

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
POLICY AND SYSTEM DEVELOPMENT COMMITTEE**

MEETING HIGHLIGHTS

June 16, 2011

Embassy Suites Burlingame
150 Anza Boulevard
Burlingame, CA 94010

Planning Council Members in Attendance:

Beverly Abbott, Chair
Barbara Mitchell
Celeste Hunter
Adrienne Cedro-Hament
Mark Refowitz
Cindy Clafin
Joe Mortz
Glenn Hutsell
Steven Grolnic-McClurg

Planning Council Staff in Attendance

Andi Murphy, Staff

Others in Attendance

Kathy Trevino, Disability Rights California
Joseph Robinson, CASRA

Presenters

Louise Rogers, Deputy Chief of Health, San
Mateo County & Chair, CMHDA 1115
Waiver subcommittee
Rusty Selix, California Mental Health
Association

The meeting was called to order and introductions around the table commenced at 8:35 a.m.

Updates From Other Groups/Issue Requests

- The TAY subcommittee Health Care Reform paper was very good and should be distributed to the entire committee. Murphy agreed to do this. CAYENNE has a simplified one-page document outlining the major points which was designed for youths.
- The amended Narrative Work plan for the PSDC should be sent out to committee members and included in each meeting packet, along with the time line, and charter. Murphy agreed to send them out upon returning to the office.

Work Plan & Time Line Review/Collaboration Roster Planning

The work plan will be approved at the next meeting due to the fact that the narrative work plan was not enclosed in this meeting's packet. However the following comments/observations were made:

- We need to make sure we clearly define what each committee is working on to avoid overlap. One of those distinctions is that health care reform and integration are the focus of the PSDC while the ASOC is looking at best practices.

- The PSDC might want to use the ASOC Seal of Approval criteria when judging effectiveness of evaluating methods of integrating services under health care reform.
- The Seal of Approval models might be used as a frame of reference in RFAs that counties and cities circulate when awarding contracts, or service providers can refer to when planning their programs, or for consumers and family members to use when advocating for services within their communities.
- The five core elements of recovery and wellness will be embedded at the top of the work plans as the common thread that ties all of the activities together.
- We need to work to get everything on the Narrative Work plan onto the Time line chart, which serves as a map for completing the tasks.
- The Disparity definition could be broadened to add other groups, such as sexual orientation, and include the impact unequal outcomes as well as unequal access. Cedro-Hament agreed to look for a more inclusive definition that addresses more aspects other than treatment.

1115 Waiver Implementation

Louise Rogers presented on the impacts and opportunities that the 1115 waiver would have on Drug and Alcohol and mental health services in California. Historically, Seniors and Persons with Disabilities (SPDs) were not enrolled in public managed health care plans in most counties, which created an uncoordinated, costly system of service provision. The waiver did not set out to address mental health at all when the renewal was first being crafted.

The 1915b waiver is the waiver that covers Specialty Mental health services that is billed and reimbursed through Medi-Cal, and the 1115 waiver is predominantly medical services. Anytime there is discussion about mental health managed care in California or realigning the mental health managed care funds, they are talking about the 1915b waiver. The counties are the provider, or the provider networks, you are automatically enrolled (no freedom of choice) if you demonstrate medical necessity. The county sets up the contracts and rates and enrolls its own providers.

- Q. Are the 1915b waivers available to the new enrollees in the 1115 waiver?
- A. The waiver is just the “bucket”, and the “apples” in the bucket vary from county to county.
- Q. Will there be a Balkanization of services in the state where people will have to move or prove residency in a more comprehensively served county?
- A. This is a concern of the Feds and the state. California is viewed as an experiment in this respect.

Under the 1115 waiver, the feds tell the state to contract with counties, or through HMOs, to enroll as many people as possible. Some counties have submitted more comprehensive plans than others. Everyone is mindful that there may be a drive to completely eliminate the 1915b waiver, and roll those services into the 1115 waiver, so the planning is very deliberate and cognizant of the risks that may be coming up. There is concern that trying to shoehorn a variety of services may result in a dilution of them.

Enrollees who do not select a provider will be assigned one, and if they are dissatisfied with the assignment, they can change them during open enrollment.

- Q. Are the managed care entities going to ensure there are sufficient providers for the increased demand in services?
- A. Cannot say for sure. The more recent agreements are held under a higher scale of accountability. There have been performance incentives related to access – in the millions of dollars.

For dually-eligible – Medicare and Medi-Cal pilot project is being crafted via and RFP right now. Once awarded, pilots will be established in four geographic areas and cover 150,000 beneficiaries using an integrated medical, long term care, and behavioral health model. The goal is to have a statewide expansion of the model in 2015.

- The federal Parity law is in effect now, and it is hoped that ultimately, the 1115 waiver will look like Medi-Cal with 1915b –type specialty mental health services incorporated.
- The lowest income group – the MCE enrollees will be automatically covered by Medi-Cal and the higher income group – the HCCI- will be covered by commercial insurance by 2014.
- Most of the counties who are offering the Substance Use benefit under 1115 are more robust than those offered through Medi-Cal.
- Out-of-network services will be easier to obtain under 1115 than through Medi-Cal.

Q: Will managed care entities be required to ensure that there will be an adequate number of providers who are willing to take the Medi-Cal rates?

A: Right now, the information on contracts and accountability is not very clear or available. Generally speaking, the more recent managed care agreements have a higher level of accountability, as do the providers. There are generous incentives for hospitals and health service providers who can demonstrate increased access for newly insured.

Q: One of the biggest challenges in treating people with mental illness is, accessing the services initially, and following through with treatment. Insurance companies do not consider it a service that should be covered, that it is not a medical issue.

A: It is a challenge, and very short sighted of the health plans to not recognize the effectiveness and savings of holistically dealing with health issues. However, some of that is due to the ineffectiveness of messaging the savings and efficiencies as a business model.

Q: Is Knox-Keene licensing required in order to apply for the Medi-Medi requirement? (Knox-Keene requires sufficient cash on hand to bear risk, provide managed care, and pay claims).

A: Yes, they do.

Q: Under Federal Health Care Reform, different levels of plans are discussed. The requirements for minimal care are nearly ready to be announced. It appears that the state of California is going with the most minimal requirements.

A: Yes, right now, that appears to be the case.

Q: If California goes with the Silver (lowest) level of services, does that mean that counties who have opted to provide higher levels of service will have to reduce their services?

A: Two issues: What is the future of the Medicaid program? And what is the future with the Exchange? Medicaid is distinct from the 1115 waiver, and it will probably have a certain level of service for those on SSI than it will for others.

- In 2014, the healthcare provided to the newly enrolled MCE people will be 100% covered by the Federal government for the first year, and will gradually reduce in 10% increments in the following years. In the meantime the existing Medi-Cal enrollees will be reimbursed at 50%. That means they will represent a more significant financial risk for the seriously mentally ill than for the newly enrolled, and most likely a disparity.

Q: How will Federally Qualified Health Centers fit into this picture?

A: FQHCs have been required, in the past ten years, to develop a plan for delivering mental health services. They are viewed as safety net providers and are eligible for enhanced reimbursements. Under this waiver, they are viewed as one of the major vehicles for delivering primary care. So, the question is what types of mental health and substance use issues can clinics provide reasonably, and obtain reimbursement based on the clinician (MFT vs. LCSW).

Q: Can people maintain their FQHC relationship if they choose if they are covered by Blue Cross?

A: Blue Cross has to have a contract with that FQHC in order to reimburse. This is a policy issue that is being worked out. You can go to the FQHC, and they will get a managed care payment and can then balance-bill to the state.

Q: How do the counties determine what services are billable on a county level for mental health services for LHIP enrollees? Is it related to “carve-in” or “carve-outs”?

A: Due to the predominantly medical slant of the 1115 waiver, mental health services were not really defined, other than to only require the minimum of mental health and not required drug and alcohol services at all. They are not related to carve-ins or carve-outs at all.

Q: How can we increase the presence of the Mental Health Boards?

A: Remember that county Mental departments or the State DMH did not have a presence when the waiver was being developed. Mental Health Boards were not consulted or invited. This relates directly to the lack of planning or advocacy for mental health services.

Legislating Protections for MHSA Funding

- All of the changes and departures from DMH have left a fairly ineffective shell which is not that relevant anymore. When people want information, they usually just go to CMHDA.
- The highest positions in DMH are being filled on a temporary basis by people without a mental health background, and the corresponding positions at DHCS etc. also do not have a mental health background.
- This is an opportunity to dispense with the overlap and possibly create a new entity.
- Pages 51-55 of AB102 are the most significant pages regarding mental health and realignment.

Firewalls and Realignment:

Realignment has not officially happened (budget was not signed *at that time*). The biggest chunk of what was going to be realigned (EPSDT) is still with the state. There has been a lot of information exchanged regarding the diversion of funds from MHSA for EPSDT services without an identified reimbursement stream of funding is illegal. AB100 is illegal only if Realignment is not enacted when the legislative session ends. It is a tricky, sticky process. Democrats have written in some tax extensions or increases that may not be authorized or upheld in a vote. A general vote on tax extensions will not happen in time to accommodate a constitutional level of fiscal protection. The State Constitutional Amendment has not been passed but it calls for enactment of Realignment on October 9, 2011.

The SCA calls for funds to be allocated to the counties in accordance with the AB100 plan in October, which is when the firewall issue becomes relevant. Some county representatives question the wisdom of having firewall. One of the things in the SCA is the obligation to comply with federal law and federal entitlements. The pieces being realigned (EPSDT) are federal entitlements and include assurances that all medically necessary services are being provided. If counties don't perform, it is up to the state to enforce it. People are concerned that local services will gobble up the mental health dollars, but the local entities have not been able to procure mandatory dollars, only discretionary ones.

- Can you write the realignment legislative language in a way that is better than a firewall? It is not a simple thing. CSAC does not want any firewalls, so CMHDA cannot advocate for it, but the CMHPC can.
- MediCal managed care is being realigned in a way that essentially eliminates the right of first refusal in most counties. It becomes a moot point under the SCA because all responsibilities revert to counties. The firewall question becomes relevant when adults are considered due to the adults in the probation system that will become eligible for services.

To have no firewall and no protective language is unacceptable. The language in the SCA is insufficient other than the phrase "maximum flexibility except for compliance with federal entitlements and federal laws", which is, in itself, more protection than other realigned services have. A firewall is something to advocate for, but everything relates back to timing. The first step is to get the budget done, the next is to get the SCA passed. Nobody wants to debate the allocation issue, because it divides the legislators along geographic lines more than partisan lines, making it harder to get simple majority vote. Once you start to write the realignment statute, the first thing addressed is the allocation to counties. The confusion sets in when counties need to determine on whether there are firewalls or not, which is a source of contention between various factions.

One thing that should have a firewall is the "fix" of the 1991 Realignment. Does it get swallowed up into the new pot, or does it remain as a mental health piece with the growth formula for funding attached to it? Mental Health would not have to fight anybody for that money. (The 1991 Realignment was intended to give mental health 1/3 of the revenues, but Social services quickly went to the front of the line when In Home Support Services

became part of the landscape, reducing mental health to about ¼ of the funds – from 34% to 26%). The MHSA has raised \$4.7 billion dollars, and the amount that Mental Health has lost due to the Realignment loss is \$4.7 billion dollars. The fix that should be advocated for under this new Realignment, is that Mental Health would no longer be part of the old Realignment and it gets normal growth without the diversion to IHHS. At the end of 10 years it would be \$500 million dollars better than it would be under the Old Realignment.

- If the PSDC or the Council wants to advocate, they should advocate for firewalls and protective language on the entitlement – argue for data and state requirement to collect data that demonstrates the counties’ commitment to providing medically necessary mental health services.
- It is about more than EPSDT – it is also about Medi-Cal Managed Care mental health services.
- Mr. Selix offered to forward some early legislative language his office drafted early this year.

Oversight of Counties:

When AB100 eliminated the state approval of county plans, the approval was no longer relevant. The data the DMH collected was not related to criteria in the guidelines, but to serve its own purpose. The guidelines for the CSS Plans were good, but the forms that were generated to evaluate the plans were not. The four legged stool of accountability were

- Evaluation Framework:
 - Where is the money going?
 - What levels of success were demonstrated
 - Providers’ services- most successful
 - Four Categories: Leaders, Followers, Technical Assistance needed, Resistors
- Technical Assistance
- Stakeholder Process that is qualitative vs. quantitative and includes an appellate stakeholder process
- Compliance Issue - A checklist that counties could use to ensure they reported their activities

Q: Where do you think the JPA (CalMHSA) might be helpful in all of this?

A: The JPA is an incredibly valuable tool, but it cannot do the compliance function. It cannot do the appellate process for the stakeholder process, but it can do the county part of it. It can do the evaluation process, at least partially, but it cannot house all the data. It seems like it could do the licensing and certification function, because that should not reside with DSS or DHCS.

Housing Update

Donna Ures, from the DMH MHSA Housing program provided an update on the housing applications received and reviewed by the state.

- Since the program began, 112 applications have been received. Out of \$400 million made available, \$246 M has been requested, and \$153 Million remains available for housing applications.
- Under the Realignment plan, the Housing review process will remain with DMH.
- CMHDA does not facilitate the workgroup on housing any longer due to the loss of Stephanie Welch, who went to the JPA.

Q: Of all the counties who have applied, how many have fully spent their full allocation? Does it seem to be the larger counties who are more set up to claim their tax credits?

A: The 112 applications received are from 31 counties and cities, but it does not take into account the applications that are still in the planning stages or under review. We will need to pull that information together and send it to Andi to send out if that is okay.

Next Steps, Meeting Evaluation and Plan for Next Meeting

The meeting was generally judged to be informative and timely. We should give more time to Housing next time. We should also have more action items, but staff can work with the chair to draft some for the committee to approve at the next meeting. We should have some type of “action mentality”. A conference call might be in order. The importance of the stakeholder process is front and center with us and we will discuss it with Ann to see if or how we can support her efforts as she represents our concerns to other organizations.

Respectfully submitted,

Andi Murphy