Alameda County Health

9/3/24 CPAG Meeting Q&A

Alameda County Health Behavioral Health Initiatives presentation
Presented by Karyn L. Tribble, PsyD, LCSW, Director; Vanessa Baker, LMFT, Deputy Director, Plan Administration; Tracy Hazelton, MPH, MHSA Division Director

Q: What percentage has MHSA grown annually--or the trend that you've seen?

While there has been a generally upward trajectory with the revenue we've received, MHSA remains a volatile funding stream, because it is based on tax revenues. For example, in 2023-24, due to the poor economic and budget outlook, the State decided to withhold the 3rd quarter payment to counties and deferred taxes. This left some counties scrambling. Another complication is that we receive funding two years in arrears—so counties also have times when actual tax revenues outperform forecasts, and counties receive additional funding that they have to scramble to spend according to the requirements. So generally, it is going up but year over year, it can go up and down for a number of reasons.

Q: Given the shift away from prevention and towards individuals in serious crisis, how do you balance those two, particularly since you don't want people to fall into crisis because you have fewer funds for preventable services?

We anticipate having to lean more toward our mild-to-moderate partners. When the State clarifies how it will specifically approach the prevention dollars, we'll have to do some analysis. We think we will probably have to shift programs to early intervention, and make a prevention program for people who have less severe symptoms. The language is "at risk of developing more severe symptoms," which may give some room. Without that, we would be creating a huge gap. We will be looking at how we can work with and coordinate with our partners. In 2 years from now, we'll start to see this impact.

Q: Alameda County Behavioral Health spoke of being an HMO. With the health plans, we know what the denominator is because patients are assigned to the health plan. How does that work for specialty mental health, especially if people haven't been connected to the system?

The State looks at the number of total Medi-Cal beneficiaries in the county, and they regularly audit the data we submit, and they extrapolate. Even if we have never seen X number of people of this demographic in a specific area, we are required to meet network adequacy for the potential number of people in various populations. For example, our API community utilization stats show a discrepancy between services accessed and the level the State expected. So we launched several new programs, including traditional Chinese medicine and other ethnically appropriate services, to bring them into service to address the denominator.

Q: Is there work to integrate with the health plans? A person with moderate severe behavioral health could be billed through a health plan. Where does the reconciliation happen? How do you ensure you're not billing for the same people?

CalAIM is a driver of coordination, and ACBHD has been working closely with the managed care plans to implement the No Wrong Door policies. The State is envisioning that the health plans will pick up the services County BH is not able to provide and also provide preventive care. For anyone

who needs additional levels of support or services, the managed care plans will refer them back to the mental health and SUD plan. When we see what they will have as prevention programs, we'll have a better understanding of the State's vision.

Another example is the Children Youth Behavioral Health Initiative (CYBHI). It is a way through CalAIM that school districts (or LEAs) can hire clinicians to do therapy for all children, regardless of insurance. And then LEAs can bill the state as a specific rate that has been set. That is another way of working together where the schools are filling some of the gaps.

Q: Is the vision that the vast majority of people will go more into the managed care side and then moderate to severe, especially mental health, will be more episodic and more focused in a smaller population?

Yes, this is essentially the State's vision, which they require counties and managed care plans to implement.

Q: Was there a gap in services for the severe services that BHSA is addressing?

No. Some counties did have that issue, but in Alameda County, our data did not show that we were not serving people. We saw that the length of time people spent in the system was reasonable, our numbers for 5150s had decreased, and quality of life showed a significant increase. The biggest gap —seen in all counties, including ours, was in longer term locked settings for care for non-acute MH/SUD. We are building some now in the county and that's going to add substance use services as well. The gap remains that we need more locked beds and facilities.

There was also a gap with accountability. The State did not have a way to tell the story of impact of MHSA succinctly because every county does it a little differently. And the State did not provide tools or metrics to ensure that counties were reporting in the same way. With BHSA, there will be more levels of accountability, scrutiny of use of dollars, and reporting.

Behavioral Health Collaborative presentation

Presented by Matthew Maddaus

Q: Should we work on the solutions presented at a local level (with local collaboration)? Or are they state or federal level advocacy?

We need to find a way to not constantly be reactive. It would be good, even at the local level, to be able to influence at the state and federal levels. It would be great to have a pilot to bridge FQHCs and the specialty mental health world—is there a small group that can try this out and then we advocate for an expansion? It needs to happen at both local and state/federal levels—we need to have cross representation at different tables.

Q: For providers, what strategy do we need to put forward with all these reforms (CalAIM, payment reform, etc.)?

The one I hear the most often is creating a table for the highest risk clients, where we can leverage/braid funding, and use that to extrapolate for other programs. Also, collaboration and leaning together and having cross-representation across silos and sectors.

Q: Can you say more about the multi-year contracts and what you're envisioning? That would be a paradigm shift locally.

The biggest thing is to have some predictability across multiple years. To not know if you're not going to have your costs increase within your contract, makes it difficult for planning administrative and staffing costs. It would be helpful to have clarity for three years, even if it's not the contract we want. It would also be helpful to have some predictable escalators.

Q: Can you describe the gap between cost-based reimbursement and fee for service (FFS)? I hear that specialty mental health is always underfunded, but you're getting your costs reimbursed, so why is it underfunded? FQHCs are trying to move away from FFS because it's so underfunded.

In an ideal world, you can serve more people if you are more efficient. In FFS, you're locked into certain rate. And yes, with cost reimbursement, CBOs are locked into a provisional or maximum rate as well. But with FFS, you don't have to do a cost report and you can keep some money. With cost reimbursement, you only get reimbursed for your costs.

Q: How are organizations included in the Behavioral Health Collaborative nonprofit/CBO network? How do you expand or how are they selected?

There is an informal process. Anyone who provides behavioral health services to the public sector and is a nonprofit can reach out. We meet with them and our Membership Committee. Then meet with the full membership of the General Council, and then we sign off.

Q: In terms of data, how do all of the agencies collect and reflect an unduplicated count of people?

It's a range of things—electronic health records (EHRs), MHSA reporting, Salesforce, etc. We ask every agency to feed in the data.

Q: Who is missing or who would you like to be part of the Behavioral Health Collaborative?

I am excited that there's a new coordinating council that includes Probation, Child Welfare, the schools, the Juvenile Court, First 5—that body will be looking at cross sector things and will be focused on kids and youth. Not sure we're missing anyone.

<u>Building Opportunities for Self Sufficiency (BOSS) presentation</u>

Presented by Donald Frazier

Q: How do we translate the message of hope to all of us? There's a lot of things happening now—violence and other things people can't grasp. Hope is a powerful tool that we can use.

We found engaging with people and giving people something real, something they can hold onto, and something they can be a part of. It gives them a sense of belonging and helps to create that in the community. It's four basic things: love, respect, a sense of belonging, and safety. We provide that to folks and the community. We respect them and tell them that "You belong" and that's the way we change.

Q: Can you explain what you mean by "policy violence"? Building Opportunities for Self-Sufficiency (BOSS) takes a risk (as a business and organization) in doing these kinds of major interventions. And you make it work by braiding and leveraging funding. What if it goes away because of some policies? Is that what policy violence means?

Prop 47 opened up a lot of funding sources (ex. Board of State and Community Corrections, adult reentry grants, etc.), and now Prop 36 is on the ballot, and it can take all of that away. That's policy violence. Policy violence is legislative and administrative policies that don't benefit the people that we serve. Poor people don't have lobbyists.

Q: There are a lot of grassroots and emerging groups that are getting to the population in different ways than the County can and they may not be part of the system. BOSS subcontracts with these emerging groups at great risk. Other than the financial risks, what else are you picking up to be able to work with these grassroots groups? They can't operate within the system because they don't have the infrastructure. But they have the contact, the will, and the reliability in the community.

From a billing perspective, we pay them, and we have to wait for them to invoice. And then we have to wait to get paid from the State, which can take up to a hundred days to get paid. We use work with a financial institution and get a line of credit, and base it on our receivables. It's tough. We are here to do work for our community and there are so many invisible people out there. The grassroots organizations live in these community and know the people. They are the touch point. Right now, with our violence prevention work, we're working with eight violence prevention grassroots organizations. These folks are out there saving lives, and we're partnering with them. The money is a big deal, but the work is also so exhausting, and there is trauma. We also have to provide them with a level of training and space and support for them to help them breathe and come back to the world before they go back out.