

California Mental Health Planning Council

Healthcare Integration Committee

January 15, 2015

2270 Hotel Circle North, San Diego, CA 92108

(619) 297-1101

Tropical Room

8:30 a.m. to 12:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions	Steven Grolnic-McClurg, LCSW, Chairperson	
8:40 a.m.	Presentation: Behavioral Health Inland Empire Health Plan	Dr. Peter Currie, Clinical Director of Behavioral Health Inland Empire Health Plan	A
9:40 a.m.	Questions/Comments		
10:15 a.m.	Break		
10:30 a.m.	Committee Discussion		
10:45 a.m.	Discuss Chair and Vice-Chair Assignments		
10:55 a.m.	Choose mentors for new members		
11:05 a.m.	Work Plan Review and update		
11:40 a.m.	Public Comment		
11:50 a.m.	Next Steps/Develop Agenda for Next Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
11:55 a.m.	Wrap up: Report Out/ Evaluate Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
12:00 p.m.	Adjourn Committee		

The scheduled times on the agenda are estimates and subject to change.

Committee Members:

Chair: Steven-Grolnic

Vice-Chair: McClurg

Members: Josephine Black Terry Lewis

Dale Mueller Deborah Pitts Jeff Riel

Joseph Robinson Cheryl Treadwell Cindy Claflin

Daphyne Watson Robbie Powelson

Staff: Tracy Thompson

HEALTHCARE INTEGRATION COMMITTEE CHARTER

ADOPTED 10/17/12

OVERVIEW

The California Mental Health Planning Council (CMHPC) is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Governor and the Legislature on priority issues and participate in statewide planning.

PURPOSE

The purpose of the Healthcare Integration Committee (HCI) is to develop a framework for tracking, addressing, and responding to the multitude of issues resulting from Federal Healthcare Reform that impacts California's mental health system.

The HCI promotes the inclusion of five core elements from the Mental Health Services Act to guide all mental health work:

- Promoting Consumer and Family oriented services at all Levels
- Ensuring Cultural Competence
- Increasing Community Collaboration
- Promoting Recovery/wellness/resilience orientation
- Providing Integrated service experiences for clients and families

MEMBERSHIP

The Committee membership is listed below.

The Chairperson and Vice-Chair will be appointed by the CMHPC Leadership. In the Chairperson's absence the Vice Chair will serve as the Chairperson. Terms will begin with the first meeting of the calendar year, and end with the last meeting of the calendar year.

MEETING TIMES

The Committee meets four times a year, rotating locations in conjunction with the standing meeting times of the plenary and other committees. The Committee meets on Thursday from 8:30 AM to 12:00 PM.

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.

The Chair and Vice Chair hold meetings as needed to plan for the full Committee meetings.

ROLES AND RESPONSIBILITIES

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

- Attend meetings. Speaking on behalf as requested.
- Speak at relevant conferences and summits when requested by the Committee leadership
- Develop 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.

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

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. 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 via email.

DECISION-MAKING

Council and non-council members of 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 using the gradients of agreement. Minority views will be included in the meeting highlights.

MEDIA INQUIRIES

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

SUPPORT

Tracy Thompson, Associate Governmental Program Analyst, tracy.thompson@cmhpc.ca.gov

Healthcare Integration Committee Membership

NAME
Steven Grolnic-McClurg, LCSW, Chairperson
Josephine Black
Cindy Claflin
Dale Mueller , EdD, RN
Terry Lewis
Deborah B. Pitts, PhD
Robbie Powelson
Jeff Riel
Joseph Robinson, LCSW, CADC II
Cheryl Treadwell
Daphyne Watson

Updated: 12//12/14

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
Healthcare Integration Committee
Meeting Highlights
October 15, 2014
1:30 P.M. to 5:00 P.M.

Committee Members Present:

Steven Grolnic-McClurg, Chair Tracy Thompson

Cindy Claflin, Vice-Chair

Terry Lewis

Darlene Prettyman

Deborah Pitts, PhD

Joseph Robinson

Jeff Riel

Arden Tucker

Cheryl Treadwell

Others Present

Abbie Totten, Director of State Programs, California Association of Health Plans

Staff: Tracy Thompson

Welcome and Introductions

The HCI is working on healthcare integration. Part of this is based on ACA and the Health Care Reform and insurance expansion. We have been tracking the influx of new individuals into medi-cal. Also looking at issues having to do with the integration of primary healthcare and mental health care and a variety of projects connected to that. Starting to look at integration of substance use services with mental health care. One of the things looking at is using peer navigators within the system. Tracking the issue of the benefit that the ACA has brought about for individuals that have medi-cal they now have a mandated benefit for mental health services if they are in need of low to moderate mh services from the health plan. This has caused a lot of changes in the overall landscape of mental health services. There has always been a historical relationship between the health plans and the mental health plans but this benefit has caused those relationships to become even tighter. Previously because there was no benefit for the low to moderate health care the counties were providing these services under the mental health plan. Now these services are not reimbursable under the megalith health plan. The health plans are huge new player within the mental health arena. It is very important for the CMHPC to get acquainted with the health plans.

Presentation: Parity and the Healthcare Integration

Abbie Totten, Director of State Programs, California Association of Health Plans provided a presentation on parity and the healthcare integration. The California Association of Health Plans (CAHP) is a statewide trade association representing 42 full-service health care plans that

provide coverage to more than 22 million Californians. CAHP works to sustain a strong environment to which the members plans provide access to products that offer choice and flexibility to the Californians they serve. Most member plans provide coverage to Californians through the individual and group markets. Many member plans partner with the state by participating in government programs that provide health coverage to children, adults, and seniors.

California's health plans provide comprehensive coverage to 22 million Californians through HMOs and PPOs, commercial for-profit, and not for profit health plans, public plans including county organized health systems and local initiatives, regional plans, and fully integrated health systems.

Currently, more than two-thirds of Medi-Cal beneficiaries are enrolled in a health plan. This will increase as millions of Americans gain access to Medi-Cal through the ACA and as more populations transition to managed care.

Questions/Comments

- Jeff Riel: Is every county required to have a mental health plan in their county system?
Answer: Counties can opt-in but all but one county have opted in.
- Grolnic-McClurg: How do we in the mental health community and in the CMHPC develop better relationships with the health plans? *Answer:* Reach out to the health plans, invite them to sit at the table and learn who the CMHPC is and what your role is within the mental health system. This will build relationships and create dialogue.

Committee Discussion

- Joseph Robinson will draft a list of the 22 health plans and compile a list of meetings. This will assist the CMHPC in having a presence at these meetings and reaching out to the health plans.
- The HCI Committee should draft a letter encouraging the CALMHB/C to invite the head of their health plan and mental health plan to talk about the MOU. Joseph Robinson volunteered to draft this letter. Staff will follow up.

Discussion: HCI Committee presentations for January PC full session

- Staff will invite George Scolari to present
- Cindy Claflin will coordinate the invitations to assemble a family member panel.
- Steven Grolnic-McClurg will provide a short overview before presentations
- Committee members discussed the possibility of an interactive activity to tie all the presentations together. Time constraints may be an issue. A small workgroup will discuss the in more detail via conference call.

Next Meeting

- Staff will invite Dr. Peter Currie from Inland Empire Health Plan.
- Committee Discussion time.

- Discuss future work plan and possible focus
- Discuss mentors for new members

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
Healthcare Integration Committee
Meeting Highlights
June 18, 2014
1:30 P.M. to 5:00 P.M.

Committee Members Present:

Steven Grolnic-McClurg, Chair
Cindy Claflin, Vice-Chair
Terry Lewis
Darlene Prettyman
Deborah Pitts
Joseph Robinson
Jeff Riel
Josephine Black

Others Present

Beverly Abbott, Telecare Corporation via Teleconference
Toni Tullys, MPA, Deputy Director, Alameda County Behavioral Health Care Services
Andrew George, Deputy Director, Help Center, Department of Managed Care
May Farr, CALMHB/C

Staff Present: Tracy Thompson

Welcome and Introductions

Overview:

The HCR Committee has been focusing on issues around Parity. There is a new benefit that is available to Medicaid recipients who have low to moderate mental health needs. It is the responsibility of the health plans NOT the mental health plans. There are two different entities: the mental health plans which are doing specialty mental health care are part of the carve out. In the carve out they are serving folks who have a mental health diagnosis who also have a functional impairment. And for individuals who do not have that functional impairment they are being considered low to moderate mental health. The health plans is now responsible for proving substance abuse and mental health care for Medicaid recipients. Who is responsible for ensuring that individuals who are low to moderate are actually getting that care that is required? Who is responsible for making sure that care is good?

There is a new important relationship between the mental health plans and the health care plans. Individuals do not necessarily fall neatly into this box of low to moderate or serious mental health issues. What can be done when there is a disagreement about where someone should fit? How did you determine if they receive the right kind of care? We will hear how Alameda County is dealing with these questions.

The HCR is staying up to date on the Substance Abuse Waiver that the DHCS is proposing. SA services are not managed in Ca. DHCS is writing an demonstration waiver that will set a up a system similar to the mental health plans where each county can decide to opt in. It would create an organized system of care. There will be a centralized intake that will determines your level of severity and what services you are edible for and there is a set of dollars where you try to ensure that your plan area has the right level of care from inpatient to outpatient.

There is some data around newly expanded Med-Cal. According to Covered California there are 3.3 million Californians who are newly covered under the health care expansion. 1.4 million are from the exchange (those above the threshold for Medi-Cal) and 1.9 million in Medi-Cal. Most of the newly enrolled or soon to be enrolled are newly eligible. 800,000 individuals were previously eligible for medi-cal and just had not signed up. Newly eligible recipients receive 100% of their mental health care coverage by the feds for 3 years, and then it decreases to 90%. The cost to the county for providing mental health care is very low. For previously eligible recipients it is a 50/50 match (50% covered by feds and 50% covered by the county)

Presentation: MHP and MCP MOU

Starting on January 1, 2014, the Department of Health Care Services (DHCS) expanded the array of Medi-Cal mental health services available to Medi-Cal beneficiaries DHCS has identified the existing MOU between health plans and mental health plans as the primary vehicle for assuring beneficiary access to appropriate mental health treatment. DHCS is working closely with the Department of Managed Health Care (DMHC) and MCPs to assure plan readiness, complete the necessary DMHC material modification processes, and amend the managed care plan contract language. DHCS has released two “All Plan Letters” outlining Managed Care Plan responsibilities for mental health services. The purpose of this All Plan Letter (APL) is to describe the responsibilities of Medi-Cal managed care health plans (MCPs) for amending or replacing Memoranda of Understanding (MOU) with the county Mental Health Plans (MHPs) for coordination of Medi-Cal mental health services. These requirements are in addition to existing MOU requirements for specialty mental health services provided by MHPs. Fully executed MOUs are due to DHCS by June 30, 2014, and are subject to DHCS approval. Toni Tullys, MPA, Deputy Director, Alameda County Behavioral Health Care Services, provided a presentation regarding the MOU.

Presentation: Parity

Health Care Reform Committee members requested more information regarding parity specifically regarding the appeals process and parity penalties. Andrew George, Deputy Director, Help Center, Department of Managed Care, provided a presentation on this topic. Mr. George offered to reach out to someone from the Department of Managed Care provide a follow up presentation on network adequacy. The HCR Committee will assist in linking the Department of Managed care with stakeholder if needed. Staff and the chairperson will continue to attend or listen in to the DMHC Mental Health monthly Stakeholder Meetings and share dates with the committee.

Committee Discussion

- Steven Grolnic-McClurg: Do we want more information about the network adequacy monitoring? Josephine Black: I think updates will be appropriate from this point on.
- When staff follows up with the presenter we should extend the invitation to partner with the DMHC to have a stakeholder conversation. Staff will see what groups are present at the stakeholder meeting/call (scheduled for July 31, 2014) before moving forward with this invitation.
- The California Association of Health Plans is also a helpful resource. We can invite them to the next meeting. It would be helpful to invite the health plans and hear how they are supporting their members.
- The California Behavioral Health Directors Association (CBHDA) is sun setting their Health Care Reform Committee. We may want to discuss the Health Care Reform Committee's future as well. One possibility would be to look at integration of care with one topic being the health plans and the mental health plans and their need to be integrated. We can carve out time at the next meeting to think through the future of the HCR Committee. There are a lot of workforce issues as well.
- Committee members agreed to change the name from the Health Care Reform Committee to the Health Care Integration Committee. Members will review charter changes at the next meeting. Staff will change Federal Health Care Reform to Health Care Integration on the charter
- Members would prefer a written letter of thanks to presenters.
- I would like to know more specifics around parity at the operations level. What does parity actually mean? What benefits are available? This may be something to look into for the January 2015 meeting.
- Any effort to include more members of the public is important.

Next Steps/Develop Agenda for Next Meeting

- The DHCS is drafting the Substance Abuse Waiver that will be out early to mid-July. Comments from the HCI Committee will need to be done between meetings. It might be useful to return to this topic at the next meeting.
- Invite the California Association of Health Plans. This is important for relationship building. How are they are supporting their members? How can the CMHPC offer support? Staff will reach out to CAHP.
- Discuss what the HCI Committee will present to the full PC at the January 2015 Meeting.

Meeting adjourned

California Mental Health Planning Council
HEALTHCARE INTEGRATION COMMITTEE
External Roster

HCR Chair and Vice Chair

Steven Grolnic-McClurg, LCSW, Chair
E-mail: steven.gmc.work@gmail.com
P: 510-898-1624

Committee Members:

<p>Josephine Black E-mail: jblack32@cox.net P: 805-684-4934 C: 805-895-3108</p>	<p>Cindy Claflin E-mail: cclaflin@uacf4hope.org P: 916-203-3449 C: 916-230-3449</p>
<p>Deborah B. Pitts, PhD, OTR/L, BCMH, CPRP Email: pittsd@usc.edu Clinical Faculty P: 626-799-9734</p>	<p>Dale Mueller E-mail: dmueller@earthlink.net P: 909-920-5854 C: 951-255-5533 F: 909-920-6046</p>
<p>Robert Powelson E-mail: robbiepowelson@gmail.com P: 415-924-2826</p>	<p>Terry Lewis E-mail: HarmonyHoz@yahoo.com P: 818-425-8021</p>
<p>Joseph Robinson E-mail: joseph@casra.org P: 415-572-5173 C: 925-229-2300</p>	<p>Jeff Riel E-Mail: JRiel@DOR.ca.gov VOCATIONAL REHABILITATION POLICY & RESOURCES DIVISION, Deputy Director P: 916-558-5421 C: 916-558-5415</p>

<p>Daphyne Watson E-mail: dwatson@mhasd.org P: 619-942-6588</p>	<p>Cheryl Treadwell E-mail: cheryl.treadwell@dss.ca.gov Resource Development and Training Support Bureau, California Department of Social Services P: 916-651-6020 F: 916-651-6239 C: 916-505-9964</p>
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<p>Non-Voting member</p>	<p>Staff</p>
<p>Beverly Abbott E-mail: bjkabbott@aol.com P: 650-851-8469 C: 650-868-9132</p>	<p>Tracy Thompson tracy.thompson@cmhpc.ca.gov MS 2706 P.O Box 997413 Sacramento, CA 95899-7413</p>

Overarching Framework for HCI

Five Core Elements of the MHSAs should guide all work on MH

- Consumer and family oriented services
- Recovery/wellness/resilience orientation
- Cultural competence
- Community collaboration
- Integrated service experiences for clients and families

Crosscutting issues

- Reducing disparities in mental health services
- Preserving meaningful stakeholder processes

ELEMENTS/ COMPONENTS	HCI COMMITTEE THEMES		
	MEANINGFUL STAKEHOLDER INVOLVEMENT	FIVE CORE ELEMENTS OF MHSAs PERSEVERED	DOING WHAT IT SAID IT WOULD DO? IMPROVING LIVES?
<p>Medicaid Expansion The ACA established a Medicaid funded program for most of California’s uninsured by 2014. The LIHP began this process in starting 2011 in certain counties</p> <p>As required under the 1115 Medicaid waiver, the Behavioral Health Services Needs Assessment was completed and the Behavioral Health Needs Plan was submitted</p> <p>(Lead:)</p>	<p>Keep track of Substance Abuse changes. The committee is interested in this because of Co-occurring disorders.</p> <p>The Behavioral Health Service Needs Plan was reviewed by the Committee and completed: September 30, 2013</p>	<p>Keep updated on the Special Plan Amendments for Medicaid for Substance Abuse services.</p>	<p>For all of Medi-Cal Expansion -- What happens once this hits the ground? The BH Service Plan is broad. The committee should track how it is implemented and what it really means</p> <p>Alert CALMHB/C of the MEMORANDUM OF UNDERSTANDING REQUIREMENTS FOR MEDI- CAL MANAGED CARE PLANS</p>

Overarching Framework for HCI

<p>Dual Eligible demonstration projects (Cal-Medi Connect)</p> <p>Integrates Medi-Cal and Medicare funding for clients who are eligible for both and creates demonstration projects to explore various configurations of services and systems. Originally 4 counties were selected. The Governor's Budget for 2013 expanded this to 8 counties (San Diego,) and described it as an initiative not a demonstration</p> <p>(Lead:?)</p>	<p>Participate in all stakeholder calls regarding the dual demonstration project; give input as appropriate No input at this time; the program design phase is done but the committee will continue to track.</p>	<p>Review all documents with the 5 principles in mind; particularly person centered care (very much evident in the documents); cultural competence; wellness oriented services; and integrated service experiences for clients and families. Give input as appropriate</p>	<p>Track outcomes measures selected for the dual eligible demonstration projects. Suggest new outcome measures specific to our focus as appropriate</p>
<p>Integration of Primary and Mental Health Care</p> <p>Under HCI all clients will eventually have a health home, which will be responsible for the coordination of all their medical care.</p> <p>Individuals with SMI may be part of a health home. Where will these health homes be? In primary care or in MH clinics</p> <p>(Lead: Terry Lewis , Deborah Pitts?)</p>	<p>Strategy: Health Navigator: How is it being utilized and spread? Creating and keeping track of Partnerships and looking at what they are doing to engage clients</p>		

Overarching Framework for HCI

<p>Covered California (California Exchange)</p> <p>For those who are not eligible under the LIHP/Medicaid Expansion (due to income), they will be required to purchase insurance and will be able to do so through “Exchanges” – which have to offer BH services at parity.</p> <p>Churning</p> <p>Residual Uninsured</p> <p>(Lead: Joseph Robinson)</p>	<p>The Committee can be helpful in being sure that various consumer and family stakeholder groups can get information on how this is working and how people are accessing this new resource</p>		
<p>Children Issues</p> <p>Healthy Families Transition (Performance Outcomes)</p> <p>Covered California as it affects children</p> <p>(Lead: Cindy Claflin)</p>	<p>Healthy families has transitioned to Medi-Cal Statewide</p> <p>The Committee should monitor the performance metrics that have been established for this program and review the monitoring reports. The Committee should help stakeholders (parent partners and others) to give input and review results. The Committee can be helpful in being sure that various family stakeholder groups can get information on how this is working and how children and families are accessing this new resource</p>		

Overarching Framework for HCI

Workforce Capacity (Lead: Dale and Joseph)	MFT in Medicare Issue Review the Workforce Section in the BH Service Plan and give input as appropriate Continue to track only		
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x INFORMATION

TAB SECTION A

 ACTION REQUIRED

DATE OF MEETING 10/15/14

MATERIAL
PREPARED BY: Tracy Thompson

DATE MATERIAL
PREPARED 09/19/14

AGENDA ITEM:	Presentation: Behavioral Health Inland Empire Health Plan
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

At the October 2014 meeting Abbie Totten, Director of State Programs, California Association of Health Plans, provided a presentation. The HCI Committee has been focusing on issues around Parity. There is a new benefit that is available to Medicaid recipients who have low to moderate mental health needs. It is the responsibility of the health plans to provide the new benefit and not the mental health plans. The mental health plans are providing specialty mental health care to individuals with severe mental illness. They are serving consumers who have a mental health diagnosis and also have a functional impairment. For individuals who do not have functional impairment they are being considered for low to moderate mental health services. The health plans are also now responsible for providing substance abuse and mental health care for Medicaid recipients.

Inland Empire Health Plan (IEHP) is a public health plan serving low-income families and individuals in two of the geographically largest counties in the country: Riverside and San Bernardino, California. With healthcare reform and Medicaid expansion, IEHP's membership will expand significantly by 2015. IEHP wanted to take proactive steps to improve services for their members with the most significant physical and behavioral health issues, including people who are eligible for both Medicaid and Medicare. Dr. Peter Currie, PhD, will provide a presentation.