

**Summary of Stakeholder Comments from July 12, 2011 Meeting
Regarding Transfer of Medi-Cal Related Mental Health Services to DHCS by July 1, 2012**

1. What are your comments on the organizational placement of mental health functions and behavioral health leadership in DHCS?
 - Positive response to having high level, behavioral health DHCS leadership
 - Maintain identity of mental health services
 - Resolve the problem of mental health and Drug Medi-Cal services not being treated on an equal footing with each other or other Medi-Cal services
 - Do not lose the identify and treatment of Drug Medi-Cal services among other DHCS Medi-Cal services

 - Keep experienced staff
 - Assure expertise in DHCS across the service spectrum and populations: rehabilitation for adults and EPSDT for children
 - Develop an advisory body for ongoing input and feedback

 - Support the integration of mental health services and Drug Medi-Cal
 - Support integration of all currently “divided” services (1115 and 1915(b) waivers) and treat the whole person

 - Use transition to address neglected issues such as:
 - Underfunding of mental health services
 - Need for administrative efficiencies (e.g. reduction of paperwork)
 - Need for prevention and early intervention services in the primary care system including better use of EPSDT services
 - Current racial and ethnic health disparities in utilization and outcomes
 - Data on client utilization, outcomes and disparities
 - Assuring county compliance with providing required services and EPSDT, particularly in the least restrictive environment

 - Consider incentives to reduce utilization of institutions and use savings to increase use of home and community based services

 - Address the challenges of school districts ability to get reimbursement for services and differing county requirements
 - Clarify intent of integrated financing and plan to achieve it
2. What are your recommendations regarding the role of stakeholders and the interactions between stakeholders and:
 - a) DMH and DHCS during the transition; and
 - b) With DHCS after the transition?
 - Slow down the process to better engage stakeholders

- Provide funding to facilitate stakeholder participation (travel & accommodations) or provide statewide audio/video options
 - Consider that stakeholders have different levels of knowledge and expertise
 - Consider formats to increase participation of stakeholders from underserved and underrepresented communities
 - Have pre-meetings with client/family stakeholders
 - Process should respond to stakeholder questions
 - Make clients part of the decision-making process
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- Provide information in way that is easier to understand (literacy) and explain terms
 - Record meeting discussions
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- Clarify Medi-Cal versus non-Medi-Cal functions for purpose of discussion
 - Clarify what AB 102 mandates versus what is flexible and open for discussion
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- DHCS should have a high level behavioral health expert
 - Consult with mental health and alcohol and drug treatment specialists during this transition
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- Consider that there are significant differences in urban and rural access and infrastructure
 - Insufficient safety net leads to increased use of hospital emergency departments
3. How can DHCS and DMH best ensure continued access and quality of services pre-and post-transition, with no service interruption for clients and providers?
- Address racial and ethnic disparities in use of services and need for culturally competent services
 - Translate stakeholder materials into multiple languages
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- Don't presume that access exists or is equitable
 - Provide guidance to counties and mental health plans regarding legal obligation to provide services, identify covered services
 - Assure continuity of services across counties
 - Address inequities in services across counties
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- Expand use of peer support services
 - Implement community defined practices even though they may not be evidenced-based
 - Clarify plans for MHSA programs and services
 - Ensure that clients maintain access to all services (Medi-Cal, MHSA and others)
 - Facilitate provider administration and delivery of service across programs (Medi-Cal, MHSA, and others)
 - Stress the importance of the recovery and rehabilitation model, not just medical

- Current grievance process is problematic; consider Department of Managed Health Care's model of Help Center to address client grievances
4. What changes and efficiencies do you think the departments should consider in this initial phase of the Medi-Cal mental health services transfer to DHCS? What is the fiscal and programmatic impact?
- Integration of services
 - Address the challenges of the current carve-out of services with different systems of care, service limits, etc.
 - Examine 1115 and 1915(b) waivers for coordination and/or consolidation to achieve efficiencies
 - Consider the role of health care reform and its requirements
 - Integration of services and better primary care will result in efficiencies and will lead to savings in "physical" health care
 - Look for administrative efficiencies and redirect savings to direct services
 - Consider whether the "Money Follows the Person" grant and services fit in with this transition
- Use a stakeholder process to discuss and recommend efficiencies
 - Continue current DMH advisory bodies and meet their support needs
 - Consider the importance and impact of peer support and social rehabilitation, including vocational education and training
 - Certify peer support services and include them in the State Plan
 - Provide education, training and support to help clients move through the system of care
- Protect database during the transition and its impact on claims
- Improve communication with the education community during this process and thereafter
5. Considering questions 1-4, what are your priorities for discussion in future meetings?
- Expansion of peer support services in Medi-Cal and MHSA programs
 - Continued communications with clients and families
 - Improve access to services and address varying levels of access and services among counties
 - Reimbursement of same day visits for behavioral and physical health services
 - Inclusion of culturally appropriate services