November 20, 2014

Mr. Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, California 95899

SUBJECT: CBHDA's Proposal for California's 1115 Medicaid Waiver Renewal

On behalf of the County Behavioral Health Directors Association of California (CBHDA), which represents the public mental health and substance use disorder programs in counties throughout California, I offer its perspective on improving health outcomes for beneficiaries with multiple complex conditions, including serious mental health and substance use conditions, through California's 1115 Medicaid waiver.

CBHDA commends the Department's commitment to building on the approaches and successes of the existing Bridge to Reform Waiver as we move forward with expanding and improving our Medi-Cal program through delivery and payment system transformation.

According to national research, individuals living with serious mental illness face an increased risk of having chronic medical conditions.[1] In 2006, a devastating national report was released asserting that individuals living with serious mental illness die, on average, 25 years earlier than other Americans, largely due to treatable medical conditions.[2] According to the report, the rates of mortality from diabetes, cardiovascular, respiratory and infectious diseases for the population with serious mental illness are several times those of the general population. While, according to the report, suicide and injury account for about 30-40 percent of excess mortality, 60 percent of premature deaths in persons with schizophrenia are due to *largely treatable* medical conditions such as cardiovascular, pulmonary and infectious diseases. Almost ten years later, this enormous disparity in morbidity and mortality has largely remained the same. This is unacceptable.

Prior to the implementation of the Patient Protection and Affordable Care Act (ACA), this disparity was often attributed, in part, to a lack of healthcare coverage for this disproportionately indigent population. While some individuals with serious mental health conditions may have qualified for coverage based on their mental illness, a significant portion of this population was largely uninsured. The ACA offers states a tremendous opportunity to significantly expand

[1] Colton, C.W. & Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Preventing Chronic Disease: Public Health Research, Practice and Policy, 3(2), 1-14.
[2] Parks, J.,et al. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

Medicaid coverage to historically uninsured populations. According to one report, half a million uninsured California adults with mental health needs will become eligible for health insurance coverage in 2014.[3] States are then, in turn, to guarantee coverage of certain essential health benefits. Mental health and substance use disorder services are notably included as one of ten categories of service that must be covered as essential health benefits. Furthermore, the ACA also mandates that mental health and substance use disorder benchmark coverage be provided with parity to covered medical and surgical services, compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008).

California has taken tremendous steps in implementing the opportunities offered to this population under the ACA; most notably in the state's recent expansion of Medi-Cal coverage to include qualified individuals with incomes at or below 133 percent of the federal poverty level. California's expansion of Medi-Cal eligibility means that qualified adults will for the first time have access to mental health and substance use disorder services through the Medi-Cal program or subsidized insurance without having a disability. As part of this historical coverage expansion, California also expanded the benefit package for all Medi-Cal beneficiaries to include a fuller continuum of mental health care, which now ranges from primary care-based consultation to inpatient psychiatric care, with a robust continuum of rehabilitative and other services in between. Medi-Cal managed care plans and county mental health plans share in the responsibility of caring for the physical and mental health needs of their enrollees.

CBHDA Proposal for 1115 Waiver Renewal

Behavioral Health Delivery System Reform Incentive Program

The 2010 Delivery System Reform Incentive Program (DSRIP) has been critical in supporting the public hospital and clinic system safety net in anticipation of health care reform. Under this program, the 21 public hospital systems have built a strong foundation of delivery system transformation that will help ensure access to quality healthcare for California's Medicaid beneficiaries. CBHDA strongly supports continued investment in California's public hospital system through a successor DSRIP as part of the waiver renewal.

In addition to a successor public hospital DSRIP, CBHDA proposes that California implement a parallel DSRIP focused on reducing the morbidity and mortality of beneficiaries with serious mental illness. As underscored earlier in this letter, the majority of mortality in this population is attributed to largely treatable chronic health conditions, such as diabetes, respiratory and cardiovascular disease.

The 2006 NASMHD report on mortality and mental illness outlines six recommendations for steps states should take to address this disparity:

1) Prioritize the public health problem of morbidity and mortality and designate the population with serious mental illness as a priority health disparities population.
2) Improve access to physical health care.
3) Promote coordinated and integrated mental health and physical health care for persons with serious mental illness.
4) Support education and advocacy.
5) Address funding.

[3] UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, "Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions."

6) Develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services.

Now is the time to act. California has taken tremendous strides over the last few years to improve access to care for individuals with serious mental health and substance use conditions – including recent expansions in coverage and benefits. Medi-Cal managed care plans and county mental health plans have increasingly begun to work across systems in order to be able to more appropriately coordinate care for shared beneficiaries. California's Cal MediConnect Program has provided a more targeted opportunity in those demonstration counties to improve shared accountability across systems for a particularly vulnerable population. California's mandatory enrollment of seniors and persons with disabilities into the Medi-Cal managed care program also provides a new opportunity to better coordinate care and improve outcomes for complex beneficiaries.

CBHDA recommends that California develop a DSRIP under the waiver renewal in which incentives are earned based on performance on measures that the Medi-Cal managed care plan and county mental health plan can jointly influence. CBHDA particularly supports the tiered approach offered by a DSRIP that allows for a phased-in implementation. CBHDA believes that a phased approach to achieving a greater level of shared accountability and savings between managed care plans and county mental health plans makes the most sense for California. For example, in the first year, measures could be process-oriented, representing tangible, measurable activities that indicate collaboration and exchange of information that form the foundation necessary for integrating care. Such measures could include activities such as the establishment of care plans, health information exchange structures and emergency services and hospitalization notification. The measures would then evolve to health status improvement, system quality improvement and other outcome measures in subsequent years. Such outcomes might include reduced emergency and inpatient utilization for the enrolled population.

Priority areas for shared accountability and savings could include:

1) Inpatient and Emergency Utilization

2) Pharmacy

The ultimate goal of the proposed behavioral health DSRIP would be the reduction in the preventable consequences of chronic disease and mental illness and an incremental increase in the lifespan of the enrolled population. The benefits of this performance-focused collaboration between the health plans and the county mental health plans would result in improved care and lower cost for Medi-Cal beneficiaries with mental illness and chronic health conditions.

<u>Drug Medi-Cal Organized Delivery System Demonstration</u>

CBHDA strongly supports the state's proposed demonstration to test new and innovative organized service delivery system models that improve care, increase efficiency, and reduce costs in the Drug Medi-Cal Program. California has a historic opportunity to fill known gaps in access to substance use services through the recent expansion of Medi-Cal eligibility and benefits. This promise will only be realized through an expansion of provider capacity. The proposed "organized delivery system" demonstration provides the state, counties, and providers the chance to jointly develop the resources needed to address the service gaps that now result in a lack of treatment.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration will enable counties to leverage their resources and develop strategies for screening, referrals, and service delivery depending on local conditions, including network capacity, geography, and cultural or linguistic diversity. The DMC-ODS demonstration also gives state and county officials authority to better select quality providers that meet treatment needs. The DMC-ODS demonstration is the best way to strike an appropriate balance between expanding access to vital services and assuring that high quality substance use services are consistently provided.

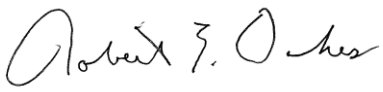
Finally, the DMC-ODS demonstration will maximize services for beneficiaries through improved coordination of substance use treatment with county mental health programs, public safety systems, primary care, and other local human services providers. The program will support coordination and integration across systems with the goal of more appropriate use of health care – such as reduced emergency room and hospital inpatient visits – for beneficiaries.

Whole Person Care Pilots

CBHDA joins our county partners in recommending that California propose authority for the development of County "Whole-Person Care" Pilots to test innovative care coordination and collaboration strategies for targeted Medi-Cal populations. The pilot program would allow participating counties additional flexibility in how they allocate resources to best address the issues contributing to the target population's health conditions and current utilization of services across sectors. Part of this program would be hinged on federal financial participation for services not traditionally covered in the Medicaid program, such as targeted housing assistance. While counties would have flexibility to test approaches for identifying the target population and range of services and supports provided, all participating counties would be measured against a uniform set of identified outcomes focused on overall improvements in health, well-being, and efficiency.

Thank you for your continued commitment to California's community behavioral health system. We welcome the opportunity to discuss our comments and work collaboratively with DHCS to ensure a successful waiver renewal. If you have any additional questions, please do not hesitate to contact Molly Brassil on my staff at mbrassil@cbhda.org.

Sincerely,



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