Comments from:
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Framework for Understanding Mental Health and Substance Use in California's Duals Demonstration

****DRAFT****

California's dual eligible population includes many individuals who need mental health services. This includes people with short-term needs and those with chronic needs who qualify for Medicare and Medi-Cal due to a psychiatric disability. Substance abuse frequently co-occurs among these individuals. Patient-centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance use services in a seamlessly coordinated manner. The following concepts have been drafted to set the stage for future conversations around the coordination of mental health and substance use services within California's Duals Demonstration.

1) There is no one-size-fits-all approach to coordinating mental health and substance use services.

- The appropriate model depends on patient needs, on-site capacity, the funding environment, community resources, and local partnerships.

2) Care management should be broadly defined and aimed toward recovery.

- Reimbursement structures should support care management and service provision based on a recovery trajectory and not a narrow medical model.
- Care management should employ multi-disciplinary team-based approaches, including the use of Peer Providers, and where possible, alternative options for consultations, such as telemedicine and an e-referrals, and the ability to do outreach

3) Adequate screening within primary care and links to services for mental illness and substance use disorders can facilitate treatment of these conditions before they become severe and disabling.

- Coverage of federally allowable mental health and substance use benefits will be important for care coordination.
- Plans should include traditional mental health and substance use providers in their networks, and cover a full array of rehabilitative services that are home and community based.

4) Person-centered health homes that emphasize communication, coordination, shared records and active outreach can improve care for beneficiaries with mental illness and substance use disorders.

- Ideally behavioral health and medical services would be co-located. The primary health home should be clearly designated so there is clear responsibility for leading care coordination. For those with severe mental illness, that health home often will be located with a community mental health provider.
- Data sharing/privacy guidelines and data management tools should facilitate sharing of essential treatment-related information while protecting confidentiality.

5) Financing arrangements should be developed with a focus on aligning incentives to deliver the right care where and when people want and need it.

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- Care coordination has the potential to rebalance service delivery away from the hospital and emergency department and instead to community-based services, resulting in improved health outcomes and lower costs.
- Coordinated models should reduce the administrative overhead required for claims processing.

6) Most of the disabled adult population with serious behavioral health issues experience significant disparities in access to healthcare and overall health status.

- Outcome measures will be critical to assure that this population is successfully accessing both health care and behavioral health care in these new models, and that the care provided is meeting beneficiary needs. These outcome measures should include access, service utilization, and quality indicators for both behavioral health services and physical health services. (See HEDIS, CAHPS, IOM or other measures.)