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Mental Health Commission
Behavioral Health Services (BHS) Regular Meeting
May 8, 2025

> KENIA FUENTES: We are 11:00 a.m. I'm hearing a conversation in Korean or I don't know who -- I don't know if it is our Korean interpreters.

(voice in the background coming through) okay welcome everyone. This is the LA county behavioral county meeting their regular meeting. Today is May 8. I'm Kenia Fuentes I will do an intro of myself. Brown skin, brown eyes, dark brown curly hair and wearing a white sweater top with black trim. Black pants and black shoes.

For those who have -- this is your first time restrooms are outside to the left and into the hallway. We have snacks in the back. Coffee. Please help yourself. Welcome on. Chair.

>> MICHAEL MOLINA: This is Michael Molina at our Behavioral Health Commission. Thank you for your attendance in both as well as virtually.

Recognition this is mental health awareness month and thank you to our service areas and UsCCs that are participating in various activities. In recognition of this special month.

So thank you very much. For all your participation. With that, let us begin the meeting with the roll call Kenia.

>> KENIA FUENTES: Commissioner

>> Present and eating.

>> KENIA FUENTES: Commissioner Weissman. May be running late.

>> MICHAEL MOLINA: She will be absent today.

>> KENIA FUENTES: Commissioner Manalo.

>> MICHAEL MOLINA: Present.

>> KENIA FUENTES: Commissioner Friedman. Absent. Commissioner Root. Present. Commissioner Austria, Commissioner Holmes. Present. Commissioner Stevens. Present. Commissioner Absent. Commissioner Roache. Present. Commissioner Sandoval. Absent. You have a quorum.

>> MICHAEL MOLINA: Thank you. I know our Commissioner -- Commissioner Weissman is away. For everyone's knowledge as well as Commissioner Friedman that

is attending a meeting in Sacramento today. Those are the excused absences that people that reached out. We will continue with public comment.

The public could provide public comment in-person as well as virtually. We que up the operators for virtual public comment we will start with folks in the room. Anyone in the room wishing to provide a public comment at this time, there is a microphone at the table before us we invite you to come forward and make the comments at this time. Welcome. Good morning.

>> Can you hear me okay?

>> MICHAEL MOLINA: Perfect.

>> Good morning members I'm excited this is my first meeting. Joe I want to take a moment to introduce myself. I started a new row 1 month as Senior Director at Chatter Proof. I was with substance abuse mental health at -- suicide crisis lifeline. Just introduce the non-profit, we are an organization dedicated to address addiction in California across the nation. To have access to evidence base addiction treatment and work with stigma associate weekend the disease. We partnership with the treatment locator and treatment Atlas.org. I'm happy to share that at treatment Atlas.org you could find treatments across L.A. County. You know that is it a crucial step for individuals returning to recovery and we want to make the process easier. In closing I'm eager to continue partnership with L.A. County and know the commission and your work to me people deserve to know your work and commitment to be around. I look forward to working with you.

>> MICHAEL MOLINA: Thank you we look forward to get to know you better. Anyone in the room wish to be heard at this time. Please come forward.

>> Good morning. I'm Izzy Reyes. I will do the SALT 4 announcements. We have a Take Action on the 15th from 11 a.m. to 3:00 p.m. we will have food and giveaways and meditation around the time the students at LA City College are doing their testing. Their mid-terms. That is a perfect way to have meditation and yoga to relieve a*it the stress. It is hosted at Los Angeles City College. May 15, 11 a.m. to 3:00 p.m. Thursday next week. Now, I will do the other announcements we need to look at the next step. It is good to look at housing with the homeless but we need to look at the next step. The homeless that I talk to that are housed find it hard to pay for the light and water gas bills. A lot whenever problems or would worries stress them out they want to move on the streets.

We need to look at housing is a good thing we need to look at what is the next step? Like we need to look at maybe jobs. Giving them jobs faster. Hooking them up with jobs or something like that. Otherwise, non-profits' will be the only way that they are able to pay for their bills. We need to look at next step. I want to bring to attention the hot meals are needed for the homeless. Believe it or not they do development problems a lot faster because of lack of basic necessities and how they are given out is

a big problem. Like, hot meals is what is needed for the home and not just a cold sandwich that is wearing on a person's mind.

>> MICHAEL MOLINA: Thank you very much. Next speaker, please.

>> Good morning.

>> MICHAEL MOLINA: Good morning please have a seat.

>> Good morning Yvonne Sandoval with SALT 7. I want to wish -- it is May, it is full of flowers. I was raised at -- of course it is Mother's Day. Mother's Day month and Asian Pacific Islanders month. And greatly appreciated and respected it for all that each folks do with everyone else.

I have some announcements. It is the big thing is mental health month. Breakfast was -- I participated in when they had at Artesia Library. Our Commissioner was there. He gave a great information on all he does and helped us understand overall as even as a city council member of Artesia it was wonderful. I better keep going. My time is going. Santa Fe Springs had their opening with telecare. I didn't go. The last breakfast was at Santa Rosa DeLima Church in Bell Gardens. The Whittier church was yesterday. We are looking forward to the podcast with Dr. Manalo that Jamie is representing. Just fantastic. I got to hear him very personally. I'm so glad he is with us as a Commissioner.

And what he did with the library. You know, the Artesia Library how they held the Clergy breakfast it was chair yoga it was fantastic. Our next person is ready to mention. I did want to say, when I went to the library, and I met the folks that go there, they're basically descends from India. And we had all city event at the Commerce Casino. I was looking for somebody I may have recognized. I go, were you there at the library? I just met a brand new bunch of people.

>> MICHAEL MOLINA: Wonderful.

>> It was awesome.

>> MICHAEL MOLINA: At the proceeding.

>> Yeah. We do a lot of stuff. Thank you.

>> MICHAEL MOLINA: Wonderful thank you very much. Thank you. Next speaker.

Part two.

>> Good morning, everyone.

>> MICHAEL MOLINA: Good morning.

>> Today I'm only mentioning it because our new pope has been elected. He is American. Woo. Robert -- Provost. Thank you very much. And we have our SALT 7 meeting tomorrow. The service area leadership at the health line counseling center. Liberty Community Plaza in Whittier. On 14181 Telegraph Rd. And following that, they will go to Salt Lake Park and Huntington Park with appreciation of seniors. It is 1 and 2. And I forgot to mention, that today this month, is mental health. But it is also Stroke Awareness Month. Now, on Tuesday, we will be having another Take Action event.

This one will be May 13 at Rio Hondo College in the quad on 3600 Workman Road in the City of Whittier from 11 a.m. to 3:00 p.m. thank you

>> MICHAEL MOLINA: Commissioner.

>> You are doing hybrid by chance?

>> Yes. Like, you mentioned --

>> There is a second part? It is hybrid.

>> You are meeting every month as hybrid?

>> Yes.

>> Thank you.

>> Yes definitely.

>> MICHAEL MOLINA: Thank you for the clarification. Thank you Commissioner.

Anyone else in the room wishing to be heard please come forward. Good morning, sir.

>> SALT 6 Co-Chair.

(background speaking)

>>Alex, I think it is one of our interpreters that has a microphone open.

>> MICHAEL MOLINA: Thank you Kenia go ahead, sir.

>> SALT 6 Co-Chair here. We had a (inaudible) couple days ago I work with TTD in support of housing we are expanding new -- to North Hollywood and Palmdale. I went to SALT 6 Take Action. It was cooling and all but we could not get stuff because they said it was not meant for us. They gave us food but that was nothing. Cold Nacho. Snow cones. I go to SALT one Take Action they had everything. Seriously.

That is all. Appreciate you all

>> MICHAEL MOLINA: Great. Thank you very much.

>> Your SALT 6 meeting I like to know what SALTs are actually doing in reference to meeting the community? And so I think it is important to know whether these meetings are hybrid or not? Are your meetings hybrid?

>> No.

>> Thank you.

>> MICHAEL MOLINA: That means it is all in-person sir.

>> Yes.

>> MICHAEL MOLINA: Thank you very much.

>> You are welcome.

>> MICHAEL MOLINA: Anyone else in the room wish to be heard at this time. Please come forward sir.

>> Good morning, Commission. Executive Director license adult care association. I want to come today to make you aware of our efforts in developing the LARCA community place hub. I hope to come back to share our efforts. We are looking to become a community support provider under CAL-A to make the connection between the managed CARE plans and adult facilities we represent 430 state license residential communities for the elderly here in Los Angeles County. As a community support

provider we will focus on making the transitions and diversions from skill nursing facilities for those individuals that are able. To make the transition. Into an adult residential facility in the community. To make sure they are getting the appropriate level of care and the appropriate housing.

To meet their needs. So we are well on our way. We received a grant from the state. Through the technical assistance marketplace to do a feasibility study. We also applied for the CAL cited funds we submitted an application and waiting to hear back from the state. We want to make you aware of our efforts we hope to share with you more in detail at a later date

>> MICHAEL MOLINA: Great. Thank you very much sir thank you for being here. Anyone else in the room wishing to be heard before we move to virtual comments? Seeing none. Kenia you let the AT&T operator, please.

>> KENIA FUENTES: Can you provide instructions to get on cue for public comments.
>> You like to make a public comment press one followed by zero the AT&T Operator will give you a line number and put you in Q. You want to make a public comment press zero followed by one at this time. Wait a moment. We have a couple cueing up. They will be with us momentarily. Let's begin with line eight you are open.

>> Oh.

>> Go ahead line eight you are on.

>> This is Mark. Wondering if you could hear me.

>> MICHAEL MOLINA: We can Mark. Go ahead.

>> Can you hear me?

>> MICHAEL MOLINA: Yes, we can Mark.

>> Thank you. I have information from yesterday. They have -- several bills they are opposing. The Senate Bill 820. Force medications in jails.

And Senate Bill 367 dealing with conservatorships in hospitals Senate 823 extension of -- force treatment in under the care. Also, they are opposing -- I think it is 265. I'm sorry. There is a bill also, makes it easier for doctors in emergency rooms to write 5150s they are opposing that. There is one that they are supporting that is AB 255, that had is supporting housing. I hope the Department of Mental Health could take a position on this. And this is going to -- this is going to be a major step backwards for consumers.

I will send out the e-mail on that. As soon as I could get to them. Probably, hopefully today or tomorrow.

>> MICHAEL MOLINA: Great thank you, Mark we will have an update this morning on legislative matters stay tune to hear the update in a few minutes. AT&T Operator next speaker.

>> Thank you. Next line 9. Please go ahead line nine you are open.

>> Good morning. Commissioners and leaders of teams my name is Dr. Mohammed. Clinical psychologist and Equity Advocate. April 10th I introduced the cemetery pipeline

a framework now commissions official record that same day multiple Commissioners raised urgent questions about fragmentation and caregiver exclusion. Concerns directly outlined in the custody model. This framework is submitted to reduce harm. To restore access and equip the county with ethical oversight tools it is shaping reform. Across the prevention early intervention and quality service and managing division and clinical liability and risk management and access to care.

As a commission finalize the minutes and reports I urge the framework and life experiences and clinic insights be acknowledged. Equity demands accountability. System reform must include not erase the models and people that make it possible. Thank you.

>> MICHAEL MOLINA: Thank you very much doctor. AT&T Operator next speaker please .

>> Line 6. Anyone else like to make public comment hit one followed by zero. Line 6. Please go ahead.

>> Charles from SALT 6 I want to thank you for having this meeting.

>> MICHAEL MOLINA: Thank you, sir. Thank you for joining us. AT&T Operator, next speaker, please?

>> And we have no other participants cued up at this time.

>> MICHAEL MOLINA: Anyone in the room that has not been heard wishing to be heard? Seeing none we will close public comment members of the public we will reopen for items that have been agendaized you are more than welcome to do that later in the meeting. On agendaized items only colleagues we will go to item number four we have two minutes and follow-up report and budget report. Any member like to take it off in morning? Seeing none, we will take a motion in a 2nd to approve the consent to agenda, please.

Thank you Commissioner. Commissioner Second that is approved. Move on to standing items. 5. I believe we will begin with SAPC first. Representation of SAPC come forward for your information on Value-Based Care: Treatment. No problem Commissioner Stevens.

>> In reference to the minutes.

>> MICHAEL MOLINA: You want to make a change?

>> Yes.

>> MICHAEL MOLINA: Members we will reconsider section 4A, of today's consent agenda. I believe I need a motion in a second to reconsider. Can we have a motion to reconsider 4A edit from Commissioner Stevens. Thank you Commissioner. We are reconsidering item 4A of the minutes. Commissioner Stevens.

>> Thank you. Noticing the minutes are vague. We heard on more than one occasion. From even peer staff that has raised concerns in this particular meeting. Additionally, I'm, greatly concerned about the lack of participation from our service area groups as well as underserved cultural community groups. It doesn't reflect on the minutes who is

showing up to participate. We should be mindful of what is happening in our stakeholder groups and there is lack of participation. There has to be accountability. There are Bylaws that has been adapted by the Department of Mental Health for these service area or Stakeholder groups. And one requirements is to show up and to participant the Mental Health Commission. It is not happening.

So I think it is now time that we add or include who is showing up or category in the minutes. That shows who is showing up and not.

To present to the commission.

>> MICHAEL MOLINA: So Commissioner Stevens you make a motion the minutes in the future reflect in the public comment which service area or UsCC is present and provided comment.

>> Yes clearly that is the motion.

>> MICHAEL MOLINA: Thank you Commissioner Stevens a second to her motion? Thank you Commissioner Austria. Any discussion on the motion? Commission Schallert.

>> We meet on the second Thursday when the SALT 2 meets that is why we don't have people from SALT two here.

>> MICHAEL MOLINA: Kenia when SALT's don't attend they could send in a report.

>> KENIA FUENTES: That is what I do with the commission and they encourage to submit their report by e-mail or come in-person. So yes, we could continue to encourage that. They could submit and print for you if you want. You could have the printout in front of you. If those are submitted I've not received any in a while.

>> MICHAEL MOLINA: All right.

>> For the record, this is why this is important. And the department is present. It is a requirement for those who are leading the groups to participate. In the commission meeting.

>> MICHAEL MOLINA: Thank you, Commissioner. Any other questions or comments on Commissioner Steven's motion?

>> If I'm aware of some of the SALT 2. If the Commissioner Is aware of SALT activities can the Commissioner Say something during the public --

>> MICHAEL MOLINA: I would say as a Commissioner It is not appropriate public comment you could add it in the end you can. Seeing no more comments or questions can we take a vote on Commissioner Steven's question.

>> Commissioner Steven. Commissioner Austria. And Commissioner Molina. Commissioner Root. Commissioner Holmes.

>> MICHAEL MOLINA: That is approved we will go back and reconsider the minutes. Item 4A. I will assume the Commissioners Manalo and Schallert will continue their motion and second. So that is true Commissioners?

>> Yes.

>> MICHAEL MOLINA: Wonderful. They are unanimously approved. We will move to item five standing items we will move to the SAPC report, please.

>> DR. GARY TSAI: Good to be here today. As you will recall. When we joined the behavioral health meetings we gave an overview of portfolio of work that the responsibilities of SAPC has. Each update moving forward we will provide a little bit more areas of our system that will give the commissioning a better sense of what we're doing. Value based care of the substance use system. July 1st, 2023 counties across California did Ca I AIM that is the most significant change in substance use and mental health system in decades. There are key changes related to reimbursement structure. And so that means, moving from cost base reimbursement to fee for service models. Some of what I will talk about is technical. But I will do my best to explain things clearly and address questions. We think it is important just to understand the basics of the finances of publicly funding behavioral health we advance in enhancing and growing the work we're doing. The second major change with behavioral health payment form is the finances. That moves from certified expenditures or transfers or IGT 's that was done across the country for a number of years in California. This is getting on board with what other systems across the nation has been doing. The last major change around behavioral payment form is changes to billing codes. Moving from HCPCS codes and level 1 and 2 codes to CPT codes. Some moved to that years ago. SAPC has the only specialty mental health or substance use that is implemented value base reimbursement model. That is one reason why we want to spend time to talk about this. I think it helped to provide a framing of the future from our perspective in terms of financing.

Key goals to outline, what are guide post as we approached this implementation. One is mindful of substance use systems are starting from. From a place of being historically under resourced. Our rates have not been competitive either with mental health or the medical system.

We saw this as an opportunity to set rates and establish funds that could support not just the substance use system today but for the future. The second key goal to facilitate a smooth way to cost base reimbursement to fee-for-service model.

This is a very significant change. We recognize. For our provider network. You reimburse via cost, there is some insurance your cost are covered but limitations in terms of your ability to reinvest in your agency and grow strategic ways.

And we recognize that shift is something that we will pay attention to. That is the second key goal. The third key goal, around establishing incentive payments as a driver. Just because you establish incentive doesn't mean they will gravitate toward that there needs to be supports to have training a network to be moved by incentives in order for value base reimbursement models to bring value.

Next slide.

This slide just presents the spectrum of different financing models I will not go into detail it is complex on the right. The left we start with cost base reimbursement this is the past. Where we original started from when we start the drug medical waiver or DMCODS. We moved to fee for service model that is value based. And that is the green portion of the spectrum.

And as you move right in the purple you get to morality that testify payment models and value base reimbursement that is the future that is where we look to prepare our network for and the state indicated they are paying attention to. Runway to that, maybe a number of years. Next slide.

Some things we did to prepare.

Both before we implemented and things we did to stabilize and enhance our system after we implemented payment reform. One first thing we did is right sizing contracts and specifically, actually I will talk more about this on a subsequent slide and go into detail on the subsequent slide. The second thing we did is tier our base rates.

And the general process for this is identifying what the cost were. For all the different levels of care. And then establish quality inflator so we fund the system of tomorrow. We only base rates of off current cost you only fund the system of today. It base rates off cost plus, whatever you are looking to incentive and grow in, that is the system of tomorrow.

The third item that we prepared for and acted on, thoughtful how we l'm implemented funding funds before they did something to gear them up and incentive funds they hit a particular -- set a benchmark they draw down additional funding. Fourth is practitioner specific rates that I will talk about.

Benefits of right sizing contracts is -- also optimizing the other funding sources is we needed to know what the financial resources we had to work with.

Because a lot of implementation of value base reimbursement models is managing risk. You need to know what is the margin or cushion we have and that we could invest things like incentive payments in -- specifically what we did around right sizing contracts. We looked at 3 prior fiscal years of contract balance and each agencies stood with spend on the contract amount.

And then we set the contract amount at a level that is higher than where their highest spend was over the past three fiscal years. The reason we did this, we recognize across the network as large as LA you have agencies that are under spending others that may be spending up to their contracts. But I will say, there is a good portion of agencies under spending.

And we have to budget as if those entities are spending 100% of the funds.

And if you have a number of entities under spending, you need to budget for the full amount, there is a portion of pulling that's not being used for services. That is just sitting there. By right sizing the contract we constricted the amounts to the highest utilization over the past fiscal years we don't constraint them to deliver service we

maximize the ability to the funding we have so it is not sitting in contracts unused. That gave us flexibility for reimbursement model and set the foundation.

You could see after we implementing the treatment program increased by 20% to payment form the next year. It increased over time from 2017, when we launched the system waiver to 2023, we seen 277% increase in treatment funding and leveraged Medi-Cal by 830% more prior. That is maximizing our federal draw down of funds so we could stretch our dollar further. The bottom left is a graphic of what I mean. I talk about we tiered our base rates.

So in the blue, those are the base rates you deliver a service. There is a certain service and billing code attached to that and base rate attached to that. We have a tier 1, 2, 3 rates. Tier one rates are agencies that have one or two levels of care. And tier three is more than six levels of care. The rate is higher. Because agencies with multiple levels of care has higher overhead and cost that we wanted to address. That gave us a way to address that without setting individual agency level rates.

Which is challenging in a network size as large as LA. The other thing this did, is incentivize agency within an agency. While we strive to operate as a network, we recognize that when someone is treated at ABC recovery, they have to go to, you know, XYZ recovery to receive the next level of cash that creates a point someone could drop out of care.

You are able to offer multiple levels of care within the ABC recovery, you are more likely to obtain them in services that is the key outcomes.

That we are striving for. And then on top of the base rates in blue, you could see where the green box is capacity building funds and red box is attentive funds that is our graphic payment reform approach.

On the right I mean, I mentioned on the prior slide practitioner rates. We pay rates off the practitioner type that is going the rate. In the past, whether you had a substance use counselor performing the service or physician of , The rate you got paid is the same but the cost are different. With this, approach under payment reform, that the state implemented and we strongly supported it allows us to match rates to practitioner type that makes sense.

Next slide.

This next slide just depicts more about in more detail what we focused on with respect to capacity building and incentive funds we made investments in SUD counselor workforce. In helping to support their training and certification processes.

Their workforce investments in license practitioner healing arts known as license clinicians. And you know things like loyalty and retention bonuses to help with workforce and investment in map prescribing and infrastructure and make sure they invest in accounting and other systems to be successful.

Incentives were focus on proportion of the SUD counselor workforce that is certified. That the is an important workforce 80% of the workforce in substance use are SUD

counselor we are not a license clinician workforce we are SUD counselor workforce. Vast majority that had life experience.

We focused on workforce ratios. And MAT as well as minimum wage for SUD counselors this is important. With the passage of SB 525 that is the minimum wage bill for healthcare. Substance use systems were not included, we communicated it is important to be mindful. You are hiring a social worker whether you are in substance use or mental health system you are competing for the similar workforce. That bill doesn't apply with the SUD systems it is does apply. On the right is what we're moving towards and orient the symptom to outcomes based care.

And really supporting team based care. Diversify the types of practitioners that deliver service in our network and structure bundled rates. Potentially one -- decapitation we are away from that. Manage up front predictable payments for providers and benchmarks that make sense. That is the right balance of feasibilities and ambition. You set the benchmark low everyone could hit it that is not a great incentive. You set it to high no one hits it no one is insensitive.

Hitting the sweet spot to target the incentive. I think I have a couple more slides. Four year one of payment reform we got questions how you know that implementation is successful and one question we got from a number of agencies how the new rates meet the cost with respect to goal of delivery psychosocial care. That is what this slide indicates you could see in year one compared to prepayment reform rates we saw increase in all levels of tier level of care. You are tier one lowest or tier three the highest, they saw increases in prepayment reforms. The take away, the rates were higher. In rates.

And that revenue, we've also encouraged the network to reinvest in the agency. Whether it is workforce, service delivery investment focuses, those funds could be reinvested. Across all levels of care residential settings the settings where the rate increase the most and revenue increased the most, that is important. Because from a budgeting perspective, you count up the hours within a non-residential setting outpatient setting, one could conclude as financially beneficial to open non-residential and forgo residential services. At the same time we recognize there are benefits to residential services we don't want these to wither away. We want to make sure the rate structure help us in a strategic way.

Lessons learned from year 1, ensuring that account system its have infrastructure. You don't collect data or moved by the data in terms of action, and decisions, it is really difficult to be successful in value base environment.

The second is plan perspective. We are a care center like DMH. It is important to collect fiscal reports and cost reporting data on a quarterly bases to make sure the rates are at the right level. We meeting cost going above it we want to fund the system in the future and make sure we get value. I will not spend too much on Time on this. Various levels of care. And revenue across the level of care emphasizes after the payment

reform, we are pouring more resources in the system as we build it up to better prepare it for integrating, you know, behavioral health services at the client level.

Next slide.

We developed a ten year road map. We thought this was -- (No audio) Yes.

The highest level of care, is the highest decimal point on top. My apologies we didn't have enough real estate to spell it out. He 3.5 is -- level one is outpatient

>> MICHAEL MOLINA: Can you tell us what is OTP and RBH.

>> Opioid treatment programs and Methadone clinics and recovery housing.

>> MICHAEL MOLINA: WM.

>> Withdraw management detox. Apologies for acronyms thank you for the opportunity to clarify. Yeah.

Next -- thank you.

We thought it was important also, after the first year of payment reform, to develop what we call a ten year payment reform road map to provide information to our provider network what to expect.

What we did here you could see, we broke up the next decade. Into two year increments. And so phase 1 is the first two years of payment reform. Phase two is the following two years, etcetera. And outlined what we were going to focus on as we transition. The reason it is important, we think it is important for planning with respect to planner network they know where we are investing so we are aligned. Next slide.

And goes into a bit more detail. On what we're focus on with each phase of the ten year road map you could see, workforce. Is something we focus on throughout the entire ten year that is something that takes time to change. And to invest in. There are other things.

Like MAT we imagine to make up front investments in the firsthand of years and establish enough foundation to take away those incentives but maintain the services that are offered. Because the reality is, once you build something you will maintain it. If you have the financial resources to do so that our network does.

And as opposed to taking services away when incentive payments go away. How they implement innocent sensitives it is opposed to add incentives over the years. You could have 100 incentives that no one could pursue.

In terms of this year, we plan for year three of payment reform. Effectively moved to value base reimbursement model outlined what the plans are for the next ten years.

The more detailed plans will be determined closer the road map is a road map than detail. These are all incentives.

One thing that we are starting to plan for, what alternative payment model. Would look like. Whether it is case rates there are different layers of complexity how we structure alternative payment models.

But using the information that we have with respect when the state may make the move to make sure we're staying steps ahead. We plan ahead. So wherever the state makes

the move we reduce the amount of risk with the transition. The reality is, for the spectrum of reimbursement models I presented earlier, you move to the right and to more value and alternative base models the risks increases. That is the negative part. The positive part, you peg the investments to outcomes and value. There is a plus and minus.

And I think that is my last slide.

>> MICHAEL MOLINA: Thank you I assume we have a lot of question.

>> Good morning thank you for that presentation. I'm encouraged by the things you say. And a little concerned about some things you've not said. Moving towards a value space model makes sense. That assumes we agree on what the values are and the goals are. I didn't hear about that I heard about structures and what you do over average cost for three years and building that in. That sounds like a fancy way of cost base.

What I really like to hear from you is what are the values we're pursuing? I'm not sure I particularly agree with your last slide.

Which says, the opposite of addiction is not sobriety. It is connection.

Connection is pretty darn important to sobriety long-term. And to participation as responsible citizen in the counties processes. But it is not the goal. I might. What I didn't hear in your presentation, is what are the values, those goals, those results that were we're trying to pursue? You get here next month, perhaps we could address that.

>> There is slide three that covers that. I could re-elaborate what I mean we want to prepare the system for the future. You are saying what does that look like? For time reasons I didn't get to that you are right I'm happy to talk about that.

>> MICHAEL MOLINA: Thank you doctor. Commissioner.

>> I appreciate the work you are going to try to update the system. And you are updating to a system that doesn't work well for a wide variety of people. It works for a narrow group of people. That you know fit into those practitioners specific rates and certain -- they will have all of these -- picks and different services. What I found in my career, people try to, you know, push people into what is the most -- they get the maximum money out of. So they don't necessarily need to go get your medication in an education group 5 times a week that is where you get the maximum reimbursement. So I'm concerned that we're basing treatment plan for fee for service. Who will get the maximum amount of money because we're now pushing people into these you know treatments they don't need and there are treatments that would be helpful. But we don't cover it and not reimbursed.

You know how we account for that? We are leaving a large group of people out on the side that don't need those services. But they are funneled into a narrow service they may not need to maintain or get to sobriety. That just concerns me. It is not just now you move to that. It is, and healthcare, mental health, who do we get reimbursed and maximize it and not about treatment.

>> Thank you Commissioner. Couple things. One is, fee for service is not where we will end. Fee for service is where we are now. I think, the purpose of us doing this work is to set up a system that is outcomes based. Value based. So that gets at the outcomes and services you could not cheat outcomes if you don't deliver good services. I don't want to convey our system is perfect. The reason why I'm here, because I think our system is very imperfect and a number of things we need to do to make it better. I believe that we're taking a small step to improve the system every day. I think, payment reform is a big step. And, you know, hopefully the presentation gives you a general sense how we approach it

>> I'm concerned you limited the practitioners to these certain people that you mentioned that you will compete with. Those are the same practitioners that are, you know, they are needed in mental health and here. Instead of looking at other practitioners that could fill the need we decided these four or five practitioners are the only ones that could provide the services we need to look beyond that.

>> Sure my presentation didn't get into the different practitioner types we use thank you.

>> MICHAEL MOLINA: On this side. Any questions?

>> Thank you Mr. Chairman I don't have questions. I'm always impressed with your presentations. My mind could not even begin to wrap around the complex question of the challenges you have with your department. I'm really thrilled to () be able to have you partner with us and all of us to learn more about the great work you are doing. I appreciate it.

>> MICHAEL MOLINA: Commissioner Schallert.

>> I'm sorry. Confused. Thank you for your presentation. What I gather the money that helps you to increase the payments is coming from agencies that didn't spend their money and make their contracts.

>> Not really. The money comes from the state Medicaid dollars the agencies under spending that is our budget.

So the additional increases in terms of revenue in the different levels of care on the table that I presented, those are Medicaid revenues.

Obviously there is a portion of the non-federal share or local match. We contribute a portion of our local match. The majority is federal dollars.

>> Where is the money coming from? And where it is?

>> Most money come from Medicaid.

>> This is new money?

>> DR. GARY TSAI: It is still Medicaid money. It is new money in the sense we implemented a payment reform there are changes in the reimbursement model. Moving away from cost base reimbursement and move to transfers and there is a lot of technical changes that come with that. For example, Medicaid pays us with inter-governmental transfers once it hits the county it is called patient care revenue. We could use to draw down additional federal dollars.

So that is a benefit. My -- aim is to try to get -- not to get into detail it's is complicated. But the short answer is the bulk of these dollars are Medicaid federal dollars.

>> MICHAEL MOLINA: Commissioner Roche.

>> I feel bad because you give us the great presentations full of information that is more targets for us. And a lot of people asking questions. I have basic questions. Please I will plead ignorance. Give me a tangible example of the difference in the old and new model from the point of view patient provider accountant something like that to have a hands on.

>> DR. GARY TSAI: Old cost base model I'm ABC recovery and delivered 100 services, and my costs were \$100, at the end of the year, I get paid \$100 that is where the cost is. If I did extra, I delivered 1,000 services that year. Under cost base model I still get paid \$100. Because it is cost based.

Under fee for service model, essentially, the more services you deliver you get paid more. You are paid for the service. I think Commissioner Austria the point is important. The rest of healthcare there is a concern for fee for service model to establish the wrong incentive we could not jump from cost base over to the complicated alternative payment models that is the middle step for the future.

>> So that makes sense you pay for what you are doing. You build on the incentives as well and we were trying to get clarity on the other idea organizations are sort of under spending. What I mean or they means, it is costing them less than the money they were qualified to get because they are not in a cost base model is that -- the case and the money on top, that whole pool of money as I understand it in your plan, supposed to be put towards capacity building for the future that is the general understanding. Sorry to frustrate you.

>> DR. GARY TSAI: It is not. . It is different which we right size contracts ABC contract is set out at \$1 million we look back last three fiscal years they are under spent by 50%. They only spent \$500,000 of the \$1,000,000 that under spent is because they didn't use up the full contract amount. It is money that we had the budget for but not used. We reset or right size that contract, I said we would look at historical and set it to higher to the highest spent. \$600,000 in this example.

The effect is, it allows them to continue to grow. It doesn't constrain them. It reduces the contract amount to use the extra \$400,000 on things that result in services opposed to sitting in a, bucket in a budget that doesn't invest in anything because it is not used

>> Thank you for the clarification. I have two questions. Outcomes and where you are at. A couple months ago you came in and introduced an idea I thought was fascinating. That is counter intuitive that things work in the medical form you don't want them could - substance use you made the point that one measure of success is continuing enrollment in programs. How many people we serve all the time not out the door in the door? So now you talk about the tiered systems, you move toward the value base.

What is the sort of metric you use now versus the future. I have a second question as soon as I get that information.

>> DR. GARY TSAI: There are a number of data and metrics the unique clients we serve every year we want to see that number go up we want to reach more people every year. You think of outcomes treatment retention is the key outcome. How long they stay in treatment not a level of care. Someone could receive residential for 90 days and outpatient for two years after. We look at the treatment retention overall. As opposed to only at that level of care. And you look at things like access. Access to things like medications for addiction treatment or withdraw management and timely access to how quickly they get in. We move to value base reimbursement model we consider all outcomes and how the system is -- being structured so we are preparing our agencies to meet the outcomes.

To actually improve the quality of services delivered so we retain people in services longer so they hit more level of care and instead of going in one setting and discharged

>> I'm hesitant to ask this question. I never like to accuse really anyone in need to fake something. There is a system like this the possibility of fraud. A question I have, we talk about outcome, who is judging the outcome or working with the patient? The patient themselves or provider that says this is where the patient is at or this patient needs. And there by qualifies for different tiers. The reason I bring it up anecdotally I read it a month ago there was a MMA a dude from Texas his job was to sit in a room in high end coastal rehab facilities. Where he had been contacted by a recruiter who worked on behalf of certain organizations that I guess are less than reputable to fill rooms and get fake paperwork and reimbursed for it. I don't think it is a majority. But at the same time I do want to know the back stop. What -- how we check that reports and the patients are getting the care they need and want and we're not spending dollars that don't need it and only spend on people that do need it.

>> That is patient brokering that is illegal. You know, the reality is, we had wide scale Medi-Cal in 2012 that is one reasons for the drug Medi-Cal delivery labor.

And a lot of ways, in the public sector under Medi-Cal there are more requirements standards, than in the private sector. Which is where the patient brokering intakes you describes is occurring not saying the system is perfect. I'm saying the move to Medi-Cal is introduced a lot of more requirements and standards as protections and safeguards to fraud. You are right, fraud can happen in every aspect of the health sector. You know, substance use field it is the same. I would say that, you know, I know myself and team SAPC we want nothing to do with fraud and do everything we could to establish safeguards within reason. You establish so many and say you are creating barriers to care there is a sweet spot in the balance

>> MICHAEL MOLINA: Commissioner Holmes.

>> My question is quick. Thank you for your presentation I learned new things today that is wonderful. My question, related to what Commissioner Root asked. You begin

to talk about it a little bit when you -- in relation to outcomes. You talk about values and outcomes I'm interested in that aspect. You just mentioned like for example, my head I'm trying to think, s what outcomes? Are you thinking about -- things like is it sobriety or harm reduction? Or is it prevention so people don't start to use. I hear you talking about retention. And you talked about access to care. You don't need to answer this now. I would love a presentation on what are the outcomes standards that are set by your department? And how are you measuring or agencies required to measure that to get that report.

>> DR. GARY TSAI: One quick caveat today's is the treatment system that is Medi-Cal. Prevention and harm reduction outcomes those are different systems within the broader network.

>> MICHAEL MOLINA: Thank you Commissioner. Commissioner Stephens.

>> Thank you for the presentation. There is a few things that got my attention. One seeing the -- there is opportunity for flexibility when we talk about the funds. I want to research the fee for services. There are things I like to suggest to the commission and you. The a cheat sheet on acronyms so we and the public took a long-term to learn the agency acronyms that is a helpful. A list of upcoming meetings so we don't crossover questions on things not presented now. So we know that is something that is going to be presented later in the near future.

But I also am curious how we are in this presentation, so how do we -- how we see the success? The success in anything that we're doing. And also, particularly for those who are outlining the services. I turned my nose up, on the \$23 counseling for minimum wage. I was curious what does the pay wage look like? Now, with you know rent high, county and everyone else in trouble financially, cuts across the county. I'm not sure I'm comfortable just in number in reference to pay.

And maybe I'm missing something. Maybe that is an entry level I don't know.

So that is somewhat troubling for me. The other around understanding what is currently going on with the measles outbreak. I think about DPH, I don't just see SAPC I don't just see people with substance use. We are under BHSA it is important I think, for all of us to get to a place we could see that partnership and relationship with the Department of Mental Health. For those who are utilizing the services. Overall, I thought this is really good. That lists of upcoming subjects you will touch on. And really want to know how this is working with the department and what is it -- Hepatitis A outbreak now. So how is that affecting the work you are doing? And this realm to the broader -- am I making sense?

>> DR. GARY TSAI: Yes. There is out breaks in the past, we are within Department of Public Health we coordinate closely. People in homelessness.

>> And substance users.

>> DR. GARY TSAI: It is the same individuals. And I think that is the way we are related to other focus areas our population substance use population is higher for

conditions. Homelessness justice involvement there is host of societal challenges that our population is associated with that we're looking to improve. So we partner with diversion services and mental health co-occurring populations and housing for health for homeless population, etcetera. There are a lot of needs.

>> One last question or comment. I notice you are not taking notes just curious someone here is taking notes?

>> DR. GARY TSAI: Yeah.

>> I want to make sure.

>> DR. GARY TSAI: Thank you.

>> MICHAEL MOLINA: Thank you Commissioner Stevens I don't ask questions. I have a couple if you don't mind. It is going from where Commissioner Stevens left off. The night before commissioning meeting I read the reports to get ready. I made it to page through of yours. I thought I'm lost. And your presentation helped a lot.

(Captioners switch)