



California Council of Community Mental Health Agencies

Leaders in the partnership that developed and promoted Proposition 63

To: Board Members

From: Rusty Selix

Date: December 13, 2010

Re: Follow Up from Retreat

As I stated at the end of the retreat, it was only through the retreat that I became aware that the amount of work CCCMHA members will be requiring from CCCMHA staff during the coming few years is significantly greater than it has been in the past and greater than our current staff capacity. As promised, I'm getting back to the board with greater clarity about what we will have to do that is beyond what we would ordinarily do, how we intend to accomplish those additional activities, what they might cost, and how we can pay for it.

The Context

The impetus for the additional work is healthcare reform (and the state's Federal Section 1115 Waiver, which is really the first step of implementation). We will see significant changes (in the public and private sectors) in the way both mental health and drug and alcohol services are provided and reimbursed, as well as how both will be delivered and reimbursed in coordination with primary care. Foundational changes in publicly funded mental healthcare are already being proposed in many counties as they develop their plan for the Low Income Health Plan section of the waiver. This will require agencies used to being funded solely through county mental health departments the counties that fund them, and the associations representing all to significantly broaden the scope of what they do and how they interact with all players in the healthcare system as well as with other public entities be they political, financial, etc.

This additional work is incremental to the work necessary to address the current financial crisis which has created unprecedented large deficits in funding of all government programs, with no foreseeable end in sight to the dramatic imbalance between the cost of maintaining current levels of services and the available revenues.

Driving these changes are:

1. Expansion of MediCal in the Waiver – the Low Income Health Plan (LIHP): Counties will be making a determination about both expanding their MediCal population – MC (those up to 133% of the poverty level (FPL)), and about expanding or starting to provide federally matchable services to those between 133% and 200% of FPL (HCCI). Mental health services are required (at a very basic level) for the expansion population, but not for the HCCI; counties will have the option to carve out and/or enhance the scope of their mental health services for any LIHP, thus highlighting the importance of addressing their plans for serving the SMI population, including strategies for integrating behavioral health and primary care.
2. Movement of adults with disabilities enrolled in MediCal (but not dual eligibles also enrolled in Medicare during the first phase this year) into managed care plans which will be required to have a medical home and coordinate mental health and physical health and may include substance abuse coverage (presently not generally available under MediCal)

3. Pilot projects for integrated billing for dually-covered Medicare and MediCal recipients, of whom at least 1/3 are those with severe mental illnesses. These pilots will require that participating plans also have medical homes and to have all MediCal services provided under managed care.
4. Implications from the national healthcare reform law (now being called the ACA or Affordable Care Act) of a new type of entity called an Accountable Care Organization. The Act includes financial incentives for the formation of those organizations in Medicare and language suggesting that the benefits and savings for Medicare would be greater if the Accountable Care Organizations were also operating in other payment systems, meaning that they are likely to impact commercial health plans as well as Medicaid.
5. Potential for greater competition due to the reforms which expand health insurance in general as well as passage of the federal parity law, which will result in the enrollment into health insurance of populations that have very high levels of mental health and substance abuse problems. Other types of providers or payors may not have the expertise or infrastructure for treating serious mental illnesses that counties and CCCMHA members have, but they may have better business models and structures to partner with Accountable Care Organizations or provide integration of mental health, physical health, and alcohol and drug treatment, or be more efficient in the delivery of their services.

Recommended Additional Activities

- Staff need to gain a thorough understanding of the issues and create relationships with partners with whom we need to work in developing new healthcare delivery and payment structures that will evolve over the next several years.
- Staff will need to develop a strategy and support the activities necessary for making the case for the viability of the public mental health system. Making this case is not simply an advocacy issue at the state and county level but also requires the development and implementation of strategies to make this system as competitive, effective, and efficient as possible and to demonstrate and document that to different decision makers.
- Staff will need to support member agency efforts to implement strategies for increasing efficiencies/effectiveness – preparing themselves to participate in the new structures that evolve. This requires staff to become educated about available methods and to learn how to and provide support to our members in these endeavors. We will also need to play a key role in (or initiate) the discussions about design and implementation of methods to compare cost and effectiveness among agencies and counties and across the system.
- In addition, we will need to ensure that our members have the opportunity and contribute to any MHSA or other system or outcome evaluations that are conducted, demonstrating the extent to which they have been successful at increasing or maintaining their clients' recovery and preventing deterioration into more institutional levels of care.
- We need to partner with counties and state agencies to eliminate duplicative and unnecessary documentation and accountability requirements that add avoidable administrative costs to our system and divert valuable resources from service delivery.
- Because many of the evolving system design decisions are being made by counties, CCCMHA must support agencies in becoming effective county level advocates.
- Obtaining and presenting information from our member agencies on the effectiveness of their services in keeping people whom they have served from winding in these "systems of failure" that they likely will have been in before they received services.

Staffing Needs and Cost

Harriet and I agree that, in addition to her full time position, I will need to increase my time commitment, and we will need 1 additional FTE to accomplish the tasks we have set for ourselves.

As most of you are aware, I do not work full time for CCCMHA but also have been working for the Mental Health Association in California (also known as Mental Health America of California or MHAC) as well as with two non-mental health groups, the main one being the California Association of Councils of Government (CALCOG). (The other is the Association of Retired Teachers of LA). However, as of January 2011, I will no longer be working for CALCOG, which effectively frees up about 1/3 of my time. I currently devote about 50-60% of my time to CCCMHA (some of which overlaps with MHAC); therefore, I will be able to devote about 70- 80% of my time to CCCMHA , While I did eliminate a professional staff position, (Jerry Jeffe), a portion of what he did for CCCMHA will be picked up by other staff in the office, as well as requiring a very small portion of my time.

I am prepared to commit this additional amount of time to CCCMHA and would look to work with the board on a reasonable amount of compensation. I would not expect it to represent the full amount of the revenue lost from CALCOG, which would be about \$200,000 (the contract was \$284,000 but there are savings from the elimination of one position).

Both Harriet and I agree that our existing staff does not have the skills and qualities necessary to provide us (and you) the support that we need in taking on these activities, nor do they have the available time. So, in addition to the additional time that I will contribute, some funds should be made available for an additional staff position, either part-time or full-time, and possibly some consulting services. The proposed distribution of roles and responsibilities follows.

It will be necessary for Harriet and me to develop knowledge and relationships with other types of organizations that are players within healthcare and to learn about the different financial policy governance, political, and healthcare business models being developed and how these might play out. We will need to assess what we learn and work with these organizations, advocating for structures which support comprehensive inclusion of the public mental health system providers as the experts at effectively serving people with all levels and types of mental health needs.

I would at the same time work together with Harriet and other staff on improving the competitiveness of our member agencies and of the public mental health system, addressing the needs identified above. The training we receive through the National Council will enable us to educate our member agencies using a variety of tools and to support their efforts to engage in their own self-assessment and development activities. In addition, we would be working closely with the mental health directors and their Joint Powers Authority (CalMHSA) to impact the system-wide issues related to effectiveness, efficiency, and structure.

The skills missing in current staff capacity include research and support for me and Harriet as well as the technical and creative expertise to help us develop high quality educational materials and vehicles for training and supporting agencies and also to assist us in promoting our system (and your capabilities) to a variety of non-public sector organizations that are not familiar with what you do.

Contract-based professional consultation may be needed to assist us with the development of the variety of advocacy materials and strategies necessary to achieve some of our goals as well as with thinking through and developing advocacy strategies to address the possible new waivers, payment methodologies, and larger system re-structuring opportunities that could well present themselves.

Accomplishing all of this will also require more participation by members, which will result in more detailed plans, more frequent meetings of the board, and the formation of several special committees to guide CCCMHA staff in these undertakings. Additional staff time to support member participation will be necessary.

The cost of the services is expected to be between \$100,000 and \$200,000 annually and is expected to last for approximately five years. At that time we would expect a new system to have stabilized, and while there will continue to be transformational activities going on, it is quite likely that the level of services required will be able to be reduced. The easiest way to finance this increased need is through increasing dues; however, there may be some potential to rely on other revenues to achieve these financial goals. These include:

- Revenues from our Workers Compensation program that exceed current projected budget
- Expansion of membership, possibly including prevention and early intervention contractors which tend to be smaller non-profit agencies. These small agencies generally have small budgets, under \$1 million, and we would have to set up a different dues structure
- Revenue growth for member agencies that is captured through existing dues formulas (probably modest now but potentially very substantial starting in 2014)
- Financial support from counties or foundations or other government agencies (an area we have not sought out in the past but one which other associations have pursued)

The 2011 Work Plan addresses all of these issues plus other ongoing policy and/or budget issues that must be addressed this year. Please let me know if you have questions or wish to discuss this proposal in greater detail.