Summary #2 – Comments from July 26 & 27, 2011 Stakeholder Meeting Series With Consumers, Families & Consumer Advocates; Providers & Provider Representatives; and County Mental Health Directors & County Representatives

- Client Associated Issues
  - Clients need to have more input on data issues
  - Need to establish a client task force
  - Some clients cannot utilize the meeting call-in number; need full geographic participation rather than meetings only in Sacramento
  - Stigma is high – a safety net for protection needs to be established, as adult protective services will not help mental health clients who are not also physically disabled
  - Use lay terms rather than acronyms
  - Be sure services are not interrupted
  - Find a better system for distributing meeting notices and other information – one example: via pharmacies
  - Develop a plan for ongoing community input
  - Cultural competency needs of the lesbian, gay, bisexual, and transgender community must be considered
- Program Transfer Issues
  - The Department of Health Care Services (DHCS) needs to release a more descriptive timeline that includes explanations of when systems and contacts will change
  - Is there an opportunity to look at functions to address constraints rather than just a transfer?
  - Need to ensure that Department of Mental Health (DMH) expertise is not lost
  - Staff need to be trained to understand different cultures and needs of the entire person- not just medical needs
  - This is an opportunity to review consistency within the 58 Mental Health Plans (MHP)
  - As funding and oversight changes, analyze what is federally required, what is beneficial and appropriate for clients, providers and consumers
  - It appears arbitrary to split Medi-Cal from non-Medi-Cal functions as there is a high overlap in clients served by both programs
  - Need proactive state level oversight to hold counties accountable
  - Need a strong representative leader – someone who can achieve change
  - Statutes and regulations must be reviewed and amended
  - Develop a robust liaison office, ombudsman, and/or membership services function
  - Include the Department of Alcohol and Drug Programs in all meetings related to the transfer
  - Concern about the continuity of care for special education students and the relationship of Medi-Cal, non Medi-Cal, and AB 3632 services. Many special education children/families move in and out of Medi-Cal eligibility.
  - Mid-term opportunities:
    - Review appeals process timelines, which are not consistent with federal requirements
    - Review federal requirements associated with Prepaid Inpatient Health Plan
- Funding & Other Fiscal Issues
  - Need to be sure that payments to counties and providers continue while the transition is occurring
  - Need to provide the opportunity to weave funding

  - Bi-furcation of funding streams is confusing
  - Full service partnerships provide both Medi-Cal and non Medi-Cal services with multiple funding streams – how are they to slice out Medi-Cal yet still retain current services?
  - Need clarification as to how the transition links to Substance Abuse and Mental Health Services Act (SAMHSA), the federal New Freedom Initiative, and the Mental Health Services Act (MHSA)
  - Concerns about needing to bill Medicare before Medi-Cal – this policy causes many difficulties – edits need to be in place so do not have to bill Medicare every time
- Access and Services Issues
  - Do not presume that access already exists
  - Target age-specific programs including those directed at transition age youth, and older adults
  - DHCS should review the California Network resources on peer support, best practices, and full service partnerships under MHSA
  - It is essential to value and expand peer support services and community defined best practices, especially where there is co-occurring substance abuse or developmental disabilities along with the mental health diagnosis
  - Need to focus on integration of services (e.g. through CalMEND, a consent form was developed for release of records to primary care providers)
  - Clients are not taken seriously by primary care providers
  - Need to focus on wellness, recovery and resiliency
  - Add services for maintenance or peer support to the Medi-Cal specialty mental health services waiver
  - The state should look at geographic regions with no mental health providers and reduce barriers for providers to participate
  - Need to gain consistency of services and approaches across the counties
  - Services need to be recovery oriented – work with the Centers for Medicare and Medicaid Services and the SAMHS entities to help determine how to combine the health care and rehabilitation models.
  - Review current obstacles in providing services due to the care out and medical necessity requirements.
  - Review the language describing eligibility requirements – currently even children need to be diagnosed in order to receive services
  - Consider consultation and integration in primary settings
  - Re-think the same-day service limitations.
  - A focus committee should be formed to look at all pieces in the services/benefits area from both the fee-for-service and managed care perspective, including coordination of services between the seriously disabled persons program and the county MHPs.
  - The change to DHCS is an opportunity to fix many issues; providers feel much of DMH have been focused on state hospitals and not Medi-Cal related issues
  - Consider quality improvement and evaluation for the program
  - Annual chart review/fiscal audits and tri-annual policies/procedures audits should be consolidated and done at the same time
  - The transfer is an opportunity to redesign the system to focus on prevention and early intervention with a greater intensity of primary care and outpatient services

  - Standard routine reports, eliminate redundancy, and work with providers to agree on data need
  - Providers will need to be notified when changes will occur; where to send Treatment Authorization Requests, data, etc.
  - Consider integration of systems with other state departments
  - The 58 county MHPs do their data systems in 58 different ways – DHCS needs to be sure that the IT systems can talk to one another and that there is some consistency
  - Need to look at the overlap of Medi-Cal services, MHSA, the 1991 Realignment, and programs for developmental disabilities
  - Clarification is needed regarding Medi-Cal school-based LEA services and waiver mental health services. DHCS should participate in the AB 3632 Realignment to encourage LEAs not to forego the federal match that they can obtain for the Medi-Cal eligible children and families they serve.
  - Questions about staffing, loss of historical knowledge, and staff training.
- County-specific Issues
  - The contracts with DMH have expired and have not been renewed for three years.
  - The counties are looking forward to fresh dialogue and clarity
  - Discontinue annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) chart audits and instead, integrate the EPSDT audit into the existing tri-annual Medi-Cal Specialty Mental Health compliance review and chart audit.
    - Streamline the audit process to reduce the workload impact on the counties
    - Need administrative efficiencies in general
    - As the EPSDT program is realigned, the State should rethink punitive audits on providers, as this a cause of major costs for providers and results in redundant work
    - Collapse separate annual chart review/fiscal audits and tri-annual policies/procedures into one audit
  - Discontinue the annual External Quality Review Organization (EQRO) on-site county review. Instead conduct tri-annual on-site EQRO validation review to verify MHP compliance with federal data and performance improvement requirements. Coordinate the EQRO reviews into existing DMH compliance reviews to prevent duplication and overlap.
    - Focus on specific providers rather than aggregate results
    - There is no clear direction of how to prepare Perform Improvement Projects for audits. Is it the state or federal government that is requiring two audits?
    - The state needs to share the concerns of the federal government with the counties
    - The county concern about EQRO is not about providing data, but rather the annual on-site visits
    - The state seems to be asking for more and more data – is it all needed/mandatory?
    - Include the counties in conversations about what changes can/should be made to audits
    - DMH's EQRO is very different than the EQRO conducted by DHCS – DHCS should take into consideration the current DMH efforts and available data rather than re-creating

        - There is a redundancy in the audits
        - Federal regulations around EQRO need careful and consistent interpretation – the regulations are very broad and can be interpreted in many ways
        - On-site audits were cancelled for counties with 'good' audit results, but the replacement desk audits took more time to prepare for than the on-site audit
        - The State does not need to do reviews annually – counties will continue to send data and meet the requirements. The major concern is with the workload increase associated with on-site visits.
        - Consider changing the EQRO road map guiding tool, which was constructed as a research project; there are other models available
        - EQRO – look at differences in payment levels; counties use EQRO for purposes such as quality evaluation
    - Clearly identify specific points of contact or the system navigator within DHCS for county consultation regarding Medi-Cal regulatory, policy and other critical county business and operational issues
        - This is especially critical for Medi-Cal Claims Customer Service Office and IT staff
        - Include more information about the DMH and DHCS 'programs' that are involved in the transfer
    - Review federal reimbursement processes with a focus on improving the efficiency and timeliness of interim federal Certified Public Expenditure payments and final settlements.
        - There is a need for improving the process for reimbursing counties
        - need to review the cost settlement issue – counties have not been paid the 06/07 settlements
        - review the Department of Alcohol and Drug Programs cost report - it is quicker than DMH's
        - Request for one cost report for both programs since both will be under DHCS
    - As they are transitioned, examine current DMH functions and priorities in light of the intent specified in AB 102 to focus on statewide accountability and outcomes.
        - Examine to determine if functions are meeting needs
        - Examine data and outcomes and provide feedback to counties
        - Find a better way to conduct the work
        - Improve timeliness of state reports
        - Need a uniform set of reporting requirements
        - Need clear and concise requirements for data purpose
    - Complete the state/county MHP contract discussions and finalize the required contracts
        - Need to know what services are federally required
        - DHCS needs to now be part of this process
        - Disagreement exits between state and county in the fiscal section
        - Interested in developing an ongoing amendments process
        - Need to talk about Therapeutic Behavioral Services, supplemental payment structure, the intergovernmental contract requirements, and contract amendments

- Need a process to amend the financial portion when funding is not sufficient – counties must cut services when the state Estimates are too low.
- Need the same timelines for state and county, and timely payments
- MHPs have been caught between the interpretation of DMH and DHCS on federal mandates.
    - DMH has said only 'mandated' services are needed, and cut the county budgets.
        - DHCS has said that there are minimum federal requirements, but once a service is added, there is an obligation to provide the services.
        - DMH cut the managed care obligation in half with the assumption that responsibilities were reduced and counties are now trying to function with reduced allocations based on incorrect information
        - The baseline funding needs to be increased to return to where it was before DMH cut the budget
        - Need clarification as to what services are actually mandated

- Address recent significant delays in the processing of claims through Short-Doyle 2 and ensure cash flow to counties is not worsened during the transition of responsibilities to DHCS.
    - Claims are not being processed – no cash flow is allowed
    - There are too many edits to the system
    - Need regular dialogue on the issues
    - Short-Doyle 2 is a difficult process to implement
    - Need increased communication between the state and the county
    - Need to discuss the State Controller's proposal to edit claims after the department has scrubbed claims.
    - The lack of paid claims has led to a freeze on county hiring