December 23, 2019

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

Subject: CalAIM Proposal -- Payment Reform Comments and Recommendations

Dear Ms. Cooper:

The California Alliance of Child and Family Services (the Alliance), the California Children's Trust (CCT), and the Association of Community Human Services Agencies (ACHSA) are pleased to submit comments in response to the California Advancing and Innovating Medi-Cal (CalAIM) initiative led by the Department of Health Care Services. The enclosed feedback and recommendations are specific to the payment reform elements of the CalAIM proposal.

The CalAIM proposal creates promising opportunities to increase access to quality care for children and youth. To make the most of this Medi-Cal transformation, we urge DHCS to prioritize the following goals:

- **Establish a workgroup of representatives from child-serving agencies** to maximize state and local funding for Medi-Cal Services
- **Ensure rates are adequate** -- rates must cover the full cost of providing services, in order to capitalize on CalAIM's potential to improve access to quality care.
- Reimbursement systems should **expand the role of non-clinical providers**, including peers with lived experience and parent partners, in the design, delivery, and evaluation of programs and services
- **Create a set of standardized documentation requirements** based exclusively on federal requirements.
- Ensure the **switch to Level I codes** maintains **full coverage for all Specialty Mental Health Services** and creates opportunities to **further streamline documentation**.

The Transition to Intergovernmental Transfer-Based Funding

We support CalAIM's proposed move from Certified Public Expenditure (CPE)-based funding to Intergovernmental Transfer (IGT)-based funding. This evolution creates invaluable opportunities to increase funding for Medi-Cal services. We encourage DHCS to work closely with counties and providers to maximize local funding sources as a means of increasing federal match. In addition, we look forward to working with DHCS to transform the state's overly burdensome documentation demands with an efficient reimbursement process based exclusively on the federal CMS requirements. DHCS should ensure that **the transition to IGT requires alignment with the implementation of HCPCS Level I codes to ensure that that the payment and claiming system designed meets the goals outlined in CalAIM**.

As the state considers the shift to IGT as a fiscal model for Medi-Cal services, we offer the following recommendations:

1. **Establish a Workgroup of Representatives from Child-Serving Agencies to Maximize State and Local Funding for Medi-Cal Services**

It is critical that DHCS explore how the IGT mechanism can be used to leverage federal reimbursement on existing expenditures in other child-serving systems. Critical to addressing the youth mental health crisis is increased funding for mental health and social-emotional supports for children and families in their communities. This means a dramatic increase in the scope and nature of programs available in schools and other child-serving systems. We urge DHCS to take full advantage of this opportunity by playing a leadership role in marshalling existing sources of state and local funds that could be used to earn additional federal Medicaid funds. DHCS should create a workgroup of experts from all child-serving systems (including education, child welfare, juvenile justice, and developmental disability services) in order to create a plan to coordinate and pool these existing but currently unmatched sources of local and state funding.

2. **Clarify and Engage Stakeholders in Understanding the Proposed Implementation of an IGT-Based Funding System with Respect to Federal CMS Guidelines and Administrative Claiming**

We request that DHCS clarify whether MHPs will be able, under the IGT system, to claim a higher service rate for purposes of claiming Federal Financial Participation (FFP) compared to the lower rate it would pay providers for that service. It appears that this approach might

contravene regulatory guidance recently proposed by CMS[1] that requires that federal matching funds be based solely on Medi-Cal expenditures, and that all federal funds generated by those expenses be retained by the provider who delivered the service.[2]

In addition, please clarify the impact of the change to an IGT-based system on MHP administrative costs. Currently, under the CPE-based system, there are three types of administrative costs that MHPs may claim: 1) Administration (capped at 15% of total cost under Medical Loss Ratio rules) 2) Medicaid Administrative Activities (such as program planning and policy development); and 3) Utilization Review and Quality Assurance. We ask that DHCS clarify how these costs will be handled under CalAIM.

3. Create a Statewide Set of Standardized Documentation Requirements

IGT also creates an opportunity to streamline the plethora of administrative barriers that restrict access to services. Most importantly, the Alliance, CCT, and ACHSA strongly urge DHCS to create a set of statewide documentation forms and requirements that are standardized across all counties. In the absence of clear guidance and limited audit exposure from DHCS, our state now has 57 sets of requirements for SMHS documentation, a system which burdens mental health workers serving children in multiple counties. This fragmented system creates a myriad of barriers to care, including those listed below.

- **Screening that results in denying children access to SMHS**. In spite of DHCS guidance regarding the difference between children and adults[3], some MHPs require providers to complete medical necessity "screening" forms that incorrectly indicate that children are not eligible for SMHS unless the level of their mental health impairment is severe. These requirements risk denying services to eligible youth; DHCS has confirmed that county MHPs should serve all youth with a SMHS covered diagnosis – regardless of their level of their impairment.

- **Complex documentation rules that vary from one MHP to the next**. While this variation occurs in county MHPs throughout the state, it is especially problematic when neighboring counties utilize differing documentation requirements. In the densely populated areas of the state, for example, youth are particularly likely to move between counties, and mental health staff often work with clients in several counties. As a result, variations in documentation rules for nearby counties create even greater administrative burdens for staff. We list just a few examples below.

    - **Different Definitions of the Word "Collateral"**

[1] Federal Register / Vol. 84, No. 222 / Monday, November 18, 2019 / Proposed Rules

[2] https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2019-medicaid-fiscal-accountability-regulation-mfar

[3] https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-018.pdf

In one county, the question of whether a service must be billed as "Collateral," rather than "Case Management," hinges on the type of person with whom the staff has communicated. In contrast, in another, the definition of "collateral" services depends on the type of communication[4].

- **Different Rules Regarding What Services Are Billable**

In County A, for example, observations of a child's behavior in the classroom and consultations concerning the client between two staff with the same provider organization are both billable services. In County B, however, the same services usually are not billable[5].

- **Different Requirements Concerning Who Can Write Plan Development Notes**

In County B, for example, BA level staff can bill for writing plan development notes, while they cannot bill for the same service in County A.

- **Requirements that Forms be Submitted in Different Colors**

One county requires providers to submit specified SMHS documents on paper of a particular color. "Consent for Coordinated Services" forms, for example, must be on lilac paper, while Service Authorization forms must be green. Treatment plans must be pink – but NOT salmon – because that color is reserved for yet another form.

- **Document Sharing Between MHPs**

Because documentation requirements differ from one MHP to the next, MHPs will often not accept SMHS paperwork for youth who move to a new county. As a result, at a time when children are facing the stresses of moving to a new home, their mental health counselors are forced to spend valuable time completing a new set of duplicative paperwork. This also contradicts DHCS's emphasis on continuity of care.[6]

- **Frequently Shifting MHP Rules That Appear Arbitrary and Capricious from the Provider Perspective**

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[4] In County A, "collateral services" are defined to include communications with a "significant support person," such as a caregiver. Communications regarding the client's care with other types of people are considered "case management." In another county, "collateral services" can include collaborations concerning the client's treatment, which can include discussions with teachers and other providers. "Case management," in contrast, refers to follow up and monitoring services.

[5] In County B, these services are billable only if performed as part of the development of a new treatment plan, a time-consuming process that requires staff to obtain the caregiver's signature on the new plan, which usually entails requiring the caregiver to travel to the provider's location.

[6] https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-059_Continuity_of_Care/MHSUDS_Information_Notice_18-059_Continuity_of_Care.pdf

Although counties provide thick manuals describing county-specific documentation requirements, county MHP reviewers also frequently reject claims based upon changing documentation rules and seemingly arbitrary enforcement practices. One county MHP reviewer, for example, disallowed over $37,000 in claims for the entire three-month review period simply because a provider submitted a DSM 5 Change of Diagnosis form one day before the MHP was scheduled to begin accepting the new form.

We acknowledge that many of the MHP-specific documentation rules outlined above stem from a legitimate desire to avoid recoupments in state and federal audits. **This also stems from a lack of coordination between DHCS staff responsible for issuing MHSUDS information notices and the contracted auditors tasked with chart reviews and recoupment.** However, the documentation problems flagged in last year's federal audit[7] were clearly substantive, such as a failure to provide any progress notes or a lack of documentation that a service was provided. These legitimate grounds for recoupment differ from the MHP-specific issues detailed above. These examples further demonstrate the need for a single set of state-approved forms, supported by training and guidance from DHCS, and consistency between those that provide training and those that audit charts.

Per DHCS' request at the December 13 workgroup meeting, providers are currently preparing materials to outline the current billing and claiming process from the CBO perspective, to be shared in early January 2020.

Finally, we understand that federal law requires providers to maintain medical records that fully disclose the extent of services provided (42 U.S.C. 1396a(27)) and that providers must follow billing code documentation rules established by the National Correct Coding Initiative. **We urge DHCS to ensure MHPs utilize these minimum federal requirements**, rather than imposing additional, county MHP-specific documentation demands, and that **DHCS auditors limit their scrutiny to the federal requirements as well.**

4. **Thorough and Ongoing Technical Assistance Across the System from DHCS will be Critical**

The inconsistent MHP documentation rules discussed above stem in part from a lack of clear guidance from DHCS regarding the steps MHPs must take to avoid audit recoupments. Under CalAIM, thorough training and guidance from DHCS will be critical to ensure that the new system does not revert to the fragmented and burdensome rules that currently clog the SMHS

[7] California Claimed Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services, Office of Inspector General, August, 2018, A-09-15-02040. The audit explained the expenditures were not reimbursable because of the following substantive errors: 1) the services lacked documentation showing they were medically necessary; 2) the services were not supported by a signed client plan; 3) the services were not supported by progress notes (in half of these cases, the plan could not provide any progress notes); or 4) no documentation that SMHS services were provided to the beneficiary.

delivery system. DHCS may want to explore the statewide Medicaid documentation guide prepared by Washington State, *IMC Service Encounter Reporting Instructions*, which provides billing documentation guidelines and explanations of CPT and HCPCS billing codes. The outdated but previously helpful EPSDT Chart Documentation Manual developed by CIBHS in 2007 served this purpose, and this could be expanded to include adult services documentation.[8]

Rate Adequacy and Rate Setting Process

Adequate rates are key to the success of CalAIM's system reform. They must be sufficient to cover all services necessary to screen for and "correct or ameliorate" a child's mental health "condition" -- as required by federal EPSDT law. California's current provider rates are far too low to meet this federal requirement; with less than 5% of eligible children receiving any SMHS service,[9] our state clearly is failing to ensure all youth receive the care to which they are legally entitled.

Rates also must be sufficient in order to ensure that providers can attract and retain qualified mental health staff -- a critical challenge considering the severe shortage of mental health workers in California. Our state currently meets just 30% of the demand for professionally trained behavioral health workers.[10] UCSF researchers predict that, in one decade, California will have 41 percent fewer psychiatrists and 11 percent fewer psychologists, marriage and family therapists, clinical counselors and social workers than will be needed.[11] In addition, the statewide unemployment rate remains near record-level lows of just over 4%, creating a "seller's market" for California workers, and enticing many mental health professionals to find jobs in the private sector and in higher-paying fields.

Further, SB 3 (Leno) was signed into law in 2016, requiring the state minimum wage to increase by $1 per year from 2019-2022. By 2022, all staff who work for an organization with 26 or more employees will earn at least $15. California labor law ensures that exempt employees make at least twice the state minimum wage to protect exempt employees from being unfairly compensated. Currently, employers with 26 or more employees must pay exempt employees $49,920. By 2022, such employers will have to pay exempt employees $62,400 to be compliant with labor law–the equivalent of a 20% wage increase in a little over two years. **Without rate increases to compensate for this exempt salary imperative, many nonprofit CBOs will be caught in an untenable situation and be unable to comply with state labor law.**

[8] https://www.cibhs.org/sites/main/files/file-attachments/epsdt_chart_documentation_manual_9-5-071.pdf?1354216612

[9] DHCS 2018 Performance Outcome System Children and Youth Reports.

[10] Kaiser Family Foundation: Mental Health Care Health Professional Shortage Areas

[11] Coffman, J., Bates, T., Geyn, I., and Spetz, J., Healthforce Center at UCSF (2018). *California's Current and Future Behavioral Health Workforce*.

In addition, **it is essential that DHCS ensure future rates are not based primarily on historical Medi-Cal spending patterns.** This approach would only perpetuate the profound inequities in access to care that currently exist between California MHPs. SMHS provider rates often correlate directly with the access that eligible youth have to Medi-Cal SMHS services. For example, a recent comparison of SMHS provider rates in Contra Costa and Santa Clara reveal that Contra Costa's rates are typically less than one-third of Santa Clara's rates. Not surprisingly, Santa Clara's penetration rate for children (5.3%) is significantly higher than Contra Costa's rate: (4.9%). Orange County, whose rates are roughly one-half of Santa Clara's, reports a distressingly low penetration rate of 2.8%.[12]

Instead, CCT, the Alliance, and ACHSA encourage DHCS to develop rates that ensure all children and youth can receive the care they need to thrive. Key factors include:

- Unique needs of the population served (for example: rural areas with significant transportation needs; low income areas with higher rates of social determinants of health; populations with particularly low penetration and/or utilization intensity rates).
- Areas with particularly challenging network adequacy issues. The ten counties who received financial penalties due to their inability to meet network adequacy requirements, for example, should be able to offer rates high enough to attract more critically needed mental health professionals.
- Provider criteria necessary to deliver quality care, including: staff experience and training; staffing ratios; worker caseloads; and staff language skills.
- The additional costs providers must incur to adapt to new CalAIM systems. These expenses will include new technologies, such as updates to electronic health record systems, as well as training for mental health workers and QA/QI staff on new billing and delivery systems. Historically, providers are not included in state budget allocations for system change and must simply adjust without adequate compensation or financial support.
- Clear standards regarding the types and amounts of services included in a set rate.
- A periodic rate adjustment tool that accurately accounts for increases in local costs of living as well as other cost increases.

Value-Based Payment Models

1. Use Value-Based Payment Approaches to Encourage Preventive, Early Intervention and Other High Value Mental Health Services

CalAIM presents an opportunity to enhance payment systems to encourage providers to deliver preventive, early intervention and other high value mental health services. The state has

[12] DHCS Performance Outcome Systems Reports for Fiscal Year 2014-2015.

pioneered this approach in its Global Pool Program Payment Point Values, which is designed to reward providers who deliver preventive, primary and supportive services in more appropriate settings and in more coordinated ways.

To build upon this approach via CalAIM, DCHS could expand its program of supplemental Medi-Cal payments as a transitional measure. Currently, DHCS uses funds from Proposition 56 (Tobacco Tax funds) to provide supplemental payments for plans and providers who deliver services described by a list of CPT codes. We applaud DHCS's recent inclusion of PEARLS screens among these services, and we encourage DHCS to expand the types of children's mental health care that qualify for supplemental payments. We look forward to working with DHCS to identify improved mechanisms for rewarding and incentivizing higher value services that reflect an investment in prevention and quality.

Specifically, DHCS should offer similar incentives for the following services:

- **Follow-Up Assessments and Early Interventions Necessary to Address Issues Identified in an ACEs Screens**

DHCS's decision to make PEARLs screens Medi-Cal eligible was a critical first step in ensuring more youth are screened for exposure to trauma and other key Social Determinants of Health. However, in order to ensure those screens bring meaningful benefits to children, providers also must be adequately reimbursed for any follow-up assessments and early interventions that address risks and emerging conditions uncovered by those screens. The condition-based eligibility category recommended in CCT's and the Alliance's December 16, 2019 comments, also included in comments submitted by the National Health Law Program, would help ensure these youth are found eligible for these critical early interventions.

- **Early Intervention and Support Services that can Lower the Risk a Youth will Need More Expensive Residential or Institutional Care** These services could include:

    - Infant-parent home visiting services such as the Infant-Parent Model of Consultation. These early intervention home visiting services, which have been found to reduce the effects of trauma, still fail to reach the vast majority of families who could benefit from them. Recent research, for example, found that, of the more than 151,000 California children who would benefit from evidence-based home visiting services, only about one in five (under 32,000) received those services. *Home Visiting Can Improve Outcomes for Children, But Few Receive Services*, California Center on Budget and Policy Priorities, July 2019.

    - In Lieu of Services (ILOS) Package of Early Intervention Services As proposed by the California Alliance and the California Council of Community and Behavioral Health Agencies in their ILOS Recommendations, dated December 2, 2019, DHCS

could create an additional package of early intervention support services for children (including, for example, respite care for parents of children at risk of Child Welfare involvement; parenting classes and support groups; and services to strengthen the family's natural sources of support. These services could provide a cost-effective alternative to more expensive services, such as Wraparound and Mobile Crisis Response services.

- Wraparound Services, Mobile Crisis Response Teams These services can lower the risk a child will need more costly residential care.

- More child psychiatrist services These incentives are crucial given widespread shortages of child psychiatrists participating in SMHS provider networks. According to USC Annenburg's Center for Health Journalism, California has fewer than 1,135 child and adolescent psychiatrists to serve almost 10 million children and teens younger than 18 years.[13]

- **Behavioral Health Services Delivered in More Accessible Locations, Such as Schools** Research tells us that youth are much more likely to access mental health services when they are delivered at a school.[14] Supplemental payments to schools could be used to encourage school districts to engage with MHPs and CBOs to provide more Medi-Cal funded mental health services. Leveraging CBOs as the providers of school-based mental health services ensures access to high quality treatment that can extend beyond the school campus and flexibly outside of school-day hours, and outside of the school year. And the EPSDT entitlement demands that children and youth receive the service that ameliorates their condition regardless of the calendar, school hours, or schedules.

- **Programs that Expand the Role of Non-Clinical Provides, Including Peers with Lived Experience and Parent Partners, in the Design, Delivery, and Evaluation of Programs and Services** As discussed above, California faces a workforce shortage crisis; expanding our supply of mental health workers must be a top priority. Most importantly, service providers such as peer counselors and parent partners increase the quality of care delivered. Studies demonstrate, for example, that the use of peer support specialists in comprehensive mental health or substance abuse treatment programs helps reduce client hospitalization, improve client functioning, increase client satisfaction, alleviate depression, and diversify the workforce.[15] In addition, the inclusion of more staff from

[13] https://www.centerforhealthjournalism.org/2019/04/22/there-s-huge-shortage-mental-health-providers-kids-who-need-help

[14] Journal of Adolescent Health, (01 Jun 2003, 32[6 Suppl]:108-118). See also:School-Based Health Alliance website: Access to Health Care

[15] The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization, Psychiatric Services, 69(10):1069-1074, October 2018; Evaluation of a Peer-Run Hospital

culturally diverse communities and other impacted populations is essential in order to shift power and economic opportunities to these communities.

- **Incentivize Early Screening and Intervention for Substance Use** It is critical to include in any early intervention package screenings for substance use in any improvements to screening and early intervention. This could include incentivizing use of the SBIRT (Screening, Brief Intervention, and Referral to Treatment) or other tools for healthcare and other professionals.

Transition to Level I HCPCS Billing Codes

As it implements the switch to Level I HCPCS codes, DHCS must ensure that providers can be reimbursed for all current SMHS services and that this change maximizes opportunities to streamline documentation requirements. We offer the following recommendations for consideration:

1. **Providers Must be Able to Continue to Bill for All Services Currently Reimbursable by Mental Health Plans**

As several participants mentioned at the Payment Reform Workgroup on December 13th, there are a number of services that mental health plans pay for that are not included in Level I codes. These services include: travel, transportation by service provider, phone calls, many rehabilitation services, and time spent documenting services. As all appeared to agree at the workgroup meeting, each of these services must remain reimbursable under CalAIM.

Transportation is an essential benefit that must remain fully reimbursable, at the same rate as the underlying service. As DHCS staff expressed at the December 13th meeting, it is critical that behavioral health staff are able to travel in order to work with clients in their homes and communities. We must urge DHCS to allow providers to continue to bill travel time as a portion of the underlying service delivered to the client. We strongly advocate for this approach because it will prevent MCPs and MHPs from reimbursing travel time at a lower rate than the rate for the primary service. We understand that DHCS would like providers to bill travel time separately, so that it can gather data reflecting time spent on the primary service. However, it is unclear why DHCS needs to gather this data, and how it will be used to improve access to care. Any disincentive to provide community-based services works at cross-purposes with DHCS' intention to ensure the provision of high quality and accessible treatment in alignment with best practice standards. This will also undermine the MHPs, MCPs and providers ability to meet the federal network adequacy requirements.

Diversion Program: A Descriptive Study. American Journal of Psychiatric Rehabilitation 14(4):272-286, November 2011

2. We Encourage DHCS to Preserve and Expand Opportunities For MHPs and Providers to Use Billing Codes that Minimize Documentation Burdens

We understand the need for the state to come into compliance with federal standards by shifting to Level I HCPCS billing codes. Because many Level I billing codes provide more detailed descriptions of the service delivered, this change should often reduce provider's documentation burdens. However, we have significant concerns regarding this potential change without rigorous study and crosswalking of current codes and documentation requirements. For example, if there is a Level II code that currently can be used to bill for a program that delivers multiple related services, and the switch to Level I codes will require the provider to bill multiple codes, that switch could result in significantly greater documentation burdens for providers. This may be especially true for providers of programs that deliver a package of related services to each client, such as Therapeutic Behavioral Services (TBS). It was clear in the December 13 Behavioral Health Payment Reform discussion that this has not been carefully studied and must be before any significant system-wide change is designed or implemented.

a. Establish Streamlined Documentation Standards for Mental Health Staff who Use Multiple Billing Codes for One Client in a Single Day

We understand that the state plans to establish peer group rates based upon HCPCS Level I billing codes, and that this is a necessary first step toward establishing case rates in the future. Provider members of the California Alliance, CCT, and ACHSA are in the process of gathering data reflecting the staffing costs of many SMHS services, and we stand ready to share that information with DHCS if it would be helpful to the rate setting process.

One key concern regarding a rate structure based on Level I billing codes is the risk that this system will continue to require mental health staff to prepare, for each billed unit of time, extensive documentation that far exceeds the level of detail needed from a therapeutic perspective. As explained below in our discussion of milieu-based treatment programs, many SMHS programs deliver a variety of complex and integrated services that are difficult and time consuming to capture in a series of multiple billing units tied to relatively short units of time. We therefore urge DHCS to explore and develop billing and rate structures that keep documentation demands to the minimum levels required under federal law and that offer staff the flexibility to document their services in longer units of time that can better capture the value of the care delivered.

Possible approaches include: 1) allowing staff to write one progress note per day that describes services delivered pursuant to multiple billing codes; 2) permitting providers to use Level II billing codes -- rather than a series of several more narrowly defined Level I codes -- when that approach enables staff to more efficiently describe the variety of services provided; 3) request changes to HCPCS Level I codes from CMS.

Below are specific examples of programs that can be more efficiently and effectively billed with a combined billing unit approach.

b. Confirm with MHPs that Day Treatment Programs can Bill with a Single "Bundled" Billing Code and Corresponding Rate

We ask DHCS to clarify that MHPs can use a single billing code to reimburse providers of some programs that offer a set of related services to an individual. For example, milieu-based day treatment programs, which serve youth and families with acute service needs in non-public schools, counseling enriched classrooms, and stand-alone day treatment programs, used to bill those services to MHPs at a single "bundled" per diem rate. This approach greatly reduced documentation burdens, because providers could use a single billing code and progress note to claim reimbursement for a range of interconnected services provided to a child throughout the day.

Unfortunately, more recently, MHPs have been reticent to allow providers to use a bundled rate for this service due to previous audit findings (many of which were later deemed erroneous and overturned), and the majority of milieu-based behavioral health services in California now are documented and billed under minute-to-minute billing requirements. This billing structure fails to capture many milieu-based services, including brief interventions that occur throughout the day; fluid interventions delivered in group settings; and non-verbal supports. Minute to minute billing also greatly increases the time workers must spend documenting each service, which severely weakens staff morale, and leaves much less time for services to children.

We request that DCHS clarify for MHPs that a bundled day rate for milieu-based services, in which services are billed at a standard rate per client per day of attendance, is an appropriate reimbursement option. This billing code could be similar to the Day Treatment services billing code, in which each youth receives a daily progress note and weekly clinical summary.

c. Develop Additional Flexible Billing Mechanisms that Enable Providers to Use a Single Billing Code for a Set of Intensive Integrated Services.

In addition to confirming that providers already can use billing codes such as H2012 (Day Treatment) for milieu-based day treatment, we encourage DHCS to create additional flexible billing options for other programs delivering a variety of coordinated services. Programs that deliver intensive, complex, and highly individualized services, such as Wraparound (ICC and IHBS), TBS, and crisis intervention services, are extremely difficult to bill on a minute by minute basis, for many of the same reasons that milieu-based services are poorly suited to by-minute documentation. Wraparound providers, for example, must be able to respond to a crisis on a 24/7 basis, collaborate with professionals in a variety of child-serving systems, and work creatively to help the youth build supports within their community. These strategies rarely fall

neatly into a 45-minute billing code. Moreover, these programs frequently are jointly funded by other child-serving systems, such as child welfare, that impose an additional set of service requirements. As a result, a bundled reimbursement rate that incorporates a variety of appropriate wrap strategies and is based on a daily, weekly, or even monthly rate will more accurately capture the value of the package of services provided.

Some states, such as Washington State, already have developed a monthly case rate for Wraparound services. In developing that rate, Washington policy makers considered several important factors that DHCS may want to incorporate when developing comparable bundled payment rates. Those factors include: extra hours of staff training; additional time in each day for cross-system coordination, documentation, and team meetings; and a significantly higher number of crisis hours per month, compared to monthly case rates for outpatient mental health services for youth in lower levels of care. And, of course, it would be important to consider how this would be designed in California, given our unique structures and wide range of service costs across the state. The success of any transition hinges on development of rates that cover the full cost of the services.

3. DHCS Should Create a Fee for Service Exception to Case Rates for Providers Willing to Accept "No Reject" Referrals for Youth with Exceptionally High Needs

As DHCS considers options such as case rates for services under CalAIM, we strongly encourage DHCS to consider exceptions for services provided to youth and families with the most complex needs. Providers who serve California's highest needs youth will be unable to participate in delivery systems with case rates unless those payment mechanisms include an "escape valve" provision that applies when youth incur unexpected and exceptionally high expenses. The small group of providers in California who are able to accept unconditional referrals for clients with high intensity needs must be able to switch to a Fee For Service payment system when the costs to treat an individual client increase beyond reasonable expectations. Without this type of protection, few if any providers will accept referrals for these youth, and they will most certainly be transferred to out-of-state institutional care as they have been in the past and are currently.

Integrated Purchasing, Assessment, and Evaluation Mechanisms

We recommend that DHCS implement payment mechanisms that encourage coordination and collaboration across child-serving systems, including the education, child welfare, juvenile justice, and developmental disability systems. CalAIM, for example, should **incentivize collaborative purchasing models**, which can expand local Medi-Cal funding sources, as well as create more integrated service programs.

Similarly, **common assessment tools and outcome measurements** will facilitate the collection of comparable data across systems, which can be used to strengthen transparency and accountability for both plans and providers. In addition, common assessment and evaluation measures can help providers better coordinate services for clients involved in multiple systems. For example, because county behavioral health and some county social services departments already use the CANS assessment tool, DCHS may want to explore the potential of using CANS more broadly across child-serving systems.

Medi-Cal Contracting Practices

1. **DHCS should encourage MHPs to offer more flexible contract structures that enable providers to more effectively access available Medi-Cal funding**

Currently, the structure of some county MHP contracts creates unnecessary restrictions on providers' access to Medi-Cal funding. MHPs indicate concern that due to the structure of 2011 Realignment and limited access to additional dollars from the state, that they are essentially "capped" in terms of their ability to meet the federal entitlement for EPSDT. For example, some MHPs impose program budget limits on annual expenditures, regardless of whether those funds turn out to be sufficient to meet actual client needs. This "capped" contract structure frequently prevents providers from accessing all available funds because they must be careful to avoid any risk of exceeding the program cap and incurring uncompensated expenses. As a result, providers often fail to claim the full expenses allowed under a contract.

On the other hand, some larger providers may be able to take that risk in order to ensure clients receive the care they need, and these providers often find themselves delivering unreimbursed services in the final weeks or even months of an annual contract. In this case, MHPs negotiating future contracts with these providers will often use the average cost of the services delivered -- which is artificially low due to the weeks or months of uncompensated care -- to demand lower contract rates for the next year.

To alleviate the financial burdens of these contract caps, some MHPs do allow providers to shift expenses between multiple similar program contracts within the same MHP. Other MHPs, however, do not allow this type of cost shifting, which exacerbates the budget problems created by these program caps.

The combination of inadequate rates with contract caps creates a "perfect storm" for CBOs - it is nearly impossible to achieve staffing levels needed in order to provide enough services in order to maximize contracts. At the same time, rates do not fully cover the cost of providing services. As a result, even if positions are filled, the amount of service and documentation staff

must complete in order to fully utilize contract is more than the staff can reasonably provide. Further, burdensome documentation and insufficient salaries resulting from low rates result in staggering turnover, resulting in challenges to meet clients' needs.

2011 Realignment Transparency and Accountability

For the past several years, EPSDT penetration rates have remained below 4% despite the fact that counties have received nearly $.5 billion in Growth Special Account revenues between FY 2012-13 and FY 2017-18 and have retained billions through growth in the Behavioral Health Subaccount. It is clear that the 2011 Realignment policy has not benefited children in need of mental health services. Further, there is no mechanism for DHCS to monitor the number of overall youth served across the MediCal behavioral health system nor how much counties are spending. DHCS should ensure that any payment reform that eliminates the cost settlement process (currently the only method of monitoring expenditures) is replaced by a clear and transparent accountability mechanism to track what counties spend on children's mental health, the number of children served system-wide, and other metrics developed in collaboration with stakeholders.

Thank you for your consideration of these recommendations and comments, and for your work to improve our state's most important safety net for children and families. We look forward to continuing to stay engaged in the CalAIM process and ensure the final proposal reflects California's commitment to ensuring that young people are given everything they need to grow and thrive.

Sincerely,

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