

**Written comments submitted to the Department of Health Care Services (DHCS)  
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS**

**Comments received August 24 through August 30, 2011**

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**National Alliance on Mental Illness (NAMI) California Policy Statement**

Department of Mental Health (DMH) Reorganization

NAMI California supports the position of the creation of a new Department of Mental Health and Drug and Alcohol Services for all related non-Medi-Cal services and programs.

NAMI California believes that any reorganization of the State Department of Mental Health should provide individuals living with mental illness with services and supports that increase health and recovery outcomes across the life span, are culturally and linguistically competent, and are integrated and coordinated to provide linkage to needed treatment and services regardless of funding stream.

California should use this reorganization opportunity to truly integrate our Medi-Cal, non-Medi-Cal, and MHSA services to prioritize assistance to all Californians based on their severity of need.

As various reorganization proposals are discussed, NAMI California urges policy makers to answer the following questions:

- How will a reorganized Department of Health Care Services (Medi-Cal) and Department of Mental Health (non-Medi-Cal mental health) and increased localization ensure that children, youth, adults and older adults with the highest or most complex mental health needs are prioritized?
- How will reorganization ensure that a full array of services and supports are available, accessible, and culturally and linguistically appropriate throughout the state? In addition to traditional psychiatric services, an array of services should, at a minimum, include:
  - Housing with supportive services
  - Employment and education supports
  - Transportation services
  - Reduction in engagement with the criminal justice system
  - Wrap Around Services
  - Integrated mental health and substance use treatment
  - Prevention and outreach services
  - Case management and care coordination
  - Community skill building
- How can California prioritize services and supports by severity of need, rather than by source of funding?
- How can California facilitate decreased demand for state hospital beds and reduce rates of incarceration and re-hospitalization.

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Any reorganization of California's mental health system can only be successful if it facilitates the coordination, integration, and linkage of Medi-Cal, non-Medi-Cal, and MHSA services. This integration must be accomplished in order to achieve positive outcomes for all persons living with serious mental illness. To achieve this integration and coordination goal, NAMI California supports the position of the creation of a new Department of Mental Health and Drug and Alcohol Services for all related non-Medi-Cal services and programs.

**State Hospital Care and Reorganization Proposals**

*Successful* reorganization of mental health funding and functions should facilitate reduced demand (need) for state hospitalization, improved health and wellness outcomes for patients and fewer instances of re-hospitalization.

California will need to decide if:

- A new Department of State Hospitals be created under the Health and Human Services Agency;
- Or, the responsibility for the state hospital system remains within the domain of a new community-based mental health care department as described above.

NAMI California calls for a comprehensive review and analysis of the pros and cons of the above choices to determine the most appropriate placement of responsibility for California's state hospital services. NAMI California does not support the transfer of state hospital responsibility for forensic patients to the Department of Corrections and Rehabilitation.

**Senior Policy Advisor**

- NAMI California believes any reorganization of California's mental health system can only be successful if it facilitates the coordination and linkage between Medi-Cal and non-Medi-Cal services and programs. This integration must be accomplished in order to achieve positive outcomes for all persons living with serious mental illnesses.
- Effective coordination and development of policy can only be accomplished at the highest level of California's health care system.
- NAMI California supports the concept of a senior policy advisor at the highest level of the Health and Human Services Agency.

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First of all, I think this is an outstanding document. It's clear, easy to read and yet addresses the complexities of this transfer, and reflects an understanding of our stakeholders' priorities. I think these are very lofty goals which appropriately start with a smooth transition, and then move

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to process/service improvements. Below are a couple of comments offered by one of the Mental Health Services Oversight and Accountability Commission (MHSOAC) senior staff who worked at the Deputy Director level for many years at the Department of Mental Health (DMH) in the Medi-Cal arena.

"It was unclear to me if all DMH functions would be maintained--such as support to the counties through technical assistance. The summary does not explain the overall Medi-Cal system for access to pharmacy. It's not essential to the transition since it's not changing, but it could help complete the background since access to and cost of medications/biologics is of such great importance to specialty mental health services."

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When a government official is appointed make sure they have "walked" in those shoes or have a family member that has experienced "challenged" behavior i.e. family member, Mother, Father, sibling etc.! We the taxpayers are having to deal with these "challenged" behaviors and patterns

on the city streets everyday!! Stop the "legal" drug pushers – "DOCTORS" --stop over-medicating and go back to school as trends and behaviors of the individuals change!!

Medication does not work for everyone—especially for the challenged individuals who have been on street drugs for years! Make sure these 'DOCTORS' continue to be given "mental" agility tests every 2-5 years and are tested themselves!!!!

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As the Governor's appointed advisors on Independent Living, the State independent Living Council (SILC) asks the Administration to maintain its commitment to community-based services for people with mental health disabilities. In these economic times, the unfortunate necessity of collapsing bureaucracy to reduce administration costs is understandable, and the State can ensure people with mental health disabilities continue to receive high quality services through:

- Designating a Deputy Director for behavioral health
- Maintaining a robust stakeholder feedback process
- And Realizing the vision and values of the Mental Health Services Act.

In the past, the Department of Mental Health has progressively emphasized community-based treatment for individuals with mental health issues so they may live independent lives outside of

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institutions. The SILC's hope is that with the Department of Mental Health transition to the Department of Health Care Services this focus will continue. We do not believe it would be beneficial to those individuals if the transition results in a medical format approach. The Independent Living mantra, "Nothing about us, without us," reiterates the vital need for stakeholder feedback. It is the wish of the SILC that under the Department of Health Care Services, the stakeholder process continues to be integral to service planning and delivery.

We believe Disability Rights' California developed some good guidelines for consolidation and attach their recommendations to this letter. There are Council members, staff, and committee members who are people with mental health disabilities and have expertise in the rehabilitation and independent living needs of this community. Please don't hesitate to call on us for support in this new transition.

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The California Alliance of Child and Family Services is a statewide association of 120 accredited, private nonprofit human service agencies that provide a wide array of services to children, youth, transition-age youth, and families, including the full continuum of mental health services and support. California Alliance member agencies work in collaboration with county public mental health departments, child welfare and juvenile justice agencies, and local school districts across the state.

1. It is imperative that a Children's Mental Health Policy Office be included in the transition plan for the transfer of Medi-Cal Specialty Mental Health Services from the Department of Mental Health to the Department of Health Care Services.

The draft transition plan currently lacks specificity on where children's mental health policy will exist within the Department of Health Care Services (DHCS). The policy section of the transition plan discusses waiver renewal, state plan and regulations but it isn't clear where children's policy issues will be addressed. Specificity regarding where and who will develop children's policy is necessary because of the unique federal requirements, provider specialization, and treatment methodologies, all of which require policies, procedures and regulations different from those for adult mental health care.

**For the past 18 years, statewide changes in mental health services for California children have been the result of lawsuits (e.g., Timothy T., Emily Q. and Katie A.), not policy initiated at the state level.** In order to avoid this pattern, we are hopeful that DHCS will take a pro-active approach to children's mental health policy to ensure that children have access to effective, culturally appropriate services delivered in the least restrictive setting that meets their needs.

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2. The lawsuit compliance group charged with implementation of the settlements in the *Emily Q.* and *Katie A.* suits should remain intact for the transition. They are responsible for working with the court appointed special master and vested parties. Ultimately this group is responsible for implementation of all aspects of the settlement including but not limited to the development of manuals, educating and training counties, and tracking data to ensure delivery.
  
3. In order to help identify and assure that contracted providers of children's mental health services have the necessary expertise and administrative infrastructure to meet Medi-Cal requirements, DHCS should require that provider organizations be certified by a recognized accrediting body, such as the Council on Accreditation, the Joint Commission or the California Alliance. Accreditation provides public notification that an agency meets the standards of quality set forth by an accrediting body and reflects the fact that the agency has conducted a self-study and undergone external review by knowledgeable experts, not only to meet standards, but to continuously find ways to improve the quality of the programs and services it provides. If we would not send our children to unaccredited schools or have them treated in unaccredited hospitals, why would we permit unaccredited organizations to provide mental health services for the state's most vulnerable children?

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The California Association of Health Facilities (CAHF) represents free-standing long term care facilities (Skilled Nursing Facilities and Institution for Mental Diseases that provide facility based Behavioral Health Services to Medi-Cal beneficiaries and others. CAHF has reviewed the draft transition plan and acknowledges the difficult task placed on the Department of Health Care Services (DHCS) and the Department of Mental Health (DMH) to effect the transfer. Overall DHCS and DMH staff have done a good job in attempting to address all of the issues. In completing the draft plan and ultimately the actual transition, DHCS needs to emphasize integration of the stakeholder input on Improving Business Practices (Page 22). Additionally, CAHF would suggest that an additional issue of Reducing Time to Process Level II PASARR Screens be added to the list. Given diminishing State financial and personnel resources, as well as administrative costs associated with service delivery by the provider community, these practices are key to conserving available resources to the benefit of all stakeholders, including DHCS. Again, good job in completing the draft plan and working through this process.

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It's a great idea to transfer Medi-Cal specialty mental health services to the Department of Health Care Services (DHCS). As you will find with many Medi-Cal funded programs they are highly ineffective and extensively mismanaged as a result of inappropriate management qualifications. Licensed health care professionals who have a much greater understanding

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health conditions and health systems as well as having a far higher level of accountability should be managing these types of programs.

Please also consider also transferring In Home Support Services (IHSS) from the California Department of Social Services to DHCS. I believe there would be tremendous improvement in the way the program functions as well as improvement in the delivery of services to the client's of IHSS, a Medicaid program.

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**COMMENTS ON THE TRANSITIONAL PLAN DATED AUGUST 18TH, 2011**

Each county in California is mandated to have a local Mental Health Board who's duty is to review and evaluate the mental health needs and services of it's community, yet no local boards were asked to be a part of the formation of the transition Plan. You are not going to find a more local source than the County mental health board composed of family, consumers, and members of the public. Mental Health boards or members were not on the Mental Health Stakeholders list. The State ignored the local knowledge and life experiences of Mental Health Board members. Now it is time to listen to what the most local stakeholders have to say about the transition plan. Although I spoke at the August 22nd Hearing, I said that I would also submit written recommendations by e-mail.

I became a Mental Health Advocate in 1987, and originally became a Alameda County Mental Health Board member in 1993 because I knew that Realignment would affect how the County spent it's funds on Mental Health needs. I served from 1993-2003, and was asked to return, and was reappointed in 2008. In Alameda, County Mental Health Board members are a part of the budget planning process and also sit on the Quality Improvement Committee for Behavioral Health Care Services. That means we know how to cut when needed, where extra funding or grants might be applied to, and work on stretching the dollar.

The most common fear for this incorporation of the State Department of Mental Health into a large State Department of Health is that Mental Health needs will become just one more item on a long list of health needs, despite the statement that "specialty mental health programs and services will maintain visibility and significance." For too long mental health needs were ignored or not funded, and just when progress in recognizing what these needs are, and obtaining specific funding thru proposition 63, changes to Realignment, State funding levels, and Proposition 63 funding hit like hurricane Katrina, initiating fear over service losses, reduced funding, and changes in how funds from Proposition 63 will be approved.

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Mental Health Advocates are afraid that funding revert back to silos of funding, instead of providing funds for a system of treatment. The original realignment plan allowed counties to have a designated funding stream so that a system of care could be developed for individual county needs. Unlike many counties, Alameda has 85% of services provided by Community Based Contractors. Links between services could be developed. Counties want to provide a system of care instead of funding a patchwork of care needs. Many Consumers have a dual diagnosis of mental health and alcohol or drug addiction.

Combining Mental Health Services with Alcohol and Drug services can benefit many clients. Anything that reduces the length of time it takes to get paid for services already provided is an improvement. Getting reimbursement for Children's services is particularly difficult and requires experienced staff. Retaining staff that understand MediCal and Medicare Billing processes is essential in this transition.

Comparability of services does not exist between counties now. Only 5 counties have completed the planning processes for Mental Health Service Act funds. Each county had to participate in a process that involved consumers, family, and community members. How will the Department of Health ensure that basic services exist from county to county? Many counties have had to cut programs that no longer have a funding source. How many counties set aside a financial reserve to continue funding programs started with Proposition 63 funding in the lean years? Instead a variance of services exists that varies from county to county depending on county finances and the ability to plan ahead. Advocates do not want Greyhound therapy reestablished as individuals are given a bus ticket to another county that provides the treatment another county does not have.

#### **Improve Business Practices:**

Communication must be improved regarding hearings. On August 18th the draft plan was e-mailed to Mental Health Board members but two public hearings had already taken place. For website information to be read, individuals need to understand that current information is being posted there. The stakeholder communication plan is essential and needs to be assessable.

A major problem with the way that business is being conducted now is that it based on technology. Consumers who live on Social Security and SSI do not have the funds to own a computer, or pay the monthly cost for internet services to go online and read announcements on the web site. Using the library computer also presents a problem as the days and times libraries are open have decreased due to funding. Printing out 43 pages of a transitional plan is expensive to a consumer. Talk to consumers and family members and figure out additional ways communication about the transition can be spread. A monthly call in program to update the public about the transition could be considered.

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Stop denying Counties payment for mandated services they have performed. How can you expect a County Budget to balance when they have to provide a mandated service which is supposed to be reimbursed by the State and the State decides it can't pay counties for providing the service?

Alameda County saved dollars by examining the cost of medication and worked out a savings plan while still providing newer more effective medication. If this can't be done on a state wide basis because of legal ramifications, have counties who have learned from their experiences share their methods & procedures with other counties.

More adults will be eligible for double Medi benefits. Make sure that the people who are billing double services understand what medications are covered by which plans, instead of the system automatically enrolling them in a Medicare plan that does not cover their prescription.

Make sure the individuals who conduct annual licensing reviews understand the difference between a psychiatric hospital and a hospital and don't ding the county for not having equipment in a room that can be used by a patient to harm themselves.

Provide annually the statistical results of PASRR reviews, so that the Mental Health Boards's and County Mental Health program can be assured that older adults in skilled nursing facilities who need mental health treatment and medication are receiving it. There are less skilled nursing homes accepting mental health patients who have only MediCal/MediCare funding, and there will be an increasing need as the number of older adults who need this care increase. Start planning ahead instead of behind!

Cultural Competence must continue to be a goal for the Department. Services must be provided in appropriate languages while addressing racial and ethnic disparities and respecting the role spirituality can play in healing.

Use Tele Psychiatry services in wide spread counties. Consumers who live in Livermore have to travel for four hours by public transportation to get to the County Hospital. By setting up a Tele Psychiatrist station in already existing Mental Health locations, travel time and expense can be reduced.

All Administrative and Financial Services currently provided for the MediCal Programs need to continue without interruption. A State Metal Health Plan is still needed.

Integrate Physical Health needs into County Mental Health Services to increase the number of years an individual with mental illness will live. Put physical health services into the same

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location as Mental Health Services, not the other way around. Making clients go to two separate locations for services is wasteful and creates difficulty for clients.

Remember that not every consumer will benefit from the Recovery and Wellness Plan. While that offers the hope for many, the serious and persistently mentally ill still remain with us and need mental health care. Employment as a major goal of mental health treatment programs has to be balanced against the individuals ability to function in the community and the emotional support that they need. Alameda County has a pool of Consumer Champions that has over 400 consumers enrolled in it. Peers supporting peers programs, and Family members helping support other family members, and caretaker education programs all have an important role in the Mental Health system.

Lower the Veteran suicide rate by encouraging more cooperation between the Veteran's Administration and County Mental Health Departments so that Veterans needing help do not have to wait six weeks for service.

The Information Technology staff plan listing goals and objectives is specific. It will be extremely necessary to make sure Counties can communicate with State and other County staff quickly and accurately in preparation for Federal Healthcare changes.

At the August 22 conference flexibility in dates and deadline was mentioned, and flexibility will help address all of the concerns raised by these changes. The key to reducing public fear over these changes is frequent and detailed communication.