

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 as of July 17, 2011

Note: in some cases, DHCS has edited the responses to explain the acronym used by the writer.

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I attended your meeting and was struck by the time constraints that have been placed on the department by the legislature and the task of including stakeholder input in the development of your plan. I appreciate the enormous task that you have before you. I will therefore try to keep my comments brief and to the point.

An overall comment on the process to include stakeholder input and to reach out to others with the idea to improve access to culturally appropriate services:

- The department may want to consider providing information in all threshold languages;
- the department may want to have interpreter services especially for the consumer meetings; and
- the department may want to have someone who can sign for those who are hearing impaired.

Organizational placement within DHCS

- I support the idea for a Deputy Director for Behavioral Health. I realize that this proposal is for the transfer of Medi-Cal related specialty mental health; however, it may be more effective and efficient to have a single state agency for Behavioral Health with a strong emphasis on coordination with primary care.

Role of Stakeholders

- Close coordination during transition to understand Community Mental Health and how it functions. Close coordination on setting up new structure during transition looking for efficiencies and better ways of working together. I would normally suggest taking time on the initial planning, but this is not a luxury the department has.

Insure access and no service interruption

- Continual appropriations for Mental Health Managed Care plans, since it is the local Mental Health Plan (MHP) that has to certify that the Certified Public Expenditure (CPE) is made. This will not affect the State General fund in any manner. In past years the lack of an adopted State budget would stop Federal Financial Participation (FFP). Since the MHP made the CPE, there is no reason to stop the flow of federal funds. As in most cases, service interruptions are usually caused by funding interruptions.

What changes and efficiencies should be considered?

- Currently DMH has a process that requires each MHP to certify each provider and have that certification approved by DMH and added to that county's list of certified providers for each type of service provided. This is required even though the provider has been certified by other MHPs. Many of the providers are regional providers and serve multiple MHP. There are requirements for annual fire clearances from each county for each

provider. The current process is redundant and inefficient for the providers, the MHP and the State.

- Eliminate the 6 month/97 day claim limit for Mental Health Medi-Cal claims.
- Eliminate the UMDAP requirements that have not been updated since the 1980s.
- Allow for multiple Medi-Cal services to be provided on the same day.

These are a few of items that come to mind.

Priorities for future discussions in future meetings

- The concept of a single state agency; and effectiveness and efficiencies.

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I find the term behavioral health to be insulting. Specialty health or care is more accurate. Mental disorders and substance use disorders are not caused by BAD behavior; they are caused by brain disorders or perhaps systemic disorders that impact brain function.

Also, if substance use disorder treatment is to have equal footing with mental and primary health care, then I recommend that be reflected in all naming conventions.

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APS Healthcare has served as the External Quality Review Organization (EQRO) for the Department of Mental Health since June 2004. Our project is often referred to as "CAEQRO". We've conducted annual reviews of each county Mental Health Plan (MHP), and have written annual reports summarizing and trending our findings.

Our annual reports are posted on our web page. Individual county reports have been posted for the past 2 years. We also post data derived from claims files on our web share site www.caeqro.com.

We believe that we have data that would be useful to the transition process. We encourage the transition team to contact us so that we may support your efforts.

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Thank you for this morning's stakeholder meeting. I was encouraged by the statement early on that the new person in charge of Behavioral Health would report directly to Toby Douglas. I see two major issues in this arrangement: Will this new person be more isolated from the rest of the department, or will he/she be in a colleague relationship with the Chief Deputy that oversees the other parts of DHCS? What type of person is going to best fill this slot? Three options at the moment are: cheerleader, skilled bureaucrat or thoroughly behavioral health professional (attuned to recovery and resiliency models for adults and children). My bias is toward the third option with a deputy that is the consummate bureaucrat able to slice through regulatory

entanglements with the ease of Superman. [Note – submitter offered his assistance in the process, and that of a colleague]

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Here are two comments areas:

- 1) Given the strong voice/weighting that Counties receive in terms of exemptions and the decision-making process (e.g. County mental health services are exempt from the pending Medi-Cal “soft cap”), what safeguards are in place to advocate for the voice of Federally-Qualified Health Centers and community based organizations with the transfer – given that it is often the Federally-Qualified Health Centers and community based organizations that actually *do the work* in terms of serving the Medi-Cal population, as well as the uninsured/underserved? In their fervor to save their own programs, it has been an observation from providers across the State that many Counties appear to cut/circumvent the services of other providers in the community and then disempower these providers to make their concerns and complaints heard. A clear example was what happened with Mental Health Services Act (MHSA) funds (used to essentially supplant existing County services, with no recourse for the many providers who went to the Oversight committee from across the State).

- 2) Echoing some of [another participant’s] comment at the MH Stakeholder’s Meeting today, what provisions will be made to give a voice to substance abuse treatment providers? Please could you clarify the relationship between Alcohol and Other Drug (AOD) and MH services and oversight with the transfer? Also, can you offer a solution other than increasing County-level oversight, given Comment No. 1 above (i.e. that it is an automatic conflict of interest)? Here are some examples re: the lack of clarity: Will we use Substance Use Disorders diagnoses (proposed for the Diagnostic and Statistical Manual of Mental Disorders [DSM] V) or existing DSM-IV diagnoses for AOD – this is something that has been thrown around, with no resolution. Will AOD fall under MH? For a Co-occurring client, which diagnosis would take precedence or would these diagnoses be treated in tandem?

I am not sure is this is the appropriate venue for these concerns but given that questions of organization/leadership were raised today, I would like to take this opportunity to present these concerns, as they have historically been swept under the carpet or squashed.

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In terms of the process-- I think it is important to record the stakeholder comments from the meetings, and make these available, in order to ensure accountability. Either written or an audio recording. You indicated that you are expected to incorporate stakeholder input—if there’s no public record of what the input is, how can we be sure that the input has been incorporated?

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I am writing to comment on the transfer of Medi-Cal related specialty mental health services.

In consolidating Mental Health and Alcohol and Drug within health services for Medi Cal purposes, critical issues that are associated with historical discrimination against people with mental illness, and with mental health and alcohol and drug services that have been marginalized in healthcare programs, must be given attention. There is a need for a department head for community mental health, or some other highly visible leader with clear authority, who can represent mental health interests in state government, policy, and fiscal decisions. This would be the biggest concern in what has been proposed.

Unfortunately, no assurances that mental health is important and that the needs of people with mental illness will be treated equally to other healthcare needs can adequately address the history of discrimination both within healthcare systems and within society. Because of that history, putting all of community mental health inside a department with a far different mission is a very problematic proposition. Moreover, there does not seem to be a precedent in other states for taking such a step and demonstrating that this can be done successfully. Therefore, eliminating the Departments of Mental Health and Alcohol and Drug Programs should be withdrawn and the state should pursue other alternatives.

Efforts to have no state department of mental health will lead to savings in terms of reduced staff of less than 1 million dollars, but the likely costs in the criminal justice system, education system, and child welfare system are many times that. Moreover, the suffering and discrimination faced by individuals and families with severe mental illness creates an enormous need to ensure that this subject remains important in the structure of state government. The additional cost of this approach will be limited to literally only a handful of management positions and all the operational functional staff would be the same whether mental health has its own department or not.

It should be noted that that the current structure of the state department of mental health has also not worked well and that issues of greatest concern have seldom gotten the attention that is needed while significant state resources have been expended on outdated approaches to oversight and accountability that are neither effective nor efficient. Thus, the reorganization is also an opportunity to rethink the best approach to these and other issues. For example, a possibly adequate substitute would be the creation of a high level division of mental health and alcohol and drug services (which could also be called behavioral health services) within the Department of Healthcare Services if this would be a primary place in which the attention needed for Medi-Cal and other publicly funded or managed programs are considered. Ideally that division would also address the adequacy of funding the appropriate models of care to achieve the aims of healthcare reform for better health through better services and lower cost with an emphasis on prevention and early intervention.

Of importance is that the problems that are faced by the estimated 1-2 million Californians who have a severe and potentially disabling mental illness and the millions more family members who are affected by failure to address these problems requires a highly visible and high level state leader. This type of leadership would be best to exist outside of the Department of Healthcare Services because otherwise there is no recourse if the people who are leading the Department of Healthcare Services fail to take the necessary policy actions. Moreover, even if they do, they are not going to be people whose primary background is one of mental health. Accordingly they would lack the time and experience to give the mental health community the attention that it deserves. We need a prominent visible leader who has significant experience in the community mental health system and who can be the "go to"

person for the mental health community to bring these concerns into state policy and fiscal discussions and who can be the “go to” person for others in state government to make sure there is appropriate attention to mental health issues.

In summary, a Department of Mental Health and Alcohol and Drug Programs needs to be established. The savings from investing in prevention and early interventions strategies for both of these conditions results in similar savings and reduced costs to state government and the criminal justice system and reduced education and child welfare failures. For all of the foregoing reasons, I strongly urge a reconsideration of the proposal to eliminate the state department and propose that it be replaced by a new Department of Mental Health and Alcohol and Drug Programs. Alternatively and at least, I would urge the establishment and strengthening of a new behavioral healthcare services division within the Department of Healthcare Services with a clear leader with significant authority within the state governmental structure.

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Will materials & meetings be conducted in Spanish?

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