

California Mental Health Planning Council

ADVOCACY COMMITTEE

October 16, 2013

1:30 to 5:00 p.m.

Red Lion Inn – Woodlake

500 Leisure Lane

Sacramento, CA, 95815

1-866-539-0036

ITEM	TIME	TOPIC	Lead	TAB	PAGE
1.	1:30	Introductions and Agenda Review	<i>Gail Nickerson, Co-Chair</i>		
2.	1:35	New Business	<i>Adam Nelson, Co-Chair</i>		
3.	1:45	Review and Approve Minutes	<i>Gail Nickerson, Co-Chair</i>	A	19
4.	1:50	MFTs – Recognition by Medicare <i>Sara Kashing, MFT, California Marriage and Family Therapists</i>	<i>Adam Nelson, Co-Chair</i>	B	25
5.	2:50	<i>Discussion and next steps</i>			
	3:00	Break			
6.	3:20	The SPA and the Peer Certification Process <i>DHCS Representative (Invited)</i> <i>Sharon Kuehn, Program Manager, Peers Envisioning and Engaging in Recovery Services</i>	<i>Gail Nickerson, Co-Chair</i>	C	35
	4:20	<i>Discussion and next steps</i>			
7.	4:30	Finalization of Position Statements	<i>Adam Nelson, Co-Chair</i>	D	43
8.	4:40	W3 (who does what by when)	<i>Gail Nickerson, Co-Chair</i>		
9.	4:45	Develop Report Out for General Session	<i>Adam Nelson, Co-Chair</i>		
10.	4:50	Plus/Delta	<i>Gail Nickerson, Co-Chair</i>		
11.	4:55	Plan Agenda for next meeting	<i>Andi Murphy, Staff</i>		

Committee Members:

Co-Chairs: Barbara Mitchell

Gail Nickerson

Vice – Chair: Adam Nelson

John Ryan
Monica Wilson
Stephanie Thal
Karen Bachand
Caron Collins

Sandra Wortham
Nadine Ford
Daphne Shaw
Chloe Walker

Staff: Andi Murphy

California Mental Health Planning Council

Vision and Mission

CHAIRPERSON
John Ryan

EXECUTIVE OFFICER
Jane Adcock

- **Advocacy**
- **Evaluation**
- **Inclusion**

Vision

The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are culturally competent, responsive, timely, and accessible to all of California's populations.

Mission

The CMHPC evaluates the mental health system for accessible and effective care. It advocates for an accountable system of seamless responsive mental health services that are strength-based, consumer and family driven, recovery-oriented, culturally competent, and cost-effective. To achieve these ends, the Council educates the general public, the mental health constituency, and legislators.

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

Purpose: The purpose of the Advocacy Committee is to address public issues affecting the effectiveness of mental health programs and quality of life for persons living with mental illness. This includes increasing public mental health awareness through press and media, partnering with local consumer advocacy agencies for access and improved quality of care, and responding to proposed legislation, rule-making, and budget bills based on the CMHPC platform.

Mandate: WIC 5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.
- (l) To suggest rules, regulations, and standards for the administration of this division.

Guiding Principles: All advocacy efforts and proposed legislation shall be reviewed to ensure that the following best practices and principles are included.

Cultural Competence	Full Accessibility across the life span	Wellness & Recovery
Community Collaboration	Consumer & Family member driven or influenced	Integrated Services

OBJECTIVES:

1. Review and respond to pending legislation, proposed code language, regulatory, and judicial actions that diminishes or adversely affects MHS programs and compromises the state mental health plan.
2. Inform a mental health system that incorporates public and private resources to offer community-based services that embrace recovery and wellness, and are strength-based, culturally competent, and cost-effective.
3. Develop talking points to use for education and commentary on mental health issues in the media.
4. Respond to and partner with Consumer agencies and family member organizations to support their activities when needed.

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

Roles and Responsibilities:

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

Members are expected to serve as advocates for the committee's charge, and as such, could include, but are not limited to:

- Attend meetings
- Speak when authorized at relevant conferences and summits when requested by the committee or the Planning Council
- Participate in the development products such as white papers, opinion papers, and other documents
- Distribute the committee's white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

Membership:

NAME
<i>Barbara Mitchell, Co-Chair</i>
<i>Gail Nickerson, Co-Chair</i>
<i>Cindy Claflin</i>
<i>Caron Collins</i>
<i>Nadine Ford</i>
<i>Adam Nelson MD</i>
<i>John Ryan</i>
<i>Daphne Shaw</i>
<i>Stephanie Thal, MFT</i>
<i>Chloe Walker</i>
<i>Monica Wilson</i>
<i>Sandra Worthom</i>
<i>Staff: Andi Murphy (916) 440-7813 andi.murphy@cmhpc.ca.gov</i>

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

General Principles of Collaboration:

The following general operating principles are proposed to guide the committee's deliberations:

- The committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the committee's common goals.
- To that end, members will:
 - Commit to expending the time, energy and organizational resources necessary to carry out the committee's mission
 - Be prepared to listen intently to the concerns of others and identify the interests represented
 - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
 - Regard disagreements as problems to be solved rather than battles to be won
 - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

Decision Making:

The Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote. Minority views will be included in the meeting highlights.

Meeting Protocols:

The Committee's decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. Viewpoints will be recorded, but not be attributed to a specific member. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting's highlights at the beginning of the following meeting.

Media Inquiries:

In the event the Committee is contacted by the press, the Chairperson will refer the request the CMHPC's Executive Officer.

CMHPC MANDATES

	Council Activity	Deliverable
<p>Federal Public Law (PL) 106-310- the MHPC should perform the following functions:</p>	Annual review of CA SAMHSA BG application	Yes
<ul style="list-style-type: none"> • Review the State mental health plan required by PL 106-310 and submit to the State any recommendations for modification 	Annual review of CA Implementation Report	Yes
<ul style="list-style-type: none"> • Review the annual implementation report on the State mental health plan required by PL 106-310 and submit any comments to the State 	Legislative advocacy, Participation on HCR and other issue-specific committees,	No
<ul style="list-style-type: none"> • Advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems 	Workbook Project w/ Local MH Boards	Yes
<ul style="list-style-type: none"> • Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the State. 	None yet, new requirement in FY 2012-13 TBL	
<p>California Welfare and Institutions Code (WIC) 5514- There shall be a 5-person Patients' Rights Committee formed through the CMHPC. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and Director of State Hospitals regarding department policies and practices that affect patients' rights.</p>		
<p>WIC 5771- Pursuant to PL 102-321 the Planning Council shall be responsible to fulfill those mental health planning requirements mandated by federal law.</p>		
<p>WIC 5772 - The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:</p>		
<ol style="list-style-type: none"> 1. To advocate for effective, quality mental health programs. 	Legislative testimony, Participation on HCR and other issue-specific committees	No
<ol style="list-style-type: none"> 2. To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs. 	SAMHSA BG Peer Reviews, Council Meeting to showcase model programs, Legislative testimony	No
<ol style="list-style-type: none"> 3. To review program performance in delivering mental health services by annually reviewing performance outcome data as follows: <ul style="list-style-type: none"> • To review and approve the performance outcome measures. • To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources. • To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards. • To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties. 	Workbook Project w/ Local MH Boards, SAMHSA BG Peer Reviews,	Yes
<ol style="list-style-type: none"> 4. When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature. 		

CMHPC MANDATES

WIC 5772 - continued	Council Activity	Deliverable
5. To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.		
6. To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.		
7. To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.		
8. In conjunction with other statewide and local mental health organizations assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.	Coordinate training needs with CiMH and CALMHBC	No
9. To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.		
10. To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.		
11. To suggest rules, regulations, and standards for the administration of this division.		
12. When requested, to mediate disputes between counties and the state arising under this part.		
13. To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.		
14. To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
15. To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
WIC 5820 - Each OSHPD five-year WET plan shall be reviewed and approved by the Planning Council.	Participate in OSHPD WET Advisory Committee; Coordinate Council review of 5-Yr Plan	
WIC 5821 - The Planning Council shall advise the OSHPD on education and training policy development and provide oversight for the department's education and training development.	Participate in OSHPD WET Advisory Committee	

CA Mental Health Planning Council State Statutes

5514. There shall be a five-person Patients' Rights Committee formed through the California Mental Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of mental health services.

5771. (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Health Care Services shall make appointments from among nominees from various mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and representatives who are direct service providers from both the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Health Care Services shall, with input from state-level advocacy groups, consumers, family members

and providers, and other stakeholders, propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

5771.1. The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section **5772**. Such membership shall not affect the composition requirements for the council specified in Section **5771**.

5771.3. The California Mental Health Planning Council may utilize staff of the State Department of Health Care Services, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

5771.5. (a) (1) The Chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

(g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.

(h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.

(i) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.

(j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.

(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

(l) To suggest rules, regulations, and standards for the administration of this division.

(m) When requested, to mediate disputes between counties and the state arising under this part.

(n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.

(o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

(p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

5820. (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

LEGISLATIVE PLATFORM

OCTOBER 2012

Mandatory Planks

- Support any proposal that embodies the principles of the *Mental Health Master Plan*.
- Support any proposal that addresses the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity and promoting the employment of consumers and family members.
- Support any proposal that augments mental health funding, consistent with the principles of least restrictive care and adequate access and oppose any cuts.
- Support mental health insurance parity.
- Support legislation that ensures quality mental health services in health care reform
- Support expanding supportive affordable housing.
- Support expanding employment options for people with psychiatric disabilities.
- Support any proposal to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.
- Support any initiatives that reduce or eliminate the use of seclusion and restraint
- Oppose all bills related to “NIMBYism” and restrictions on housing and siting facilities for providing mental health services.
- Support initiatives that provide comprehensive health care and oppose any elimination of health benefits for low income beneficiaries.
- Oppose any legislation that adversely affects the principles and practices of the Mental Health Services Act.

Discretionary Planks (Require Deliberation & Discussion)

- *Support any proposal that advocates for blended funding for programs serving clients with co-occurring disorders that include mental illness.*
- *Support any proposal that advocates for providing more services in the criminal and juvenile justice systems for persons with serious mental illnesses or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.*
- *Support any proposal that specifies or ensures that the mental health services provided to AB109 populations are paid for with AB 109 funding.*
- *Support activities that ensure that the federal government reimburses counties for the cost of mental health services to Veterans.*
- *Remain neutral or watch all legislation related to expanding the scope of professional licensure except when it affects quality of care.*

LEGISLATION REVIEW PROCEDURE

Urgent & Non-Urgent

Approved: June 2012

1. For items that are on the “automatic” approval planks of the platform and/or are **non-urgent** (more than seven days of response time):
 - Contact staff directly via email, with a cc to the Executive Officer, requesting action, and define the level of urgency of the request, informing staff of the deadline (and nature of the deadline i.e., which Legislative committee? How close to a final vote etc.) and suggested points that should be made in the letter.
 - *Staff performs analysis and presents the information, synopsis, and recommendation, and draft support/oppose letter to the Advocacy Committee for response and recommendation with the caveat that “approval is assumed if not contested within 7 days”.*
 - *If Advocacy Committee reviews the information and has comments, its recommendation /amendments/ approval is returned to staff with a cc to the Executive Officer and Executive Committee, including Leadership, **within 7 days**. The recommendation may be developed by a workgroup **within** the Advocacy Committee with expertise in the legislation’s subject area that is available and willing to do it within the time frame.*
2. *If the item **IS** urgent (requires response in **LESS** than seven days):*
 - *Request for action/analysis is addressed **to Executive Officer and staff, who will ensure that the information is forwarded to Leadership, Advocacy and Executive Committee***
 - *Staff performs analysis, and presents information, synopsis, and recommendation, with accompanying draft support/oppose letter, **to Leadership & Executive Committee, with a cc to Advocacy.***
 - *Leadership approves/amends recommendation and support/oppose letter, with input from Advocacy and Executive committees (if requested and time permits).*
3. Items that are NOT on the “automatic” approval planks should be vetted by **Leadership, by way of the Executive Officer or staff, who will also inform Executive Committee and Advocacy.** Request should include the same information as above – the action requested, the reason for its urgency, and the nearness of the vote. Staff may wish to perform preliminary analysis, but no document will be produced unless approved by Leadership. The final document will be distributed to the Advocacy and the Executive Committee.

Copies of Bills and/or existing Analyses may be requested from: Tracy Thompson Tracy.Thompson@cmhpc.ca.gov (916) 552-8665 or Andi.Murphy@cmhpc.ca.gov (916) 440-7813

Updated April 2013 – new phone numbers, committee name change etc.

LEGISLATION REVIEW PROCEDURE

Urgent & Non-Urgent

Approved: June 2012

Requests for analyses or support/oppose letters should be directed to Jane.Adcock@cmhpc.ca.gov (916) 319-9343 for “non-automatic” items with a cc to Andi Murphy.

X INFORMATION

TAB SECTION: A

___ ACTION REQUIRED:

DATE OF MEETING: 10/16/13

PREPARED BY: Murphy

**DATE MATERIAL
PREPARED: 9/13/13**

AGENDA ITEM: Review and Approve Minutes

ENCLOSURES: June Highlights

OTHER MATERIAL RELATED TO ITEM:

ISSUE:

The Draft minutes from the June meeting in Burlingame are attached. They were also emailed on July 2, 2013.

They are attached for review and approval.

ADVOCACY COMMITTEE

**Meeting Highlights
June 19, 2013**

Present

Barbara Mitchell, Co-Chair

Adam Nelson

Presenter: Jay Lee,
*HomeBase – The Center for
Common Concerns*

Gail Nickerson, Co-Chair

Chloe Walker

Sandra Wortham

John Ryan

Caron Collins

Stephanie Thal

Karen Bachand

Daphne Shaw

Staff: Andi Murphy

New Business: Mitchell noted that a vice-chair was needed for the October meeting to help Nickerson during Mitchell's planned absence in October. Nelson volunteered and is herewith the vice-chair.

Review and Approve Minutes: Nelson moved to approve, and Wortham seconded. No corrections were requested, and the minutes were approved.

Update on Federal and State Housing Policy and Impact on Homelessness: Mitchell introduced Jay Lee, of HomeBase. HomeBase specializes in public policy surrounding homelessness and special needs populations, particularly in the area of NIMBYism.

Lee provided a quick overview of federal issues impacting homelessness and housing policy and a smattering of state policy impacts. First he reviewed the Federal anagrams:

USICH - United States Interagency Council on Homelessness- The original strategic plan to end homelessness - created in 1986. It was updated recently as the HEARTH Act.

HEARTH - Homeless Emergency Assistance and Rapid Transition to Housing – Act, signed by Obama in 2009 – bases housing program funding on several indicators and a requirement for planning and outcomes reporting as a condition for funding. HEARTH is centered around data collection and program outcomes - recidivism, length of time as homeless, etc, and will be scored by HUD as a barometer that is watched by ALL housing funders. Applications for funding also are judged on their coordination and leverage with other agencies, Strategic Planning, developing a continuum of care (COC), and sustaining, long term solutions. 30% is set aside for permanent housing for all populations, and 10% is set aside for housing for disabled.

HUD- Housing and Urban Development. Federal funders and policy makers for housing initiatives.

ESG – Emergency Solutions Grants distributed through HUD. ESG now emphasizes rapid rehousing and prevention. Rapid rehousing consists of rental assistance or help with utilities if at risk of eviction, enabling them to stay housed rather than starting over. If they have actually lost their housing and are recently

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homeless, they are housed as quickly as possible through rental deposit assistance and rent payment assistance for a few months.

Section 811 – HUD sponsored Supportive Housing for Persons with Disabilities program designed to assist the lowest income people with significant and long-term disabilities to live independently in the community by providing affordable housing linked with voluntary services and supports.

He also commented that HUD wants to divide the responsibility of care cleanly but it has had unintended consequences. For example, once you exceed 90 days in an institution (whether it is a treatment program or incarceration, etc.), you become the responsibility of the sheltering organizations. This becomes a disincentive for homeless to accept drug and alcohol treatment because they lose their shelter benefit if the treatment exceeds 90 days. The changes in the rules and definitions for homelessness, chronic homelessness, imminent risk of homeless, etc. have also contributed to a false impression that homelessness has decreased when in reality it is just measured differently. These changes have also resulted in a type of return to “fail first” system that won’t permit warm hand-offs between housing models. Therefore, people who might otherwise be eligible for transitional housing might be denied it because they are not at risk, or imminent risk of homelessness because they are being sheltered at a hospital or jail for an excess of 90 days.

When asked if he had found that there are people who don’t want to end their homelessness, he replied that it is an issue of not having identified the right mix of services rather than a preference for homelessness. HUD has made the definitions for homelessness so stringent that it is nearly impossible to “qualify” a person as eligible for services.

Lee observed that current State impacts on homelessness are loss of Redevelopment Agencies (RDAs) and the pending legislation “Rights of Homelessness” legislation (AB 5 – Ammiano 2 yr. dead). He also felt that the federal sequestration (uniform cutting of ALL program funding across the board as part of the federal budget agreement) had less of an impact on housing programs than those created by the new regulations.

Budget Update: Murphy reported that the legislature had agreed upon a budget and submitted it to the Governor, and although not yet signed, it appeared promising. The Committee was pleased to note Dental benefits had been restored, and that the proposed shift of Realignment funds to Cal-WORKS had been averted.

Mental Health “Background Check “

The material submitted for the Background check was considered very detailed and a helpful resource. Although it was noted that there would not be enough time to discuss each section or topic, it was suggested that anything that needed further clarification could be discussed. Nothing specific was mentioned, but the following suggestions for general understanding were offered:

- We should post a list of acronyms on our website - preferably with a link to the organizations referenced.
- Same with the Power Points on our websites.
- Would it be possible to do a cd of the presentations?

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- We should provide context and background in the packet when we schedule a presenter, from the public policy perspective.

Develop Communication Strategy/Position Statements -

It was agreed at the April meeting that the June meeting time would be used to review the Alternatives to Institutionalization literature that was submitted to Senator Steinberg by the Mental Health Coalition. The literature would be used to inform a position statement supporting crisis residential programs and other alternatives. The Budget document for Senator Steinberg's Mental Health Wellness Act was reviewed, and it was determined that not all of the committee members agreed with all of the points of the budget document. Therefore, it was decided to craft the statement as a consensus document, and include concepts that all could agree upon.

The following DRAFT statement was crafted with agreement to pursue its refinement in the following month (July).

The California Mental Health Planning Council endorses improved access, a more thorough continuum of care, and based on clinical need, that is represented by many available alternatives to institutionalization such as crisis residential centers.

Review of Pending Legislation/Activities to Date

Updates were provided on the Legislation and issues that the Committee had been following – in particular, SB 585 – which co-opted Senator Yee's Bill Language and proposes to allow county Boards of Supervisors to adopt Laura's Law through the budget process. The Advocacy committee has notified the Assembly Health Committee of its objection to the new language after notifying the Senate President Pro Tempore of its strong concern.

An issue that was presented for the Committee's consideration was the issue of Medicare reimbursement for Marriage and Family Therapists. They can bill under Medicaid but not Medicare, despite being a recognized care provider. Given California's commitment to the ACA, Medicaid Expansion, and Dual Eligibles project, and the known shortage of mental health providers even as parity is being inserted into the language of Essential Health Benefits, it seems unreasonable to exclude MFTs from reimbursement by such a significant funder of services. It was suggested that the committee send letter to Boxer and Feinstein supporting MFT reimbursement. There was also discussion on why the Platform specifies that it will stay neutral on scope of work issues, and whether this topic would be considered a licensure or scope of work issue. Shaw agreed to follow up on it with the former Executive Officer to learn the history and context of that Legislative plank. It was also suggested that the Committee schedule a presentation on it for the October meeting in order to better understand the issue, after ascertaining with Leadership that it does not contradict Council position on remaining neutral on matters of scope of work and licensure

W3 (who does what by when) –

Staff will schedule meetings with teleconference ability monthly to develop the statements.

Staff will follow up on pending legislation and inform committee.

Draft and send letter to governor supporting the Mental Health Wellness Act.

Shaw to follow up on guild issue

ADVOCACY COMMITTEE

Nickerson to discuss with Leadership if it is appropriate and within the parameters of the Legislative Platform for the Advocacy committee to pursue supporting the reimbursement of MFTs.

Plus/Delta

The meeting went a little slower pace, which was nice, but it still feels like there is not enough time scheduled for follow-up discussion to plan next-steps when the committee hears a presentation.

Plan Agenda for next meeting

The following items were proposed:

Follow up on MFT issue - invite CAMFT if leadership approves

Develop policy statement on alternative to institutionalization

Develop policy statement on gun violence

Peer Operated programs - Find somebody involved with the Peer Certification process to present, and find somebody involved with SPA.

Invite Eduardo Vega to present on peer certification

Follow up on Homeless issues. Find state representative to present on state issues and policy

DRAFT

X INFORMATION

TAB SECTION: **B**

___ ACTION REQUIRED:

DATE OF MEETING: 10/16/13

PREPARED BY: **Murphy**

DATE MATERIAL
PREPARED: 9/13/13

AGENDA ITEM: Medicare Recognition of Marriage and Family Therapists (MFTs)

ENCLOSURES: CAMFT – *The Federal Scene: Status of Medicare Legislation*; Riemersma
AAMFT – *Medicare Coverage of Marriage and Family Therapists*; Rasmussen

OTHER MATERIAL RELATED TO ITEM: CPCA – *Allow Medicare Reimbursement for Marriage & Family Therapists*

ISSUE:

October 1st marked the initial registration for expanded populations into healthcare coverage under Obama’s Accountable/Affordable Care Act (ACA). Prior to that, the state of California has been ramping up for the expansion through the 1115 waiver, the transference of MRMIB Healthy Families to Medi-Cal, and the Coordinated Care Initiative for the dually eligible. Throughout the plan consolidations, there have been repeated petitions and Appeals by the Administration to lower Medi-Cal provider reimbursement rates by 10%. This has created a disincentive to participate in the programs and worsens a workforce shortage that was already facing a larger care population under the 1115 waiver.

Under the ACA, mental health service and substance use disorder services is one of the 10 “essential” health benefits required to be included in health plans. The workforce for these services are spread thin in populated areas and nearly non-existent in most rural areas. Marriage and Family Therapists, who receive the same amount of training and are required to provide the same number of practice hours prior to licensure as Licensed Clinical Social Workers (LCSWs), are authorized to provide mental health counseling but are not recognized as direct billers to Medicare like LCSWs.

There have been repeated legislative attempts to include MFTs as a billable provider. Several California health advocacy organizations, such as California Primary Care Association and California Rural Health Association fully support their inclusion and federal entities, such as the Health Resources and Services Administration, consider them “core” providers. Further, an advisory body to the (federal) Secretary of Health and Human Services has gone on record as advocating for the inclusion of MFTs in the Medicare program. However, CAMFT reported in “Status of Medicare Legislation” (attached) that a study conducted by the Medicare Payment Advisory Commission on the issues of access to mental health services, equity, and cost considerations were inconclusive.

The American Association of Marriage and Family Therapists states in “Medicare Coverage of Marriage and Family Therapists” (attached) that this is not a “scope of practice” issue, and that MFTs are not seeking to expand their area of practice beyond what they are already qualified and licensed to do already. It is an equity issue for the MFTs and an access issue for individuals in need of counseling and mental health services, particularly in rural and underserved areas. CPCA states that MFTs comprise the largest percentage of California’s Mental Health Providers at 37%, followed by LCSWs at 22% (see attached).

Medicare Coverage of Marriage and Family Therapists

Issue

Improving access to Medicare-covered mental health benefits by recognizing state-licensed Marriage and Family Therapists (MFTs).

Background

In order for a mental health service to be covered by Medicare, the service must be for the diagnosis and treatment of mental illness. In addition, the mental health service must be delivered by a “covered” practitioner who is legally authorized to perform that service under state law. (MFTs are licensed in every state and the District of Columbia.) The covered mental health professionals recognized by Medicare presently include psychiatrists, psychologists, mental health clinical nurse specialists and Clinical Social Workers (CSWs). Marriage and Family Therapists (MFTs) are not listed as Medicare-covered providers despite the fact that MFTs have education, training and practice rights equivalent to or greater than existing covered providers.

Several recent reports have indicated that limited access to mental health services is a serious problem in the Medicare program. This is particularly true in rural areas, which have historically had difficulty attracting and retaining health professionals. According to a recent Surgeon General's report, 37% of seniors display symptoms of depression in a primary care environment. Equally striking is that fact that this depression often goes unrecognized and therefore untreated. The failure to treat depression often leads to more primary care visits and higher Medicare expenditures. The unavailability of qualified mental health professionals compounds the mental health crisis among the elderly population and increases the costs to the program.

Currently, the federal government recognizes five mental health disciplines as core mental health professionals. These are psychiatrists, psychologists, mental health clinical nurse specialists, clinical social workers and marriage and family therapists. Of these five groups, only marriage and family therapists are not recognized by Medicare.

The cost of adding MFTs to Medicare is modest. According to the Congressional Budget Office (CBO), the cost of adding both MFTs and Licensed Professional Counselors (LPCs) to the Medicare program would total \$100 million during its first five years, and \$400 million during ten years (CBO Score: 111th HR 3962, Sec.1308). As the number of MFTs comprises about half of the total for the two professions combined, MFTs would account for roughly half of the cited costs. MFTs and LPCs would be paid at 75% of the rate provided to doctoral-minimum practitioners (physicians and clinical psychologists), the same 75% rate applicable to Social Workers, who also are masters-minimum professionals.

The U.S. Senate has twice approved legislation recognizing MFTs under Medicare (S 1 in 2003 and S 1932 in 2005), while the House also has twice approved such legislation (HR 3162 in 2007 and HR 3962 in 2009). Currently, there is bipartisan legislation in the House and Senate to

expand Medicare to include MFTs as covered mental health professionals (S 604, S 1680, HR 2954).

Discussion

MFTs are legally authorized through state licensing laws to treat mental illness. MFTs are required to obtain a master's degree in a mental health discipline and two years post-graduate supervised clinical experience, much like existing covered mental health providers, such as clinical social workers. This legislation will not change the mental health benefit or modify the MFT scope of practice, but will merely allow Medicare beneficiaries who need medically necessary covered mental health services to obtain those services from a marriage and family therapist. In essence, our proposal increases the pool of qualified providers that Medicare beneficiaries can choose from without change the services.

Significant shortages of mental health professionals continue to exist in many areas of the country, and rural counties suffer disproportionately. Among 1253 rural counties with 2,500 to 20,000 people, nearly three-fourths lack a psychiatrist, 58 percent have no clinical social worker, and 50 percent are missing a master's or doctoral psychologist. The supply of all these professionals is far lower in the 769 counties with fewer than 2,500 people. Further, the Health Resources Services Administration indicated that 90% of psychiatric and mental health nurses with graduate degrees were in metropolitan areas. There are many counties where only a marriage and family therapist may be present to serve the elderly population. A targeted study of licensed professionals in a sampling of states found many counties with no Medicare mental health providers, but with a marriage and family therapist: including Clayton, Iowa; Hamilton, Florida; Hutchinson, Texas; and Brunswick, Virginia; to name a few.

Federal government agencies also understand the valuable role MFTs play in increasing access to mental health services. The advisory committee to the Secretary of Health and Human Services recently encouraged inclusion of MFTs in the Medicare program.

The Health Resources and Services Administration (HRSA) further recognizes MFT's participation in caring for underserved populations. One of HRSA's responsibilities is to identify areas of the country with mental health shortages. The purpose of this designation is to identify communities with unmet mental health service needs and pursue opportunities to recruit qualified mental health professionals to those communities.

Ironically, HRSA counts marriage and family therapists among the "core" providers qualified to deliver necessary mental health services. The failure of the Medicare program to recognize marriage and family therapists leaves many elderly beneficiaries without access to care and creates a conflict in federal law. For example, in communities where the only mental health professional available is a marriage and family therapist, the Health Resources and Services Administration may count that MFT and consider the community well-served. In fact, the elderly of that community have no access to the MFT because Medicare will not recognize the provider. Consequently, the government doesn't even know that there is an access problem because the two federal programs don't have consistent criteria.

Marriage and family therapists are not seeking to expand the scope of mental health services covered by Medicare, nor are they seeking to expand their own scope of practice. Instead, MFTs are simply trying to correct an inequity that restricts beneficiaries' access to a particular type of qualified mental health provider.

Furthermore, MFTs are not seeking higher payments for their services than are currently paid to clinical social workers. Under our proposal, marriage and family therapists would be paid at the same rate as clinical social workers (75% of the psychologists rate) for mental health services already covered by Medicare, which the MFT is legally authorized to provide in the state in which the service was delivered.

The importance of increasing the number of qualified Medicare mental health professionals by including MFTs is supported by many health organizations, including but not limited to the Depression and Bipolar Support Alliance, the National Council for Community Behavioral Healthcare, the National Rural Health Association and the California Primary Care Association.

Recommendation

Improve access to Medicare-covered mental health services by including marriage and family therapists among the list of providers who can deliver covered mental health services and pay for those services at the same rate as clinical social workers.

If you have any questions or need additional information, please contact:

Brian Rasmussen

AAMFT Government Affairs Manager

112 S. Alfred St.

Alexandria, VA 22314

703-253-0463

<http://www.aamft.org/imis15/Content/Advocacy/Medicare.aspx> accessed 9/13/13

The Federal Scene
STATUS OF MEDICARE LEGISLATION

Mary Riemersma, Executive Director

There are currently several bills in the Senate and House with the intent to have marriage and family therapists recognized within Medicare. In the House are HR 898, HR 3899 and HR 1522, and in the Senate are S 1760 and S 690. HR 898, if successful, would expand utilization to marriage and family therapists, S 1760, HR 1522, HR 3899 and S 690 would expand utilization to marriage and family therapists as well as licensed professional counselors (LPCs). LPCs are licensed in 45 states throughout the country, however, LPCs do not exist in California. Getting MFTs included in Medicare is critical to the profession, both to be able to work with the elderly and disabled, to be reimbursed by Medicare, and to be treated on par with the other mental health disciplines, also, many employment and reimbursement opportunities rely upon Medicare language. Passage of any of these measures, however, is no simple task. There are numerous, and sometimes insurmountable, obstacles that stand in the way of passage.

We have yet to receive a score from the Congressional Budget Office (CBO) placing a price tag on the inclusion of marriage and family therapists. Of course, we argue that there will be no increased costs, and in fact may even be cost savings. CBO likely believes otherwise. We have been seeking this score for nearly three years.

Additionally, MFTs along with various other professionals, were previously relegated to a study by the Medicare Payment Advisory Commission (MedPAC) to determine the appropriateness of MFTs and other being included under Medicare Part B (the section of Medicare where we are seeking inclusion). MedPAC met in late March to consider MFT and other professions for inclusion in

Medicare, primarily looking at three issues:

- **Is there an existing mental health access problem?**
- **Is there an equity issue?**
- **Are there cost considerations?**

Apparently, MedPAC was reluctant to acknowledge an access issue, even though there is documentation to support a shortage of mental health professionals in rural areas. There was also the belief that the access problem, if demonstrated, might only be addressed in California with the large population of MFTs here. As we understand, MedPAC did not really delve into the equity issue, and they likewise had no information on cost. Further, the presentation made to MedPAC by their staff person, a physician, was biased against the profession. The good news is that this particular staff person has now left the Commission and a new staff person has been given lead responsibility for the report to the Commission. Fortunately, the new lead is a former colleague of our

Federal lobbyist. We trust that this relationship will reap rewards. Further, our lobbyist will be working with MedPAC staff to identify Mental Health Professional Shortage Areas. Additionally, we are being assisted by the California Primary Care Association, who is very supportive of MFT inclusion both in Medicare at the Federal level and in MediCal, at the State level. They, too, have been in communication with MedPAC and have supplied them with information about need and access. They are also attempting to rouse their related organizations throughout the country to join with the CPCA in the quest to expand Medicare reimbursement.

Medicare is the primary charge of our Federal lobbyist, Capitol Associates Inc., which CAMFT and AAMFT jointly underwrite. However, in addition, CAI, and primarily Bill Finerfrock on CAI's staff has also been working to assure MFT inclusion in Federal legislation called the "Health Care Safety Net." The bill would create a Federal definition of "mental and behavioral health professional" for purposes of the National Health Service Corps Loan Repayment Program. This bill also creates a new Tele-Mental Health program, and MFTs will likely be added to this section as well, even though at this time, the legislation relies upon the language contained in Medicare law.

<http://www.camft.org/Legislative/medicare.htm> accessed 9/13/13

Allow Medicare Reimbursement for Marriage & Family Therapists

California has a severe shortage of mental health professionals, particularly in rural areas. Many community clinics and health centers across the state, therefore, are struggling to meet the mental health needs of their patients. Clinics can obtain federal reimbursement for mental health services only from categories of providers approved by Medicare. Unfortunately, in many areas of California, Marriage and Family Therapists are the only available mental health providers.

Which mental health providers are currently covered by Medicare?

- Psychiatrists, psychologists, mental health nurse specialists, and licensed clinical social workers (LCSWs), but not Marriage and Family Therapists.

Who are Marriage and Family Therapists (MFTs)?

- MFTs are state-licensed mental health providers who have had extensive education, training, clinical fieldwork, and rigorous examinations.
- MFTs' approach to therapy results in their ability to treat patients' conditions quickly and cost-effectively.

Why should MFTs be reimbursable under Medicare?

California has a severe shortage of mental health providers.

In rural areas, MFTs are often the only available provider.

- In rural areas, mental health providers are scarce and MFTs are often the only available provider.

MFTs make up the largest proportion of mental health providers in the state.

- MFTs (37%), LCSWs (22%), psychologists (18%), psychiatrists (8%), advanced practice nurses in psychiatric or mental health (1%), others (14%)

MFT services cost less than other mental health providers.

MFT services are covered under other federal health insurance programs.

- MFTs are eligible mental health providers under many health insurance plans, including TRICARE, the medical coverage for military personnel and their families and the Veteran's Administration.

For more information, please contact Stephanie Berry at sberry@cpca.org or Angie Melton at 301-529-1561 1231 I Street, Suite 400 • Sacramento, CA 95814 • Tel. 916.440.8170 • Fax 916.440.8172 • www.cpc.org

http://www.cpc.org/cpc/assets/File/Policy-and-Advocacy/Legislative/Marriage-Family-Therapists/CPCA_2010_MFTs_Fact_Sheet_Final.pdf accessed 9/13/13

AGENDA ITEM: The State Plan Amendment (SPA) and Peer Certification in California

ENCLOSURES: Center for Medicare & Medicaid Services (CMS) SMDL #07-011
Guidance Letter on Peer Certification
DHCS Background on Peer Certification to Date

OTHER MATERIAL RELATED TO ITEM:

ISSUE: Despite effectiveness and CMS guidance, Peer services are not yet reimbursable.

Explicit to the California Mental Health Planning Council’s Legislative Platform is the commitment to *“Support any proposal that addresses the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity and promoting the employment of consumers and family members”*.

Despite the MHSA’s commitment to value the experience of consumers and family members, and the 2007 CMS Guidance Letter to States (see attached) encouraging a Peer Certification process, and ensuring that “Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders”, a system is not yet in place.

Information provided by the DHCS (attached), detailing the amendment to the State Plan in 2010, (SPA 10-016) interprets “Other Qualified Providers” described as individuals who are “an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service” to be Peers.

In the 2013-14 Budget, AB 10, the following budget language authorizes MHSA funds to the Office of Statewide Health Planning and Development for establishing an avenue for certification:

Of the amount appropriated in this item, a total of \$2,000,000 shall be provided for peer support, including families, training in crisis management, suicide prevention, recovery planning, targeted case management assistance, and other related **peer training and support functions to facilitate the deployment of peer personnel as an effective and necessary service to clients and family members**, and as triage and targeted case management personnel.

With the passage of SB 82 (Steinberg, Mental Health Wellness Act) calling for the employment of peers and “ability to obtain federal Medicaid reimbursement, when applicable”, the authorizing budget language, and the increased demand for mental health services under the ACA, a means for meeting that demand and sustaining the services through reimbursement becomes even more critical to the success of the MHSA, the MHWA, and the ACA.



Center for Medicaid and State Operations

SMDL #07-011

August 15, 2007

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Background on Policy Issue

States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

Delivery of Peer Support Services

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing

Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Debra Miller
Director for Health Policy
Council of State Governments

DHCS BACKGROUND ON PEER CERTIFICATION EFFORTS TO DATE

Through a SPA process, DHCS updated the language to provide the flexibility for the County MHPs to employ Peer providers. SPA 10-016 first adds recovery and resiliency language as follows:

SPA #10-016:

- Rehabilitation definition means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

Furthermore, SPA 10-016 includes "Other Qualified Provider" which means an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service. We believe that Peer provider falls under this definition. Peer (Other Qualified) providers are authorized in the SPA to provide the following services:

Rehabilitative Mental Health Services include:

1. Mental Health Services (Other Qualified Provider)
2. Medication Support Services
3. Day Treatment Intensive (Other Qualified Provider)
4. Day Rehabilitation (Other Qualified Provider)
5. Crisis Intervention (Other Qualified Provider)
6. Crisis Stabilization
7. Adult Residential (Other Qualified Provider)
8. Crisis Residential (Other Qualified Provider)
9. Psychiatric Health Facility Services (Other Qualified Provider)

We also updated the SPA to reflect Other Qualified Providers may provide TCM under the direction of a Licensed Mental Health Professional as follows:

TCM SPA #10-12B:

- Targeted Case Management services are provided by certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for Targeted Case Management services authorized under state law.
- Targeted Case Management may be provided by or under the direction of a Licensed Mental Health Professional. Other Qualified Providers may provide services under the direction of a Licensed Mental Health Professional.

Please note that the State of California has not yet established a Peer certification process, however that is not under the purview of DHCS.

DHCS BACKGROUND ON PEER CERTIFICATION EFFORTS TO DATE

X INFORMATION

TAB SECTION: **D**

___ ACTION REQUIRED:

DATE OF MEETING: 10/16/13

PREPARED BY: **Murphy**

DATE MATERIAL
PREPARED: 9/13/13

AGENDA ITEM: Finalization of Position Statements

ENCLOSURES: CMHPC Draft Position Statement on Alternatives to Institutionalization
CMHPC Draft Position Statement on Unlinking Mental Illness from
Violence

OTHER MATERIAL RELATED TO ITEM:

ISSUE:

The Position statements were discussed at previous meetings, and some suggestions for revisions were proposed and adopted.

The consensus was that the Alternatives to Institutionalization was okay once the changes were incorporated but that the Unlinking Violence from Mental Illness had references that could be more up-to-date. However, it was acknowledged that it was to be more a statement on Stigma than on statistics on violence or violent events.

The request has gone out for additional, more up-to-date citations that support or clarify our position on this topic.

Once the position statements are approved by this committee, they will go before the Council for approval before being posted on the website and distributed.

Alternatives to Institutionalization

The California Mental Health Planning Council endorses alternatives to institutionalization that demonstrate

- improved access to services
- a thorough continuum of care based on clinical need, and
- encouragement of consumer choice

The following alternatives have demonstrated positive outcomes that include: Reduced hospital inpatient stays and recidivism, reduced incarcerations and recidivism; successful linkage to community supports, increased likelihood of stable and secure housing and employment training or opportunities; improved physical health, stronger coping strategies and preventive skills.

Many program models reflect these ideals and create a continuum of care:

- Crisis stabilization Programs – 23 hour stay, includes medical and psychiatric assessment, medication administration, counseling, and referral to additional services
- Crisis Residential Programs – diverts participants away from Inpatient Care or incarceration, de-escalates the immediate stressors, and supports strength-based recovery based on self-identified needs.
- Transitional Residential Programs – after crisis resolution, longer term system of care that strengthens skills needed for day-to-day living and self-sufficiency. Clients participate in individual activities such as job training, school, work or day treatment, developing social skills and coping strategies, finding housing and securing ongoing services and supports.

Specific examples of positive alternatives to institutionalization include:

- FSP 90 – a three-month, intense, comprehensive services plan that recruits participants from IMDs and instills living skills and self-confidence before gradually transitioning to maintenance-level services
- Progress House - a 10 bed psychiatric transitional residential treatment program that includes symptom management, relapse prevention, skill building, pre-vocational activities, and educational workshops aimed at developing healthy living in the community. The target length of stay is three months

Community-based alternatives are much more cost-effective and many of the services are Short-Doyle Medi-Cal reimbursable. (2012 figures):

The Short-Doyle maximum allowable rate¹ for Adult Crisis Residential Services is \$345.38.

The Short-Doyle maximum allowable rate for Transitional Residential programs is \$164.45 residential rate; \$131.24 day rate for on-site day treatment programs

In comparison, the Short-Doyle maximum allowable rate for hospital in-patient stay is \$1,213.75.

Concerns: *Recent modifications to federal housing regulations have created a barrier to accepting treatment due to concerns that entering rehabilitative 90-day social rehabilitation programs will result in loss of designation as “homeless”, resulting in loss of one’s housing assistance.*

¹ Maximum Allowable Rates were discontinued in FY 2011-12 so each county submits for reimbursement based on its actual expenditure rather than a statewide standardized rate.

CMHPC Position Statement

Separating Mental Illness from Discussion on Violence

Recent acts of deadly violence in public settings have started a national discussion on gun ownership and its prominence in US culture. Calls to reduce violence by limiting access to guns are countered by a response that the screening out of mentally ill individuals must be more stringent. The facts fail to support the premise that individuals living with mental illness are inherently prone to violence and the call for enhanced screening only increases the stigma of mental illness.

The well-intended resolve to increase funding for mental health services only serves to cement the myth that those living with mental illness are more dangerous than other people. This, in turn, provides a tacit justification for the continued stigma, discrimination, and eventual victimization of them. The California Mental Health Planning Council urges careful consideration of the facts and caution when linking violent acts to mental illness.

Here are the facts:

- Bullying and victimization are much more prevalent indicators for future violence than mental illness alone.¹
- Individuals with major mental disorders account for only 4.8% of violent acts compared to 34% committed by those with substance use disorders.²
- Violent incidents involving persons with serious mental disorders targeted family members or friends 87% of the time, usually occurred in the home or other private setting - not public settings with strangers - and were triggered by the nature and quality of social supports and interactions.³
- In a study conducted on inpatients, 46% reported being physically victimized by family members; and, of those, 59% reported that they retaliated.⁴
- The general population reports criminal victimization at 3.1% over the course of a year, but 8.2% of mentally ill persons reported criminal victimization over a period of four months.⁵
- Many of the reports of violence and victimization stem from environmental factors due to economic status – many people living with disabilities live in less affluent neighborhoods offering minimal public safety services.⁶

¹ Hiday VA. The social context of mental illness and violence. *J Hlth Soc Behav* 1995;36:122-37

² Swanson J, Swartz M, Estroff S et al. Psychiatric impairment, social contact, and violent behavior: evidence from a study of outpatient committed persons with severe mental disorder. *Soc Psychiatry Psychiatr Epidemiol* 1998;33:S86-S94

³ Monahan J, Steadman HJ, Silver E et al. Risk assessment: the MacArthur Study of Mental Disorder and Violence. Oxford: Oxford University Press, 2001.

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