Draft Minimum Consumer Protections and Safeguards for Behavioral Health System Integration Redesign

California has undertaken efforts that seek to improve services to Medi-Cal beneficiaries with behavioral health needs – mental health conditions and/or substance use disorders – by promoting and seeking increased "behavioral health integration." In response, the National Health Law Program, in partnership with other health consumer advocacy organizations, has developed an initial list of important consumer protections and safeguards that must be in place during any transition to integrate behavioral health service delivery in Medi-Cal at the administrative, financial, provider, or service level. These important protections and safeguards, which must also be part of any system redesign, are based on experiences from previous transitions efforts, such as the transition of the Seniors and Persons with Disabilities (SPD) program from fee-for-service (FFS) Medi-Cal to managed care, the transition of the Healthy Families Program (HFP) to Medi-Cal, and the transition of California Children's Services (CCS) to the Whole Child Model.

At minimum, integrating behavioral health service delivery in Medi-Cal must assure these consumer protections and safeguards[1]:

- Stakeholder engagement in transition
    - DHCS should keep key stakeholders engaged in the process through regular meetings and email announcements. Meetings should be open to the public and meeting materials should be accessible for individuals with disabilities.
    - DHCS should maintain an open and transparent process, with all relevant information available on a dedicated public webpage. Materials should be provided in formats that are accessible for individuals with disabilities and in all required threshold languages.
    - DHCS should seek feedback from community-based organizations that work directly with beneficiaries during any transition and seek input from health consumer stakeholders and advocates at all major decision points.
    - DHCS should address specific planning and transition issues with regular regional meetings.

[1] Please see the accompanying document, *"Taxonomy and Principles for Behavioral Health System Integration Redesign."*

- Extended continuity of care
    - Medi-Cal enrollees should maintain access to current providers and to all approved services during any transition. In order to maintain continuity, provider reimbursement rates should be maintained during the transition period, if not longer.
    - Existing treatment plans should be renewed, where appropriate, for a period of time (up to 12 months), including hours (intensity) of services needed.
    - DHCS should establish a process to transition treatment to new providers where appropriate.
    - DHCS should ensure that any transition does not jeopardize access to behavioral health services for other, non-Medi-Cal populations (e.g. undocumented individuals who receive MHSA-funded or county indigent services).

- Network adequacy
    - Time periods by which responsible entities must certify networks for new service types should be implemented. In particular, DHCS should:
        - Establish more specific standards for each provider type for specialty mental health services (SMHS) and substance use disorder (SUD) services, based on the nature of each service;
        - Require specific network certification and expertise for providers of SMHS and SUD services based on standards;
        - Require networks adequacy standards include an assessment of non-clinical staff and paraprofessionals to ensure there is adequate capacity and skill to meet members' needs; and
        - Review rates to ensure they are adequate to maintain the number and type of providers needed to deliver the full range of behavioral health services.
    - DHCS should review contracting requirements and/or incentives in order to bring outside providers into network (E.g., freeze current rates for a period of time; current rates + 5%; any willing provider).

- Adequate notices and other informing materials
    - Adequate noticing should be provided to beneficiaries early and often (e.g. monthly) to ensure that beneficiaries are aware of the transition and any steps they need to take (ideally starting at least 6 months in advance).
    - Notices should not be limited to paper notices; instead, DHCS should utilize other methods of informing, including but not limited to email and text.

- DHCS should implement a stakeholder process to review notices and ensure they are adequate and understandable.
- DHCS should implement a stakeholder process to review readability of English notices and all translations, and accessibility of notices for persons with disabilities.
- DHCS should develop and coordinate an outreach strategy that includes providers and community-based organizations (especially in limited English proficient communities) to reinforce the messages in written notices.

- Data-sharing
    - Service delivery systems should maximize the flexibilities afforded under the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2 to enable providers to share patient information and data in order to improve care coordination and optimize patient care.
    - Protocols should be developed in advance to allow data-sharing pre-transition to ensure that the receiving entity has the information necessary to facilitate continuity of care and coordination of all services.
    - Receiving entities should be able to obtain data from out-of-network treating providers in order to guarantee ongoing continuity-of-care and coordination.
    - Data collection and retention should be consistent to facilitate data-sharing across entities.

- Coordination with other services
    - Receiving entity should be tasked with coordinating behavioral health services with physical health services, as well as other community-based services and supports.
    - Robust care management policies should be in place for transitioning beneficiaries through continuation of care utilizing intensive care coordination services, the Health Homes Program, enhanced care management or other similar services.
    - DHCS should take steps to simplify the process to obtain necessary consent from individual or family members to facilitate coordination and share data for the purposes of care coordination.
    - DHCS should implement policies to facilitate coordination with other systems in which Medi-Cal beneficiaries often participate, including child welfare, criminal justice and probation, schools, regional centers, social services and housing. In particular, the department should:

        - Engage in efforts to ensure participation of, and coordination with non-DHCS contracted organizations; and
        - Take steps to ensure that mobile/transient populations are included in all efforts (criminal justice system-involved youth, unhoused, etc.).

- Effective outcome and performance measurements
    - To the extent that separate delivery systems remain in place, uniform and robust measurement must be in place in order to evaluate performance of managed care plans (MCPs), mental health plans (MHPs), and SUD managed care plans. These measures should be used to evaluate the on-going challenges and successes of the transition, and data collected should be stratified by race/ethnicity/age/gender/orientation and should account for the whole person not only each demographic in isolation.
    - Measures should include, at a minimum:
        - Standardized grievance/appeal measures (similar to IMR database);
        - Referral tracking, including referral source, and timely follow up / access the services they were referred to (not just services that were available), and the time from referral to access;
        - Detailed utilization data by service type and stratified by above demographics, including for all managed care services, SMHS, and SUD services;
        - "Alerts/Flags," across all ages and systems that trigger outreach responses and appropriate services (e.g. child's truancy or absenteeism from school);
        - Measures of need and unmet need, rather than utilization only;
        - Detailed network adequacy data (specific provider types, service delivery, time to care; participation/service to Medi-Cal beneficiaries);
        - Outcome measures that account for resilience, self-efficacy, and functioning;
        - Availability of culturally and linguistically appropriate services; and
        - Availability of services that are accessible to individuals with disabilities (including co-occurring disabilities).

- Oversight and accountability of MCPs, MHPs, and SUD managed care plans
    - To the extent that separate delivery systems remain in place, DHCS should implement effective monitoring, oversight and reporting of MCPs,

MHPs, and SUD managed care plans on the above measures and compliance with the entity's contract.

- DHCS should conduct comprehensive reviews of plan entities no less than annually, including through External Quality Review Organizations.
- DHCS should impose corrective action plans on a timely manner on entities that fail to comply with their obligations.

Acronyms Table

DMC-ODS	Drug Medi-Cal Organized Delivery System
HIPAA	Health Insurance Portability and Accountability Act
MCP	Managed Care Plan
MHP	Mental Health Plan
SMHS	Specialty Mental Health Services
SUD	Substance User Disorder