

Written comments submitted to the Department of Health Care Services (DHCS)  
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS, effective July 1, 2012  
Comments received July 28 through August 2, 2011

*Note: In some cases, DHCS has edited the responses to explain the acronym used by the writer, or to remove personally-identifying information. Specific references to the writer's organization have not been removed.*

+++++

San Mateo County Behavioral Health and Recover Services (BHRS) wishes to thank the Department of Health Care Services (DHCS), the Department of Mental Health and the Department of Alcohol and Drug Programs (ADP) for their efforts in guiding our systems through the integration of Medi-Cal programs into DHCS.

We would like to take this opportunity to frame certain principles, concerns and/or ideas that we hope will be considered as this process moves forward.

- BHRS advocates for the ongoing stakeholder participation not only during this transitional period, but afterward as well. It is an opportunity for us to have first-hand knowledge of anticipated changes as well as to influence future changes for the system.
- BHRS supports the idea that counselor certification needs to be streamlined into a single course that is accountable for the various certifications that are currently in existence. We would advocate moving alcohol and other drug certification to licensure in the future that would support higher standards of care and 3<sup>rd</sup> party billing.
- BHRS advocates moving site certification from ADP/DHCS to counties. This would be commensurate with how counties operate regarding site recertifications for the Department of Mental Health/DHCS.
- BHRS advocates moving negotiations of rates away for a state wide standard to county based rate negotiations because of the wide variation in cost of living/doing business.
- We support a deputy director responsible for both mental health and alcohol and other drug issues.
- Although outside the initial purview of transitioning Medi-Cal functions, we support that the final organizational structure for mental health and alcohol and drug programs be inclusive of all statewide responsibilities and not have a bifurcated structure separating Medi-Cal functions from the other functions.
- State responsibilities in addition to Medi-Cal should include but not be limited to formulation of state policy, Single State Agency responsibilities, outcome evaluations, needs assessment, epidemiological research.

During the initial calls there were a number of comments, pro and con whether mental health and alcohol and drug programs should be integrated into a single structure. In San Mateo County, we have been an integrated structure for the past 4 years and overall believe this reorganization has benefited our clients and community. Recognizing the complexities of those seeking our services we are now better positioned to respond in a meaningful way emphasizing total wellness and recovery. We recognize there is history that leads people to believe an integrated structure is not desirable. Our experience leads us to a different conclusion and we would encourage you to look for any and all possibilities where an integrated structure works best for persons with mental health, substance use and co-occurring disorders.

+++++

The California Association of Social Rehabilitation Agencies (CASRA) is a statewide organization of private, not-for-profit, public benefit corporations that serve consumers of the California public mental

Written comments submitted to the Department of Health Care Services (DHCS)  
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS, effective July 1, 2012  
Comments received July 28 through August 2, 2011

health system. Member agencies provide a variety of services that serve to enhance the quality of life and community participation of youth, adults and older adults living with challenging mental health issues.

Please see below for a compilation of feedback from CASRA agencies regarding the transfer of Medi-Cal mental health services from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS). You'll find that providers had difficulty teasing out this specific topic from the other major changes involving behavioral health. Therefore, some of the feedback addresses those broader issues while certainly remaining pertinent to Medi-Cal.

- Increased executive time spent managing consumer/employee anxiety over many significant changes/much uncertainty e.g. national budget specifically proposed changes to Medicaid and Medicare, potential trigger cuts in state budget, increases in Medi-Cal payments (co-pays, hospitalizations), county budgets, etc.
- Increased urgent/emergency situations perhaps brought on by heightened anxiety
- Difficulty comprehending the potential impacts of so many changes at one time particularly interplay with the Affordable Care Act and Realignment
- Concern over the loss of county/state staff with historical knowledge and commitment to recovery principles
- Frustration/concern over the delay in responses and at times apathetic responses/incorrect information from county/state contacts
- Optimism regarding the possible oversight of certification/licensure of social rehabilitation agencies by one department that embraces the recovery model
- Optimism regarding possible Medi-Cal waivers in order to use the recovery model rather than medical model due to DHCS expertise with Medi-Cal
- Optimism regarding the reduction of required data by providers that is redundant and/or not used balanced with the concern that DHCS will see redundancy and proceed to eliminate processes and proceed to eliminate them without fully considering the implications and consequences e.g. DMH's Internet Technology (IT) support for Medi-Cal systems are folded into DHCS's current IT support and fiscal/financial functions. Desire to prevent the frustration related to the protracted rollout of Short Doyle/Medi-Cal Phase II.
- Optimism for integrated IT systems
- Questions regarding the impact on the variance of available services by county. A major concern has been the lack of state oversight of county mental health programs which has resulted in county mental health programs having too much freedom in designing/operating mental health services therefore those services vary greatly by county. Instead a defined minimum mental health package should be available in every county.
- Concern regarding who will be handling the settlement issues and appeals by contractors for past years contracts. In other words, who will be responsible for money still owed to county mental health divisions and contract providers- DMH or DHCS? If DHCS, where will this responsibility reside?
- Concern with the administration of Substance Abuse and Mental Health Services grants and PATH funding that passes through State DMH. How will this money and its resultant obligations be handled?

A number of CASRA members have run community mental health programs for well over thirty years and understand the Med-Cal rehab option in detail. We are invested in this transfer being successful

Written comments submitted to the Department of Health Care Services (DHCS)  
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS, effective July 1, 2012  
Comments received July 28 through August 2, 2011

and will make ourselves available to you if this would ever be helpful. We look forward to continued collaboration.

+++++

Responses to “five questions” for mental health stakeholders, posed by the Department of Health Care Services (DHCS) and the Department of Mental Health (DMH) as part of the July 12, 2011 stakeholder meeting.

*#1. What are your comments on the organizational placement of mental health functions and mental health leadership within DHCS?* Positive move which creates opportunity for integration of medical services, including physical and mental illnesses and substance use disorders.

Opportunity to close disparity between treatment of physical and mental illness and substance use disorders. California law specifically discriminates against treatment of mental illness. MediCal - insured individuals are entitled to essential services for physical illness, while they are not entitled to essential treatment services for mental illness. MediCal match is capped for Serious Mental Illness whereas treatment for physical medicine is caseload-driven. Organizational placement within DHCS should facilitate an end to this disparity and integrated public health systems.

*#2. What are your recommendations regarding the role of stakeholders and interaction between stakeholders and (a) DMH and DHCS during the transfer period, and (b) DHCS on an on-going basis?* Stakeholders need appropriate tools to contribute, including DHCS answers to the July 12 Questions. Need “context” describing fixed objectives and limits.

What process is DHCS considering, what are your experienced executives/managers proposing? What has already been decided? Stakeholders must be informed of infrastructure, management decisions. Stakeholder participation will increase when Department addresses vacuum of knowledge.

I was frustrated by statement from DHCS/DMH that stakeholder meetings are to hear what stakeholders are “worried about.” This is not a good use of my time or time of state employees, not about therapy. Meetings should begin with briefings that can elicit informed contributions to promote responsive, effective process, and change.

DHCS must be responsible for independent policymaking in the best interests of Californians, and genuine interests of stakeholders. DHCS must act independent of special interest influences.

*#3. How can DHCS and DMH best ensure continued access and quality of services pre and post transfer, with no service interruption to beneficiaries and providers?* Obtain proposals from CSAC and CMHDA for public consideration and comments, along with analysis by DHCS experienced managers.

*#4. What changes and efficiencies do you think the departments should consider in this initial phase of the Medi-Cal related mental health services transfer to DHCS? What is the fiscal and programmatic impact?* Changes and efficiencies can be achieved along with benefits to all

Written comments submitted to the Department of Health Care Services (DHCS)  
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS, effective July 1, 2012  
Comments received July 28 through August 2, 2011

consumers with consolidation and integration of managed care system providing comprehensive and equitable services for physical and mental illnesses, and substance use disorders.

Oversight and compliance issues related to all services should be likewise consolidated and integrated. This stakeholder process is fragmented in separating MHSA from MediCal managed care, and separating AOD issues. Efficiencies can be achieved by at least bringing together these differing stakeholder group meetings to communicate a coherent set of challenges and common goals. MHSA programs and revenue must be integrated with existing community Systems of Care to comply with the law, and with the intent of voters.

The fiscal and programmatic impact should be cost-efficient and client-effective. And that does mean considering the Kaiser model philosophically, as another stakeholder commented. The mental health system for children and adults has been diagnosed as “fragmented” since the 1990’s, from reports of the U.S. Surgeon General, California Little Hoover Commission, Joint Legislative Committee, etc etc. Take some advice from decades of study please. The original concept of the MHSA Oversight and Accountability Commission (OAC) was to see that an independent body assured the public that the state Department of Mental Health and other government bodies were properly implementing the law. The OAC did not take up this task and now there will be no DMH , the OAC has advised individual consumers that they cannot address grievances or develop a grievance process, and likewise advised provider organizations that they could not address grievances with county plans, so perhaps their job is done, and the most efficient step is to phase out the Commission as part of overhauling the system to end fragmentation.

*#5. Considering the above questions, what are your priorities for discussion in future meetings?*  
NOW, “accountability and outcomes” have been largely unreported and of little value when they are. NO ONE provides **an account of county system performance**. Until that is done, and well-known standards in Welfare and Institutions Codes are utilized to make the assessment, individual program performance reports provide no guidance for quality improvements. These are too often mere theatre, and expensive at that.

Focused, high-level leadership for behavioral health would be guided by the vast body of knowledge largely ignored in the field, would articulate concrete objectives, describe the elements of a functioning system, identify the gaps today, and articulate the specific steps necessary to establish, manage, and fund Systems of Care for children, adults, and older adults.

NOW—not encouraged by DMH and DHCS failure to act. Opportunity to properly fund treatment of SMI and stop diverting mental health dollars to other social programs, stop wasting mental health Mental Health Services Act revenue on needless planning and stakeholder theatre. So-called stakeholder input is simply gathering of special interests to ensure an equitable division of pie—not to ensure quality of product.

+++++

My comments summarized, as requested during the July 26<sup>th</sup> Provider/Stakeholder meeting.

Written comments submitted to the Department of Health Care Services (DHCS)  
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS, effective July 1, 2012  
Comments received July 28 through August 2, 2011

1. Drug Medi-Cal Department of Alcohol and Drug Program (DADP) staff need to attend all Department of Mental Health (DMH) stakeholder meetings and DMH staff need to attend all Drug Medi-Cal meetings. At some point these meetings should be blended.
2. The Department of Health Care Services (DHCS) should consider adding a Psychiatrist as medical director during the transition period
3. Information on linkage to the 1115 waiver/behavioral assessment and adequacy of network needs to be developed. **Behavioral Health Services Assessment** - By March 1, 2012, the State will submit to the Centers for Medicare and Medicaid Services (CMS) for approval an assessment that shall include information on available mental health and substance use service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California. **Behavioral Health Services Plan** - By October 1, 2012, the State will submit to CMS for approval a detailed plan, including how the State will coordinate with the Department of Mental Health and Alcohol and Drug Programs outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014.
4. DHCS should dedicate staff and resources for work on the Medicaid Emergency Psychiatric Care Demonstration Project Act - Patient Protection and Affordable Care Act (P.L.111-148, Section 2707) Effective October 1, 2011 through December 31, 2015. Three-year, \$75 million demonstration project, states can apply to the U.S. Department of Health and Human Services (HHS) Secretary to cover patients aged 21 to 64 in non-governmental, freestanding psychiatric hospitals and receive Federal Medicaid matching payments.
5. Under efficiencies and improvement, significant work needs to be done on Health Insurance Portability and Accountability Act (HIPAA) and the sharing of information between and amongst mental health (MH) and substance use disorder (SUD) Medi-Cal providers
6. The ability for clinics to perform “warm hand-offs” of patients - on the same day – for physical health, mental health and substance use disorders needs to be resolved and made permissive if we are to ever integrate care
7. In rural CA and some urban areas the use of Tele-medicine should be more easily and realistically reimbursed
8. The grievance process for consumers should be permissive to include providers (due to the consumer brain illness)
9. The 2000 Little Hoover Report <http://www.lhc.ca.gov/studies/157/report157.pdf> should be reviewed by staff involved in this transition. Little has changed since the report was written.
10. State wideness is a concept that has been eroded as each of the 58 counties has interpreted the rules, regulations and statutes to meet their individual county needs.
11. Data should be carefully scrutinized as in many instances it does not capture the true utilization by consumers in each part of the state.
12. As counties close or reduce their community based levels of care there is a higher dependence on hospital emergencies departments. There is no reliable data base capturing this trend. Hospitals report a 300% increase in utilization with no tracking or funding being made available from county mental health.
13. The County Medical Services Program behavioral health pilot project and subsequent Lewin Report released earlier this year provides good information about the challenges of integrating care with this population.

Written comments submitted to the Department of Health Care Services (DHCS)  
Regarding the Transfer of Medi-Cal Related Specialty Mental Health Services to DHCS, effective July 1, 2012  
Comments received July 28 through August 2, 2011

14. Numerous statutes and regulations require either DMH and/or the County mental health plans to perform certain functions. The attached contains a list of these requirements. See yellow highlighted sections.
15. Is there a plan that lays out the logistics of the transition? Laws and regulations that will be reviewed, updated or deleted? What makes the change more palatable for providers is knowing what is happening and who is doing it and what can they expect next.
16. The Treatment Authorization Request process needs revised and updated including the 2<sup>nd</sup> level appeal process.

+++++

I am the manager of the Alcohol and Other Drug (AOD) Program for Sutter and Yuba Counties. As someone brought up, many (if not most) mental health clients have co-occurring issues. It's paramount that we (AOD) and mental health have a close working relationship with equal status and recognition, especially with healthcare integration on the horizon. Under 'behavioral health' models, often AOD sinks below mental health and therefore, those issues dip below the radar and are not addressed.

+++++