May 4, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, California 95899

SUBJECT: Invitation to Provide Public Comment – Coordinated Care Initiative: California's Dual Eligibles Demonstration

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, I am writing to communicate our perspective on the *Coordinated Care Initiative: California's Dual Eligibles Demonstration* that would impact California's community mental health system.

CMHDA strongly supports the proposal's emphasis on person-centered planning. Person-centered planning is consistent with the mental health recovery and resiliency principles outlined in California's Medi-Cal rehabilitation mental heath services state plan amendment. Effective partnership and collaboration with county mental health will make available to demonstration enrollees a wide variety of comprehensive, high quality, rehabilitative and targeted case management services. Increasing access to effective outpatient and crisis stabilization services provides an important opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental illness in the least restrictive manner possible.

California's local recovery and rehabilitation-focused mental health system plays an integral and essential role in California's public healthcare delivery system. While the proposal speaks to integration between various system partners, it should be recognized that California's current county mental health system in many ways already functions as an integrated system for persons with serious mental illness, with county Medi-Cal specialty mental health plans managing outpatient, inpatient and long-term care needs. It is imperative that the state and managed care organizations recognize the complexity of California's current mental health delivery system, and do not underestimate the valuable role that counties play in managing risk and financing critical services for Medi-Cal beneficiaries – particularly the counties' role in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries.

According to the draft proposal, specialty mental health services, which again are county-administered, will not initially be included in the capitation rate for demonstration health plans. However, according to the draft proposal, "health plans and county mental health agencies will develop coordination and integration strategies, which could include full financial integration in later years." CMHDA believes this statement underestimates the scope and complexity of

expanded mental health coverage available to Medi-Cal beneficiaries through our local risk management and financing system. Of particular note is the counties' role today in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. Additionally, coverage through the county mental health system includes comprehensive rehabilitation and targeted case management services that have proven extremely effective in reducing costly emergency and inpatient services. Counties currently play an important role in coordinating this coverage with Medicare for both inpatient and outpatient services. Furthermore, county mental health authorities utilize local revenues to match federal dollars.

In order to assist in the collective understanding of the complexity of California's public mental health system, CMHDA has outlined below a brief history and overview of California's local recovery and rehabilitation-focused mental health system. Following the background, we have provided comments on a number of specific sections within the proposal for consideration. Finally, CMHDA appreciates the opportunity to continue to work with the Department of Health Care Services (DHCS) to further develop a more robust framework for shared accountability and savings between MCOs and county mental health authorities. We have attempted to provide an initial framework for such a strategy in our comments below.

COUNTY MENTAL HEALTH BACKGROUND

The Medicaid Title 42, Section 1915(b) "freedom of choice" waiver covering the mandatory enrollment of eligible Medi-Cal beneficiaries in the Mental Health Plans (MHP) for specialty mental health, emergency and hospital services was renewed by the Centers for Medicare and Medicaid Services (CMS) for this year. Under the provisions of this waiver the county mental health plans are considered prepaid inpatient health plans (PIHP) because they are responsible for assuring 24 hour, seven day/week access to emergency, hospital and post stabilization care for the covered psychiatric conditions for Medi-Cal beneficiaries.

In addition, California has two approved state plan amendments (SPA) that increase the scope of outpatient, crisis and residential and inpatient mental health coverage provided to Medi-Cal beneficiaries when medically necessary, by the mental health plans (MHP).

- The first, which was updated and approved by CMS in December 2010, covers targeted case management for persons with mental illness.
- The second, which was updated and approved by CMS in October 2010, covers mental health services available under the Rehabilitation Option, broadening the range of personnel and locations that were available to provide services to eligible beneficiaries.

In June of 2006, the California Code of Regulations (CCR) (Title 9) regulations governing the payment for and delivery of specialty mental health, emergency and psychiatric hospital services to eligible beneficiaries in California became permanent. In addition to the required contract between the department and the MHP, these regulations form the basis for the access, beneficiary protection and payment provisions governing operation of the MHPs. Through the process of successive 1915(b) renewal applications it was ultimately determined by CMS that the MHPs are subject to Code of Federal Regulation (CFR) Title 42, Part 438 Managed Care requirements. Among other things, these federal requirements specify additional access, beneficiary protection and quality management requirements that the MHP must conform to, many of which are specified in the contract.

Both federal and state code and regulation specify that there is to be a contract between the state and the MHP/PIHP specifying the conditions under which the managed care program will operate. State regulation specifies the process for developing changes to the contract, and the current waiver indicates that the contracts shall be in effect for three year periods subject to amendments, as necessary. The regulations and contract also specify requirements for the coordination of health and mental health treatment between the county and the state contracted health plans. One component of this coordination of care is the requirement that a memorandum of understanding (MOU) be in place between the county and each health plan specifying the process for timely referral and treatment of the beneficiary's health and mental health conditions.

COMMENTS ON DRAFT PROPOSAL

Provider Networks (Page 11)
According to the draft proposal, demonstration health plans will provide 24 hour, seven day/week access to non-emergency health lines staffed by medical professionals. Additionally, some plans, described as "innovative" in the proposal, plan to conduct a network analysis for adequacy of non-medical providers, such as those who provide long term services and supports (LTSS) and mental health services. It should be noted that the county mental health system already provides 24-7 emergency and non-emergency support to clients. California should explore ways to leverage this important existing infrastructure to better meet the spectrum of needs of demonstration enrollees around the clock.

Benefit Design and Supplemental Benefits (Page 12)
See Comments below regarding Behavioral Health Care Coordination

Person-Centered Care Planning (Page 14)
CMHDA strongly supports the emphasis on person-centered planning, as described in the draft proposal. Person-centered planning is consistent with the mental health recovery and resiliency principles outlined in California's Medi-Cal rehabilitation mental heath services state plan amendment.

Behavioral Health Care Coordination (Page 15)
According to the draft proposal, "health plans and county mental health agencies will develop coordination and integration strategies, which could include full financial integration in later years." As discussed earlier in our comments, CMHDA believes this statement underestimates the scope and complexity of expanded mental health coverage available to Medi-Cal beneficiaries through our local risk management and financing system. Of particular note is the counties' role today in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. Additionally, coverage through the county mental health system includes comprehensive rehabilitation and targeted case management services that have proven extremely effective in reducing costly emergency and inpatient services. Counties currently play an important role in coordinating this coverage with Medicare for both inpatient and outpatient services. Furthermore, county mental health authorities utilize local revenues to match federal dollars.

CMHDA appreciates the opportunity to work with the Department over the next few weeks to identify specific strategies for shared accountability and savings between MCOs and county mental health authorities.

Health Plan Payments and Financial Incentives (Page 27)
According to the draft proposal, health plans have performance-based reimbursement or risk-sharing for their network providers, and plan to implement additional efforts. One such effort, as provided by a health plan, is to develop incentives to reward home- and community-based services agencies for helping members stay healthy and safe in their own homes, avoiding preventable hospital and nursing home admissions. CMHDA notes that the state and health plans may consider additional leveraging opportunities with county mental health to take advantage of the expanded coverage available through the specialty plans to assist in achieving this goal of keeping members healthy and safe in their own homes.

Potential Improvement Targets for Performance Measures (Page 29)
The proposal identifies several potential improvement targets, including reduced hospital utilization, emergency room utilization, skilled nursing facility utilization, and long-term nursing facility placements. CMHDA notes that the state and health plans may consider additional leveraging opportunities with county mental health to take advantage of the expanded coverage available through the specialty plans to assist in achieving this identified improvement target.

Expected Impact of Demonstration on Medicare and Medicaid Costs (Page 30)
According to the proposal, the state assumes that the combined Medicare and Medi-Cal federal and state savings from this demonstration will be shared equally between the state and federal governments. This assumption appears to overlook the important county partners, such as county mental health, who are poised to play an essential role in achieving savings in both public programs.

State Infrastructure/Capacity (Page 31)
While the proposal provides a detailed summary of the various state departments integral to the demonstration, the role of county government is absent from this section. CMHDA asks that this section be amended to include a stronger acknowledgement of the essential role that county mental health will play in the implementation and ongoing success of this demonstration. California's local recovery and rehabilitation-focused mental health risk management and financing system is an integral part of our state's healthcare delivery system. The valuable role that counties play in managing risk and financing critical services to Medi-Cal beneficiaries should be clearly recognized in the demonstration proposal as an essential component of the state infrastructure.

SHARED ACCOUNTABILITY AND SAVINGS FRAMEWORK

CMHDA appreciates the opportunity to work with DCHS staff and consulting partners over the next few weeks to further develop and refine a strategic framework for coordination and alignment, including shared accountability and savings, between managed care organizations (MCOs) and county mental health authorities in the demonstration. CMHDA is particularly interested in replicating the model provided by Pennsylvania as part of its Serious Mental Illness Innovation Pilot Project, in which the state created a shared savings pool from which dollars are allocated based on performance on measures that the physical health MCO and county behavioral health organization can jointly influence. CMHDA particularly supports the tiered approach to the Pennsylvania model that allows for a phased-in implementation. CMHDA believes that a phased approach to achieving a greater level of shared accountability and savings between MCOs and county mental health makes the most sense for California in this demonstration. For example, in the first year, measures could strictly be process-oriented, as outlined in Pennsylvania's project, representing tangible, measurable activities that indicate collaboration and form the foundation necessary for integrating care. Such measures could

include such activities as the establishment of care plans and hospitalization notification. The measures would then evolve to outcome measures in subsequent years. Such outcomes might include reduced emergency and inpatient utilization. In addition to the examples provided by Pennsylvania's project, the DHCS and CMS might look to the federal Medicare and Medicaid Electronic Health Records Incentive Programs which provide a good model for a tiered approach to joint accountability in achievement of specified measures.

Priority Areas for Shared Accountability and Savings

1) Inpatient and Emergency Utilization

2) Pharmacy

Key Issues for Consideration

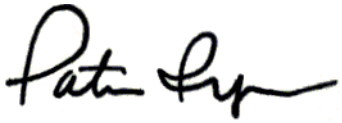
1) In order for many of the process targets to be met in the first year, a thorough analysis of current data and information technology systems should be done to ensure that the technology will support the desired information sharing between systems.

2) Similarly, regulatory and other legal barriers (or perceived barriers) to sharing essential information between systems should be identified and addressed as soon as possible.

3) If the state is to pursue a shared accountability and savings arrangement similar to the Pennsylvania model, further analysis should be done to identify opportunities for incentive payments in the first year before shared savings would be achieved as a result of the process changes implemented.

Thank you for your continued commitment to and leadership in California's community mental health system. We welcome the opportunity to discuss our comments and work collaboratively with the Department to further strengthen the proposal. If you have any additional questions, please do not hesitate to contact me directly at pryan@cmhda.org or Molly Brassil at mbrassil@cmhda.org.

Sincerely,



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