January 13, 2023

Jacey Cooper
Chief Deputy Director, Health Care Programs
State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor
Sacramento, CA 95814

Dear Chief Deputy Director Cooper,

The California Alliance of Child and Family Services (the Alliance) is pleased to submit comments and recommendations regarding the California Behavioral Health Community-Based Continuum Demonstration. We thank the Department of Health Care Services (DHCS) for presenting its proposed framework at several public meetings and soliciting feedback from stakeholders. The Alliance represents 160 non-profit community-based organizations that provide services and supports to children, youth, and families in public human services systems.

After careful review of the external concept paper dated November 2022, the Alliance has the following observations and recommendations:

Evidence based practices

DHCS intends to clarify statewide coverage requirements and ensure access to at least three evidence-based practices (EBPs) for children, youth, and their families: MST, FFT and PCIT. Will DHCS create an implementation plan to "scale up" these EBPs, especially MST and FFT? How will the costs of training and consultation be sustained beyond the initial launch of the EBPs?

MST is designed to provide 24/7 treatment access to clients. How does DHCS envision additional implementation support to counties and contract providers to address issues of staffing, support in technology, and other logistical support?

We recommend that DHCS allocate additional funding to offset costs to counties and contracted providers to train their staff to deliver the evidence-based practices. For your information:

- For FFT, the training protocol involves 11 days of training in the first year, with the additional weekly consultations throughout the first year
- For MST, the training protocol also includes a 5-day training and weekly consultation calls, and supervisor training protocols
- For PCIT, the protocol involves a 10-hour web course, additional post-web-course skill building, 100 hours of training and case completion

Given the workforce crisis facing the public mental health system, DHCS' selection of the three evidence-based practices that rely on clinicians is very concerning. We strongly recommend the addition of other evidence-based practices that leverage train-the-trainer model or paraprofessionals as well as community defined practices.

To highlight this example further:

- FFT requires a team of 3-8 Master's Level therapists
- MST requires a team of clinicians and supervisors
- PCIT can only be implemented by clinicians and Train Other Trainers (TOTs) who are also clinicians / supervisors

We would like to see other evidence-based and promising practices included in options for providers, particularly those that address substance use. For instance, Multidimensional Family Therapy (MDFT) is a family-based service that addresses co-occurring mental health and substance use issues for adolescents aged 11+. This has been demonstrated to provide better outcomes than residential programming for substance use, and we strongly encourage the department to include it, along with others, that can be implemented through the waiver.

We appreciate DHCS' intent to expand and strengthen the continuum of community-based care, especially for children, youth and their families. We encourage DHCS to also include Child First as an additional evidence-based program to expand the Statewide Continuum of Community-Based Services and to provide clear guidance to support implementation accordingly. The Child First model works with the most challenged young children (prenatal through age five years) and their families, helping them heal from the damaging effects of stress and trauma. Most Child First families live in poverty, frequently experiencing depression and other mental health challenges, substance use, domestic violence, homelessness, and racial and ethnic inequities.

Cross Sector Incentive Pool

We support the establishment of a cross-sector incentive pool. We recommend that there be a requirement that incentives will be shared with community-based contract providers that help the three systems achieve specified measures given that CBOs are the backbone of service delivery in our State for children and families in public systems. Expansion of this incentive pool to include the Juvenile Justice and Developmental Disabilities/Intellectual Disabilities (DD/ID) sector would be ideal.

As part of the cross-sector incentive pool implementation (page 16), DHCS proposes to require Managed Care Plans (MCPs) to have dedicated foster youth liaisons. We need to ensure that the work of these new liaisons do not duplicate services provided by existing staff in the local behavioral health departments or local county child welfare sectors. Reducing duplication of efforts and supports is essential to an effective and integrated system of care.

Activity Stipends

We appreciate the change from MCPs to counties, and are very supportive of how critical activity stipends will be for current and former foster youth. We have several key recommendations on how these funds can be best utilized and operationalized:

- There needs to be a clear and administratively simple way for community-based organizations to access the funding to provide stipends to the youth. In many large counties, CBOs are delivering the overwhelming majority of services to children and families in public human services systems.
- We recommend that there be no age minimum for activity stipends - i.e. removing the three year old minimum. Our members find that there are specific sensory activities that really benefit young kids - particularly those that have been substance exposed. These include early swimming lessons / parent

and child water lessons, climbing and tumbling classes, early gym classes offered through community centers, and art/ hand painting classes.
- We recommend that in addition to the activities that activity stipends be able to cover the costs of certain equipment and clothing costs. For example, a youth may need running shoes, sports clothes, a basketball, etc. to fully participate in the activity they are interested in.
- For transition-aged youth we recommend that there be flexibility in the stipends to cover mindfulness activities including yoga, ability to pay for gym memberships/ rock climbing gyms, and community sports (e.g. adult kickball leagues).

Centers of Excellence

Regarding the establishment of Centers of Excellence (CoEs) to support statewide practice transformation, we strongly urge DHCS to leverage the knowledge and expertise of current Centers for Excellence as it considers practice transformation. We also believe that having a COE focused on children and youth is essential.

FFP for Short-Term Stays in IMDs

We continue to be concerned that the Institutions of Mental Disease (IMD) component of the waiver is an opt-in by county. This will not address the lack of available residential treatment beds available in the system, particularly as STRTPs have had to reduce their capacity to avoid IMD designation. Only three STRTPs in the state are currently designated as IMDs, and they take youth from many different counties. The way that DHCS is approaching this as a county of residence vs. county of service issue, there will be little incentive to expand services to youth. There needs to be statewide support and rate relief for STRTPs. As written, this will leave many youth in shelters and on the street, with their behavioral health needs unmet.

As it relates to county option to provide enhanced community-based services:

- Will flexibility be built into the delivery of the named evidence-based practices (ACT, FACT, CSC for FEP, Supported Employment)?
- Will Supported Employment activities need to be billed to the Medi-Cal program by staff or will a county that "opts in" reimburse Supported Employment activities through stipends?

Rent/Temporary Housing for Up to Six Months for Beneficiaries Who Meet the Access Criteria SMHS, DMC and/or DMC ODS Services and Who are Homeless or at Risk of Homelessness, Including Individuals Transitioning from Institutional Care

We are supportive of the ability for Medi-Cal to pay for rent/ temporary housing for beneficiaries that meet access criteria and are experiencing homelessness or at risk of homelessness. However, we are concerned about ongoing funding that will be needed after the 6-month time frame, the lack of housing that is available, and the different kinds of housing that will be needed (i.e., supportive housing). It is critical for the TAY population and service providers to be involved in the decision making about how this is implemented, particularly since a population of focus is for individuals transitioning out of the child welfare system.

Initial Child Welfare/Specialty Mental Health Assessment at Entry Point into Child Welfare

DHCS proposes that a specialty mental health provider accompany the child welfare worker during the home visit. The CA Alliance agrees with the concept of providing a joint child welfare and SMHS assessment as a

child or youth enters the child welfare system but are concerned given the workforce crisis and shortage of staff how feasible this will be in all cases. Additionally, it will be critical to ensure that if families are identified as needing a service, that there is a network of service providers to meet their needs.

Treatment Bed Availability Platform

The idea of a live treatment bed locator has significant merit to streamline access to beds and ensure that as many beds are utilized in any given moment. However, there is very little detail in the concept paper on how this will be operationalized, and it is significantly complex. We request additional details from DHCS on how you intend to operationalize this requirement of the waiver and which settings does this apply to? Does this just apply to inpatient settings, or does it extend to residential care including STRTPs?

Promotion and Standardization of Quality of Care in Residential and Inpatient Settings

While we support the idea that residential and inpatient settings should be high quality and that standards of care are important, the CA Alliance is concerned about this effort leading to unnecessary additional regulation and oversight of organizations. STRTPs are nationally accredited, and must follow regulations developed by both CDSS and DHCS. The level of scrutiny of these programs is already very high, and frequently new requirements and regulations are imposed without additional funding to support them.
As DHCS works to more clearly articulate the details on this effort, engagement of these programs will be critical.

Accountability

We are supportive of DHCS' inclusion of a focus on improving statewide county accountability for Medi-Cal Services. We have continued to be dismayed by the lack of implementation of CalAIM elements that should reduce administrative burdens and staff time on documentation. We are also concerned that no increased access to services has occurred for the populations (including foster youth) that have been identified through BHIN 21-073. Will this level of transparency be required of all counties, or only those that opt into the waiver?

Gaps in Proposal

We do not see specifics in the proposal that will improve these currently identified as gaps in the system and believe that these need to be addressed either through the waiver or elsewhere.

- Substance Use Services for Youth – it is widely known that there is a dearth of substance use services available for children and youth in California. It seems that this waiver could be used to specifically target increased rates, specific interventions (such as MDFT) and other incentives for counties, MCPs and providers to stand-up programs for youth. One of the biggest gaps that we see is the ability to provide substance use services to youth in residential settings, particularly STRTPs. STRTPs currently must have an entirely separate contract with a DMC-ODS plan, bill through a separate system, go through a separate audit and utilization review process, and receive rates that are often half or less for very similar services to deliver SUD services in STRTPs. We urge DHCS to outline in the waiver ways that counties can address these gaps and ways to offer integrated behavioral health services in STRTPs.

- Transition Aged Youth – there is very little outlined in the proposal that addressed the needs of TAY, and specifically TAY who are transitioning from foster care. With 25% of TAY foster youth ending up homeless, it seems that some specific programming targeted to address the gaps in services and supports for this population should be outlined in the waiver. For example, the Alternative Benefit

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Program for Former Foster Youth could extend EPSDT services for these youth and provide more robust services for TAY that are transitioning from foster care. We would like to see this population specifically addressed in the waiver proposal.

- Justice-involved and At-Promise Youth – While much of the focus is on child welfare youth, it is less clear what parts of the waiver apply to youth that are involved in the juvenile-justice system that are not child welfare involved. We recommend Explicitly specifying the "At-Promise" and "Justice-Involved" children/youth would help to ensure that the needs of these vulnerable populations are intentionally addressed as part of the demonstration.

Associated questions and comments:
In addition to specific feedback on the waiver document, we would ask that DHCS address these questions.

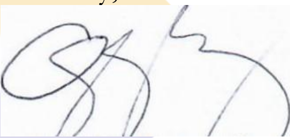
1. Will DHCS extend the backfill for FFP for specialty mental health services (beyond June 2023) to counties while the 1115 waiver application is in process? If not, there will be no current STRTP providers that will be able to participate as they will have transitioned their services array. We strongly urge the department to work with CDSS to develop a plan for organizations that have capacity to provide intensive behavioral health services to have the support needed to maintain operations while the waiver application is in process. As a critical part of the continuum that DHCS is trying to support, these organizations must get the pathway to participate in a county's waiver proposal.

2. There is a significant need for greater interagency integration at the state level between DHCS and CDSS – there continues to be a lack of understanding of the various funding mechanisms that provide services through each department, and when trying to design policy and processes for children and youth in multiple systems, this is a significant issue. We would like to see specific staff roles developed that work across the agencies (including DDS and Education) to ensure that all of the state departments are working in tandem to align financing of programs and services.

3. We continue to believe that there are programs and services (like Wraparound) that could be expanded to all Medi-Cal youth without an 1115 waiver. We encourage DHCS to monitor access to these and other services that could be being provided now but are underutilized or inaccessible due to contract limits and other county-level barriers. There are other state and local dollars that could be accessed to support FFP and draw down more federal dollars without having to implement a full waiver process.

Thank you for your consideration of our comments, recommendations, and questions. We look forward to future dialogues with DHCS and other stakeholders to further refine the Behavioral Health Community-Based Continuum Demonstration.

Sincerely,



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