Behavioral Health Coordination in California's Dual Eligibles Demonstration

December 2, 2011 Meeting Summary
Prepared by Harbage Consulting

Coordinating behavioral health services into the duals demonstration was the topic of a 2.5-hour meeting held on Dec. 2, 2011 in Sacramento. About 80 people attended the meeting in-person and another 100 called in through the operated phone line. The meeting goal was to foster discussion around the opportunities and challenges with coordinating mental health and substance use services into California's Duals Demonstration. The stakeholder input will inform the demonstration's design and site-selection criteria.

The meeting provided an overview of the mental health and substance use delivery systems in California and the major differences between Medicare and Medi-Cal. This overview reinforced the complexity of integrating behavioral and physical health services, as well as the potential for improved care and savings if integration could be done well. The meeting concluded with a discussion of county-led initiatives around integration.

State and Federal Perspectives

Toby Douglas, the director of California's Department of Health Care Services (DHCS), opened the meeting with a brief update on the duals demonstration project. Douglas announced that DHCS aimed to release draft site-selection criteria for public comment at the end of this year. Three public stakeholder meetings in December, including this one on behavioral health, would provide critical input in shaping those criteria, he said. Douglas emphasized the complexity but importance of improving coordination of mental health and substance use services, referencing studies that found about half of dual eligibles have some psychiatric illness and people with serious mental illness die on average 25 years earlier than the general population. California's county-run mental health and substance use systems add to the complexity when trying to coordinate Medicare and Medi-Cal financing and benefits.

The next speaker was Melanie Bella, the director of the Federal Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services (CMS). Bella began by emphasizing that these demonstrations are first and foremost about improving beneficiary health and care experiences. CMS requires a strong stakeholder engagement process and will have a representative at all of California's public meetings. Bella then addressed how the demonstration aims to improve financial alignment between Medicare and Medi-Cal. Currently, the programs don't work well together and sometimes that means they are at odds with what's best for the beneficiaries, she said. The demonstration projects will set high bars for beneficiary protections and CMS leadership believes that coordinated care will lead to better care. Thus, CMS supports passive enrollment that allows beneficiaries to opt out of the demonstration. Finally, Bella said CMS requires a transparent process and so plans will be posted publicly for comment before any final decisions are made.

Comments and Questions:

Several questions were asked during the comment period. In response to a question about transitioning individuals out of institutions for mental disease, Douglas said the goal is for the demonstration to provide the full continuum of services individuals need and align financial incentives to keep people in the lowest level of care that is safe. One individual asked about consumer notification. Bella said there would be a required public posting of the draft proposal before anything is finalized. Douglas emphasized that the stakeholder process would not end in December. There will be several more public meetings as the process moves forward.

One commenter noted her concerns about continuity of care and asked whether providers would be grandfathered into the demonstration. Douglas agreed continuity of care was a central issue. Another person mentioned that several counties have begun integration pilots funded by SAMSHA and suggested those counties be considered for the demonstration. Diane Van Maren, a consultant with the state's Senate budget and fiscal review committee, mentioned that California's mental health delivery system was undergoing many changes currently, including dissolving the Department of Mental Health, and recommended that DHCS develop a business plan on mental health services to track where all the moving components fit together. She suggested getting foundation support for a coordinated effort on mental health planning and service provision.

Panel One: Challenges and Opportunities with Coordinating Mental Health and Substance Use Services

The next panel included experts on California's mental health and substance use delivery systems. Sarah Arnquist, of Harbage Consulting, moderated the discussion and began with presenting some overview data that included:

- California's 1.1 million dual eligibles comprise about 14 percent of Medi-cal beneficiaries and 25 percent Medi-Cal costs.
- Roughly half of dual eligibles have some psychiatric illness, according to national estimates. Analysis from Massachusetts of *diagnosed* prevalence among duals age 55 and older found duals had significantly higher rates of mental illness and substance use than the Medicare-only population, and also high rates of co-occurring mental health and substance use problems.
- Research has shown that people with serious mental illness are three times more likely to have a chronic condition than the general Medi-Cal population, have higher chances of being hospitalized, and die on average 25 years earlier.
- In California, roughly 68,000 thousand dual eligibles with serious mental illness receive services through the county mental health system. About 75 percent are between ages 21 and 59 and nearly all the rest are 60 and older. Los Angeles County is home to about 16,000, or 25 percent, of the state's duals receiving county mental health services.

Next, Dr. Neal Adams provided an overview of the key differences between Medicare and Medi-Cal mental health benefits. Adams, a psychiatrist, is the deputy director of the California Institute for Mental Health and has a long history working in the public mental health system. Adams emphasized that the Medicare and Medi-Cal programs and physical and mental health treatment often don't work well together. They have different benefits and often are not coordinated. Medicare covers traditional "medical model" mental health benefits; care must be guided by a psychiatrist and provided within a clinic setting. In contrast, Medi-Cal covers expanded rehabilitation services that are flexible and can be provided in the field by a wide variety of professionals, including licensed social workers and marriage and family therapists. Medi-Cal also pays for targeted case management, which is critical to assisting access to services. Adams said he sees great

opportunities with the demonstration, including decreased fragmentation, improved access, improved outcomes, and better, more efficient use of resources. He also noted many challenges, including the potential to add complexity inadvertently and sacrifice quality for efficiency. Promoting person-centered solutions that preserve choice and continuity of care would be ongoing challenges, he said.

Dr. Bill Manov, the director of Santa Cruz County Alcohol and Drug Program, was the next speaker. Manov, who has decades of experience in public sector substance use services, emphasized that substance abuse, dependence and harmful use all are significantly under-diagnosed due to poor screening. He pointed to several research studies that showed treating substance use services proved cost-effective because it led to improved overall health and stability, and subsequently lower medical costs. Yet, Manov said California's substance use system is underfinanced. Drug Medi-Cal has limited benefits; there is no rehab option or case management. Services have to be provided at a certified clinic. Another layer of complexity is that primary responsibility for providing the state matching funds for Drug Medi-Cal was realigned to the Counties in 2011. Manov said that looking forward the Affordable Care Act requires provision of an essential set of substance use benefits. Manov suggested the recommended essential benefits by CADPAAC be considered for testing in the duals demonstration. Eight counties included an expanded benefits package in their Low-Income Health Programs created though the 1115 Waiver.

Comments and Questions:

In the comment section, Adams and Manov responded to a question about the ideal system for screening, assessment and referrals. Manov recommended increased screening in primary care settings using the SBIRT tool followed by immediate warm hand-offs to people trained in substance use treatment. Adams advocated for a "no wrong door" approach in which beneficiaries could access the care they need through any system entry point.

One person commented negatively on the shift away from individual therapy toward group therapy. Adams responded that individual person-centered care plans were key to ensuring individuals receive appropriate care. Someone asked whether expanded benefits would be included in the

demonstration. Arnquist replied no decisions on benefits had been made. Another individual noted the lack of physical accessibility in many mental health and substance use treatment settings and that those comorbidities should be considered. Lastly, someone asked what tools could help counties better target their services and match individuals' needs. Adams said the misaligned incentives currently impede better targeting and sharing of information for coordination. There is a role for health plans in helping to provide care management, he said. Exchanging information currently can be difficult because electronic medical records systems either don't exist or cannot sync with another system.

Panel Two: County Options for Coordinating Behavioral Health Services in the Duals Demonstration

Alice Lind, senior clinical officer with the Center for Health Care Strategies, moderated the next panel. Lind introduced the discussion by describing various principles and models for coordinating care. Key elements of integrated care include: Beneficiary-centered, holistic care models; aligned financial incentives; information exchange; multidisciplinary care teams accountable for coordinating all services; competent provider networks; and mechanism for assessing and rewarding high quality care. Lind described two organizational models for integrating physical and behavioral care: 1) benefits and financing for physical and mental health services are integrated within a managed care contracting arrangement, and 2) financial incentives are aligned through a partnership between a managed care entity and behavioral health organization. Each option has its pros and cons, which are described in detail in a paper produced by the Integrated Care Resource Center (available here: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/Public Meetings/ICRC_BH_Briefing_document_1006.pdf).

Following Lind, Stephen Kaplan, director of San Mateo County Behavioral Health and Recovery Services, described his county's work toward integration. San Mateo has a County Organized Health System. About 26% of adults seen by County Behavioral Health Services are dual eligibles. Kaplan described the key tenets of their proposed integrated care model and then the challenges to integration. The challenges included fragmentation between Medi-Cal, Medicare and FQHC funding and rules; co-location of services in a health home or behavioral health home; care management for people with the poorest health outcomes; and an

increasing aging population for substance use providers. Addressed, he said, those challenges also hold some of the greatest potential benefits.

Dr. Suzanne Tavanno spoke next about integration efforts in Contra Costa County. Tavanno is the acting mental health director there. About 25% of the roughly 12,000 adults treated in Contra Costa Mental Health Plan are dual eligibles. Tavanno said county mental health plans have become more than a provider of "carve out" services. They now consider themselves providers of specialty mental health services and work with multiple payers. Tavanno described some lessons learned from past integration efforts, including the need for a common electronic health record to bridge communication; importance of consumer participation as peer providers and in self-directing their care; having an integrated assessment and treatment plans; need for transportation; importance of partnering with community resources; and necessity for care coordination in co-located settings.

Dr. Marv Southard was the last speaker. Southard is the director of the Los Angeles County Department of Mental Health and described his vision for integrated care there. In LA, Southard envisions having model with three tiers of services based on an individual's needs: Tier 1 services for the serious and persistently mentally ill; Tier 2 services for the group not yet disabled but have needs beyond what their primary care doctor can handle; and Tier 3 services for people who receive their psychiatric care through their primary care physician. Southard said that historically the public mental health system had not dealt well with the people needing Tier 2 services. Each tier would have its own model for coordinating services. Moving toward this model will require a workforce with new or different skills. LA County plans to invest in workforce development by leveraging national grants and other new revenue sources. "We need to go beyond projects and put together a system," Southard said. I believe the dual eligible issue gives us the opportunity to build a system and not just a project."

Comments and Questions:

Several issues were raised in the public comment section. One speaker requested that end of life issues be addressed within the duals demonstration. Another participant requested the ability to opt out of managed care and that consumers should be represented on oversight

committees. When Kevin Prindiville, of the National Senior Citizens Law Center, asked whether they envisioned pursuing a model of full integration as a contractor with a managed care organization or as a partner with shared savings or performance-based incentives, they all said the latter. Someone asked whether certain Medicare rules could be waived under the demonstration, so Medicare coverage could be expanded to cover services similar to Medi-Cal. Lind responded that yes, under the demonstration the State could request various rules be waived. Finally, when asked about what they could accomplish with integrated data systems, the panelists said shared electronic health record across providers, the ability to set goals and share those with consumers, and developing a registry would all be advantages. Importantly, the system could use integrated data to detect gaps in care and share guidelines, for example, for pain management.