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Subject: Data Exchange Framework Advisory Group - Addressing HIT Capacity Gaps, Meeting #4 Comments

The County Behavioral Health Directors Association (CBHDA) represents the county behavioral health executives who administer Medi-Cal and safety net services for serious mental health (MH) conditions and substance use disorders (SUDs) in all 58 counties in California. Through various CalAIM initiatives, the public behavioral health system is in the process of undergoing significant change including expanding and improving on data exchange capabilities. The [Behavioral Health Quality Improvement Program \(BHQIP\) Implementation Plan](#) outlines requirements of county behavioral health systems over the next two years and portions of this initiative are outlined below as they relate to the proposals on HIT capacity gaps. We look forward to identifying how the single data sharing agreement will complement data exchange initiatives currently underway within the public behavioral health sector.

In our comments below, we have outlined considerations of the proposals presented on in Meeting #4 of the Data Exchange Advisory Workgroup, as they relate to the public behavioral health system.

Multi-Payer - EHR Incentive Program

Under Opportunity #1, stakeholders were asked to consider whether the state could leverage existing incentive structures such as the Incentive Payment Program, PATH, and the Behavioral Health Quality Incentive Program (BHQIP) to establish technical assistance programs to support EHR adoption.

BHQIP incentive fund activities, outlined in the [BHQIP Implementation Plan](#) have been allocated with the primary goals to support county behavioral health departments in implementing various CalAIM initiatives and will likely not be sufficient to meaningfully achieve all the existing identified milestones. As a result of this likely shortfall, CBHDA and DHCS are continuing to explore alternative mechanisms to support sufficient funding for CalAIM implementation, including Proposition 30 claiming. Proposition 30 is an important protection for local county behavioral

health agencies which requires the state to reimburse for mandates. While BHQIP is an innovative way to incorporate an incentive structure for county behavioral health plans, because of how county behavioral health plans have been financed historically, county behavioral health agencies have little ability to retain reserves or earmark funding for IT investments, and BHQIP is a first attempt to socialize incentive payments with county behavioral health plans.

Based on some preliminary estimates by individual counties the funding currently available to counties in BHQIP will fall short of covering the costs of existing data exchange targets within county plans. Should the state wish to use this financing vehicle as a means to expand adoption of a multi-payer EHR, and with the expectation that county behavioral health plans could also fund EHR adoption across its contracted providers, as proposed in Opportunity #1, CBHDA recommends the state augment funding for BHQIP considerably, consistent with this goal, and to reflect the disparities in the data exchange capability of behavioral health providers highlighted through this process.

CBHDA is supportive of the proposal to require an EHR Incentive Program to require federally Certified EHR Technologies (CEHRT). Due to various federal initiatives, California's data sharing goals, and the current landscape of the EHR market, requiring providers to adopt CEHRT would not be a significant barrier and will further support data exchange goals. In consideration of the state's goals to integrate behavioral health and physical health systems of care, it will be critical to ensure that EHRs included in an incentive program are equipped to appropriately maintain substance use disorder (SUD) information. One of the identified barriers to SUD providers and facilities adopting EHRs are challenges surrounding segmenting data in order to comply with 42 CFR Part 2 regulations.

According to the [MACPAC Report to Congress on Medicaid and CHIP](#), the Congressional Budget Office estimated that an EHR incentive program targeting behavioral health providers would cost between \$5 -10 billion over a ten-year period, stating that this is very costly and would explore other less expensive opportunities.

Given the relative lack of investment in behavioral health provider IT infrastructure at the national level, it will be critical for California to ensure that sufficient funding is dedicated specifically for behavioral health providers, consistent with the goals of the Data Exchange Framework and AB 133. While resources are often cited as a barrier to EHR adoption, further investigation is warranted to identify additional obstacles to EHR adoption, particularly among small, community-based organizations (e.g., behavioral providers contracting with county behavioral health departments) in implementing this technology.

HIE On-Boarding Program, Qualified Networks and State Data Sharing Requirements

In order to address the limited technological capacity of many health care and human service organizations to store, electronically share, and use health and human service information, stakeholders were asked to consider an HIE Onboarding Program that provides incentives to health and human service organizations to participate in information exchange, including but not

limited to connections to qualified information exchange intermediaries. As with Opportunity #1, this proposal seeks to leverage the state's investments through BHQIP.

Broadly speaking, CBHDA supports additional investment from the State to support HIE onboarding for health and human services organizations. Recognizing that the California HIE Onboarding Program (Cal-HOP) is noted as a possible model to consider, CBHDA strongly encourages further exploration surrounding participation barriers and any lessons learned, with a focus on behavioral health agencies and providers. In surveying our members, it was noted that in addition to a lack of resources, there are many additional technical barriers to overcome which will likely be even more prominent for small provider organizations and practices.

With respect to BHQIP as an opportunity, the data exchange milestones which will be required for counties to receive incentive payments include:

- Demonstrate direct sharing of data with MCPs OR Demonstrate onboarding to a Health Information Exchange (HIE);
- Demonstrate an active Fast Healthcare Interoperability Resources (FHIR) application programming interface (API) that will allow the participating entity to be compliant with CMS-mandated interoperability rules;
- Demonstrate that the participating entity has mapped data elements to the United States Core Data for Interoperability (USCDI) standard set;
- Leverage improved data exchange capabilities to improve quality and coordination of care with the following measures from [CMS' Core Set of Adult Health Care Quality Measures for Medicaid](#):
 - [Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence \(FUA\)](#)
 - [Follow-up After Emergency Department Visit for Mental Illness \(FUM\)](#)
 - [Pharmacotherapy for Opioid Use Disorder \(POD\)](#)

While county behavioral health departments will be able to significantly improve data exchange through the state's investment in BHQIP by earning incentive payments for various milestones, additional considerations still need to be explored, including whether joining an HIE will facilitate the appropriate level of data exchange to improve care coordination and promote better health outcomes for beneficiaries.

In addition, significant IT infrastructure upgrades may be necessary to facilitate data exchange, over the costs of joining an HIE. One larger county behavioral health agency noted that while their initial estimate of necessary IT upgrades necessary to facilitate data exchange and HIE are approximately \$20 million, their BHQIP allocation is closer to \$2.5 million. In fact, the total BHQIP allocation across all counties for a wide range of CalAIM implementation activities, including implementation of a major payment reform initiative is \$86.6 million.

Expand California Alert Notification Requirements

Under BHQIP, counties will be required to leverage improved data exchange capabilities to improve care coordination, and will be required to submit a quality improvement plan and periodic updates on several CMS Core Set measures, identified above to earn incentive payments. Due to the historic challenges in obtaining this information in a timely manner from providers, DHCS has expressed its commitment to supporting counties in receiving this data.

Broadly speaking, expanded event notifications are a worthy long-term objective, however, there have been significant hurdles to overcome within existing systems surrounding event notifications. Notable challenges include: ensuring the notification is timely, sent to the correct plan and provider entities, and identifies the correct beneficiary. Within current systems, unless all providers are operating within the same information exchange environment, it can be difficult to ensure the right information gets into the right hands in a timely enough fashion to support care coordination. CBHDA supports the expansion of required alert notifications, across justice and health care system partners.

County behavioral health agencies are critical to ensuring safe transitions for individuals with significant behavioral health conditions from carceral settings and state hospitals. These transitions are especially high-risk for county behavioral health clients with serious mental illness, serious emotional disturbance, and/or substance use disorders. The California Department of Corrections and Rehabilitation (CDCR) has invested time and resources into improved notification for inmates upon release. However, even with investment and intentional effort to improve communication with key partners around these transitions, much more is needed to ensure timely notifications related to individuals with behavioral health needs that include the type of information useful to managing care transitions (i.e., packets with information regarding the individual's mental health and/or substance use disorder diagnoses and treatment). Often, critical information, such as a person's COVID-19 status may be communicated to public health, but is not provided to the county behavioral health agency, challenging the ability of county behavioral health to identify a community provider, if necessary. In addition, county behavioral health agencies continue to work with CDCR to ensure that the appropriate Releases of Information (ROIs) are provided to county behavioral health where appropriate. Given the overrepresentation of individuals with significant behavioral health conditions in carceral settings, further focus on removing these barriers to sharing the right information at the right time is essential.

In addition to CDCR, Department of State Hospitals (DSH) could benefit tremendously from additional event notification requirements, particularly for those individuals being discharged to the community. If these alerts were mandated through a standardized system, it would greatly improve the ability of beneficiaries to receive appropriate treatment in community, and coordination of care. Given the vulnerability of this population, these improvements are strongly encouraged.

CBHDA also supports required event notifications related to hospital emergency department visits for mental health and SUD crisis, but recommends the state develop a separate stakeholder

workgroup to develop a set of recommendations on appropriate event notification requirements for hospital emergency departments and public and private plans.

Today, due in part to the confusion that sometimes arises around the dual role of county behavioral health agencies, as a plan responsible for care coordination and delivery of services for certain Medi-Cal beneficiaries with specialty care needs, and local oversight and implementation of the Lanterman-Petris-Short (LPS) Act, which governs involuntary treatment for Californians across all payers, current practice between providers, health plans, and county behavioral health agencies may not align with appropriate and timely event notification intended to support improved care coordination and outcomes.

For example, while a county behavioral health agency may be responsible for deciding who may place and release 5150 holds, and how, across all populations, the county behavioral health plan has a distinct responsibility to a subset of emergency department patients who may qualify for specialty mental health and/or substance use disorder services post-discharge. Medi-Cal managed care plans and private commercial plans share responsibility for individuals experiencing a behavioral health emergency, including for follow-up care. Too often, emergency departments have not communicated well with the respective responsible plans and may even fail to claim or communicate behavioral health emergency department encounters with responsible plans, which further challenges the ability of plans and providers to simply rely on electronic data transfer solutions. Without understanding the nuances of practice and the layered LPS responsibilities of county behavioral health agencies across payer populations, hospitals may interpret such an event notification requirement to mean that all behavioral health emergencies should be communicated to county behavioral health agencies, which would overwhelm county behavioral health IT and data systems and likely create unnecessary delays in follow up care by Medi-Cal managed care and commercial plans.

Public Data Exchange Capacity Building Program

CBHDA supports the increasing capabilities of data exchange between local agencies. Recognizing how limited health information exchange is currently across health and human services, this opportunity has the potential to advance California's goal of supporting provider access to information regarding social determinants that supports improved care and outcomes. However, more information is needed to understand the full scope and specific policies being considered, as well as the complexity of data privacy and exchange requirements for human services programs, and to understand any potential concerns related to sensitive personal information, such as immigration status, which may be tied to program eligibility.

Thank you for your consideration of our feedback.