but they will be captured in the public meeting summary.
- Workgroup members will be asked to use the "raise hand" function when you would like to speak.

Workgroup 6, Meeting 3 Agenda

1. Review of Agenda
2. Crisis Reimbursement Workstream Updates and Lessons Learned from Washington
3. Review and Discussion of Draft Implementation Activities
4. Public Comment Period
5. Next Steps

Workgroup 6 Members

- **Co-Chair: Anete Millers,** California Association of Health Plans
- **Co-Chair: Christine Stoner-Mertz,** California Alliance
- Amanda Levy, CA Department of Managed Healthcare (DMHC)
- Amanda Miller-McKinney, Children Now
- Andrea Tolaio, Family Service Agency of the Central Coast
- Casey Heinzen, Department of Health Care Services (DHCS)
- Chad Costello, California Association of Social Rehabilitation Agencies (CASRA)
- Corinne Kamerman, CA Department of Health Care Services (DHCS)
- Curt Guillot, California Governor's Office of Emergency Services (CalOES)
- Diana Vasquez-Luna, CA Department of Finance
- Ivan Bhardwaj, Department of Health Care Services (DHCS)
- Jacob Ruiz, Riverside University Health System
- Jana Lord, Sycamores
- John Boyd, Kaiser Permanente (Northern California)
- Ka Ramirez, Department of Health Care Services (DHCS)
- Kenna Chic
- Kirsten Barlow, California Hospital Association
- Lauren Finke, The Kennedy Forum
- Melissa Lawton, Seneca Family of Agencies
- Michelle Galvan, Optum Public Sector San Diego
- Narges Dillon, Crisis Support Services of Alameda County
- Phebe Bell, Nevada County Behavioral Health Department
- Raven Lopez, County Behavioral Health Directors Association of California (CBHDA)
- Reuben Wilson, Los Angeles County Department of Mental Health
- Ryan Banks, Turning Point of Central California
- Shari Sinwelski, Didi Hirsch
- Stephanie Welch, California Health and Human Services Agency (CalHHS)
- Tara Gamboa-Eastman, Steinberg Institute

Public Comment Overview

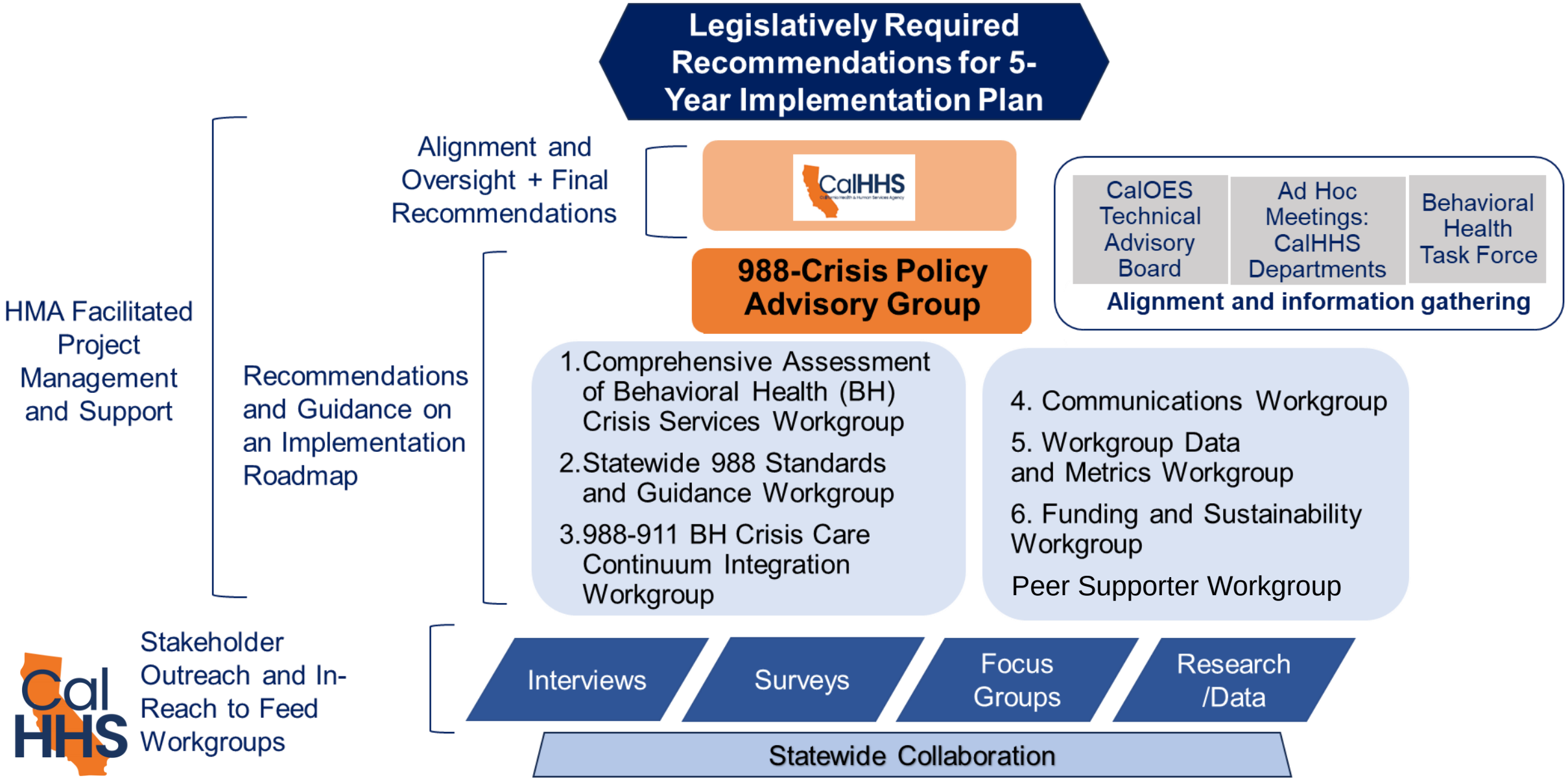
- **All comments—whether written or spoken—will be shared with the Work Group in the meeting minutes.**
- We will take comments in the order in which we receive sign-ups.
- If you are on Zoom and would like to make a public comment, please raise your hand at any point throughout the discussion. We will then write down your name and call on you to speak during the public comment period.
- Each person will have 2 minute to speak. If you have a condition that may require an accommodation (such as additional speaking time), please notify the project team and we will do our best to provide that accommodation.
- If you would like to make a comment but prefer not to do it in front of a camera or microphone, you may email your written comment to the project email address: AB988Info@chhs.ca.gov.

Code of Conduct

- Presume positive intentions
- Ask from a place of inquiry
- Be present and stay engaged
- Be brief and brilliant
- Be respectful and courteous

Note: Meetings of the Work Group are open to the public and are subject to Bagley-Keene Open Meeting Act requirements

AB 988 Organizing Structure



Workgroup 6: AB988 Required Areas

AB 988 Required Areas	How It's Being Addressed
(13) Procedures for determining the annual operating budget for the purposes of establishing the rate of the 988 surcharge and how revenue will be dispersed to fund the 988 system consistent with Section 53123.4 and Section 251a of Title 47 of the United States Code.	• CalOES has developed procedures and processes
(14) Strategies to support the behavioral health crisis service system is adequately funded, including mechanisms for reimbursement of behavioral health crisis response pursuant to Sections 1374.72 and 1374.721 of the Health and Safety Code, including, but not limited to: 1. To the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, seeking to maximize all available federal funding sources for the purposes of behavioral health crisis services and administrative activities related to 988 implementation, including federal Medicaid reimbursement for services; federal Medicaid reimbursement for administrative expenses, including the development and maintenance of information technology; and federal grants. 2. Coordinating with the Department of Insurance and Department of Managed Health Care to verify reimbursement to 988 centers for behavioral health crisis services by health care service plans and disability insurers, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code and consistent with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. Sec. 1185a).	• Focus of WG 6

Review of Previous Discussions (1)

Discussion 1: Based on the parameters outlined in the legislation and applicable codes, **how could funds be best utilized to ensure an effective, equitable, and accessible crisis response system?**

What We Heard From You:

- Staffing for 988 Crisis Centers Include supervision/ overhead
- Overhead to gather data
  - Ensure system capacity to manage volume
- Training
- Technology
  - Shared 988-mobile platform/visibility if possible
- Promotion/Education (if allowable)
- Mobile Crisis-Specific Costs (e.g., travel, downtime, uncompensated services *including people who do not share their identification information)
- Commercial funding is different from fee funding – need to manage both to ensure that fees are covering true gaps in the system
- Need to understand other funding that is supporting 988 Centers

Other Considerations Raised:

- Maximize Medi-Cal and Other Funding Sources First
- Commercial Reimbursement Challenges
- Contract/Funding Model Challenges:
  - Volume vs Flat Fee
  - Differences in Mobile & 988 Funding Models
- Number of Centers/Who Can Be Centers
- Connection with Other Medi-Cal Initiatives
- Can a Crisis Center access surcharge funds to build capacity (short term) – what are we doing to ensure equitable access? – Cal OES is exploring ways to create this process
- Is there a case for prioritizing answering 100% of calls?
- How are mobile crisis units currently funded? What are main populations that are accessing mobile crisis (are there opportunities to leverage other funding sources for this care?)- primarily funded through State and Federal funding – encounter-based fee-for-service

Review of Previous Discussions (2)

Discussion 2: What criteria should be considered in order to receive 988 surcharge dollars?

What We Heard From You:

Measurement & Reporting:

- Volume (988 Calls, Texts, Chats)
- KPIs (e.g., time to answer, answer rate, abandon rate, etc.)
- Referrals/Connections to Mobile Crisis & Other Services
- Annual Expenditure and Outcomes Report

Partnerships:

- Mobile Crisis
- County Access Lines
- Warmlines
- Local Providers/Other Resources

Federal/Vibrant Requirements:

- Accreditation
- Inclusion in National Network
- Quality management/ assurance

Other Considerations Raised:

- Connection to Local Communities (staffing, resources, etc.)
- Data Gathered from Callers - Balancing Data Collection Expectations w/ Privacy
- Data collection/ reporting beyond the KPI data
- Training and supervision
- Logic model for Mobile Crisis teams to have funds for supplies to support engagement (shoes, water, etc.)
- ICMI includes a list of items needed
- 911 diversion work needs to be taken into account – what additional staff are needed to collaborate with PSAPs?
- Need to ensure that we take care of the people who answer the needs (calls, mobile crisis, etc.)

Crisis Reimbursement Workstream and Lessons Learned from Washington

AB 988 Required Recommendation Topic 14

Strategies to support the behavioral health crisis service system is adequately funded, **including mechanisms for reimbursement of behavioral health crisis response** pursuant to Sections 1374.72 and 1374.721 of the Health and Safety Code, including, but not limited to:

(A) To the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, seeking to maximize all available federal funding sources for the purposes of behavioral health crisis services and administrative activities related to 988 implementation, including federal Medicaid reimbursement for services; federal Medicaid reimbursement for administrative expenses, including the development and maintenance of information technology; and federal grants.

(B) Coordinating with the Department of Insurance and Department of Managed Health Care to verify reimbursement to 988 centers for behavioral health crisis services by health care service plans and disability insurers, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code and consistent with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. Sec. 1185a).

CalHHS

Crisis Reimbursement Workstream

- CalHHS has been meeting with representatives from DHCS, DMHC, the California Association of Health Plans, community based organizations, and county representatives to explore challenges and opportunities, and for the state to assist in providing information about billing pathways for crisis service reimbursement.
- This work is a high priority of CalHHS and will continue past the development of the implementation plan.

Crisis Reimbursement Workstream: Challenges & Supports

Below is an excerpt of several challenges relating to commercial reimbursement we've heard in this Workgroup and other discussions. **What resources do you have or are you aware of that would support the work of the crisis reimbursement workstream?**

- Counties have noted that a significant percentage of mobile crisis responses are for individuals without Medi-Cal
- Some counties have attempted (often unsuccessfully) to bill commercial plans for mobile crisis services, while others have expressed not knowing how to bill health plans
- Counties attempting to bill commercial plans for mobile services have noted the difficulty of gathering the required information during crisis response
- Commercial plans have noted receiving incorrect or incomplete information which can delay or preclude reimbursement
- Commercial plans have limited experience with mobile services and call centers
- How are we distinguishing between BH Crisis care versus aftercare (support groups)? Using MediCal definitions in Medicaid SPA
- Misdirected claims is an issue that can be addressed (needs to be addressed) – need TA on both sides – provider and plan. Providers need to know what codes to use, what information needs to be gathered at the point of service, Plans need support to understand more about the types of care that is being covered by MediCal currently
- Need uniformity in claim submission processes – can the Plan have some mechanisms (accountability for ensuring claims are managed internally by the appropriate departments, timely payment of claims)
- How often are crisis providers unable to collect insurance information at the time of crisis – can we start collecting
- How about people with high deductible plans who end up being billed for care received in the moment of crisis
- Providers need authority to render crisis care regardless of whether in network or not. Need clear guidance about what providers can do – break down barriers for crisis care
- Aftercare – Counties work to connect people with their covered services post crisis – aftercare is sometimes unbillable – when does the crisis end (from a reimbursement standpoint)
- Question – what will come from the conversations with health plans and DMHC?
- Recommendation that FURS be considered to be crisis aftercare for youth in the child welfare system.
- guidance needs to make it clear that experiencing a behavioral health crisis is not synonymous to being on an involuntary LPS hold. To the contrary, people should be able to get immediate help for an urgent concern without fear of being involuntarily detained. It is important for people to have access to crisis care without having to be placed on a 5150 hold
- Need to remove the "requirement"/ perception that a person must start in a hospital for care- would be important to create alternatives to ED and jail care
- Some examples of healthcare providers saying that the insurance won't cover crisis care unless it is for a person on a 5150 hold

Commercial Carrier Coverage of Crisis Funding

Lessons Learned from Washington State

In January 2023, House Bill 1688 went into effect. This Bill:
Changed the definition of emergency services to include post-stabilization services. The change extends the payment requirements and balance billing prohibitions to the entirety of the emergency visit or admission.

What WA State has learned from this work:

- **Commercial Plans and self-insured plans needed support to:**
  - Understand the different service definitions of care offered in BH crisis care
  - Expand the provider types allowed to bill (to include Certified Peer Support Specialists, unlicensed Master's level therapists, Bachelor's level technician staff, etc.)
  - Develop reimbursement rates for crisis care, post crisis follow-up services
- **Crisis Providers needed support to:**
  - Negotiate contracts with commercial insurance plans
  - Bill commercial plans for crisis care
- **Commercial Plans, Crisis Providers and the State are working to:**
  - Define the expected procedures and rates for those individuals who are unwilling or unable to give identifying information at the time of the crisis
  - Develop reimbursements that support some % vacancy to ensure open access to care at the time of the crisis

Review and Discussion of Draft Implementation Activities

988 5-Year Implementation Plan

- The Implementation Plan is grounded in recommendations by the Policy Advisory Group to the State (via a set of “should” statements)
- The focus of the Plan is on the integration of 988 Crisis Lines into the Crisis Care Continuum in alignment with AB988 and related funding
- The plan and the work over the last months have highlighted key issues and areas across the continuum that need to be resolved over the 5-year planning and beyond
- The draft implementation activities focus on areas where the state has responsibility and accountability for coordinating behavioral health transformation efforts – at various stages of development – at a statewide level
- To get to a next level of detail on implementation activities will require time, resources, and ongoing discussion

Organizing Framework - Key Terms

- **Goals** = Describe the necessary components to realize an equitable, accessible, high-quality crisis system for all Californians
- **Recommendations** = Describe proposals aimed at guiding *state actions* relevant to AB988 and/or improvement to the broader crisis care continuum
- **Cross-Cutting Factors** = Key considerations that should be reflected in each of the goals and/or implementation activities.
- **Implementation Activities** = Describe more specific actions that *state departments* can take to operationalize a given recommendation

Are we doing the ***right things***?

Are we doing ***things right***?

VISION
Equitable, Accessible, High-Quality Behavioral Health Crisis System for All Californians

GOALS

A. Public Awareness of 988 and Behavioral Health Services	B. Statewide Infrastructure and Technology	C. High-Quality 988 Response	D. Integration of 988 and the Continuum of Services
Increase public awareness of and trust in 988 and behavioral health crisis services	Establish the systems to connect help seekers to the appropriate call/chat/text takers	Support the delivery of high-quality 988 services for all Californians	Increase equitable access to a coordinated system of behavioral health crisis services
Will a help-seeker know who to call?	Will a help-seeker be routed appropriately?	Will the help-seeker receive a high-quality 988 contact?	Will the help-seeker have access to immediate and ongoing care?

CROSS CUTTING FACTORS

- Data
- Funding and Sustainability
- Peer Support

Draft Implementation Activities

Recommendation: The State should implement strategies to support sustainable crisis systems at the local level that are connected to broader behavioral health transformation efforts

Implementation Activities (Draft)
a. Convene state entities, organizations and implementation partners (e.g., California health plans, behavioral health and state regulatory agencies) with the goal of ensuring/ defining network adequacy for BH Crisis care Sustainability – coverage of post-vention and prevention – address how to fund components of the full continuum
b. Provide training and technical assistance to providers and health plans to maximize reimbursement of crisis services by health plans need to strengthen this to reflect solving the issue of Counties needing to contract with multiple health plans
c. Establish a process to ensure revenue from the 988 surcharge is not used to supplant existing federal, state or local funding
d. Establish a process and related criteria for when funding from the surcharge fee can be used to support community-based crisis response not covered by Medi-Cal or other sustainable funding sources

- Will new CALOES system incorporate a form to capture information to support (insurance billing)?
- Need to solve for the cost sharing issues to prevent balance billing for BH crisis care
- Integration into broader BH transformation efforts and planning
- How do we address a broader definition of BH crisis and build sustainable funding approaches for full continuum – include aftercare and inclusion of people with lived experience in the provision of Crisis Care
- Can we learn from the 911 system and the way it is funded?
- Need clarity about what functions we expect 988 call centers to own – what parts can be billed for, what should not be billed (call/ chat/ text)
- What are expectations re: billing between 988 versus County crisis lines
- Is texting an allowed modality for Medicaid? – Are there youth serving text services that are receiving Medicaid $$?
- How do we address the expectations of the caller related to service/ billing, etc.?

Public Comment Period

Public Comment Guidelines

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- If you prefer, you may email your written comment to the project email address: AB988Info@chhs.ca.gov
- Each speaker is allocated 2 minutes to speak unless adjusted by the meeting facilitator.
- A speaker may not share or relinquish any remaining time they have not used to another speaker.
- Speakers may share one time during the public comment period.
- If time in the agenda remains after all individuals who signed up to speak have been called, the facilitator may invite other members of the public to raise their hand to speak. The facilitator will call individuals in the order they raise their hand.
- Speakers shall be civil and courteous in their language and presentation. Insults, profanity, use of vulgar language, or gestures or other inappropriate behavior are not allowed.
- Speakers should not ask questions of Workgroup members or ask Work Group members to respond to their comments directly.

Next Steps

Moving Forward

- All information from today's meeting will be posted on the CalHHS website on the 988-Policy Advisory Groups webpage: Link to Website for CalHHS 998 Crisis Policy

Adjourn