Mental Health Planning & Advisory Council

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February 29, 2012

David A. Cook, Commissioner
Department of Community Health
2 Peachtree Street, NW
40th Floor
Atlanta, GA 30303

Dear Commissioner:

Enclosed you will find the draft of the letter that the Chair of the GMHPAC has sent to Governor Deal in response to the proposed Medicaid Redesign Initiative and the Report by Navigant Consulting to the Department of Community Health.

Sincerely,

Danton Sealy, CPS
Administrative Assistant, GMHPAC

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The Honorable Nathan Deal
Governor, The State of Georgia
206 Washington Street
111 State Capitol
Atlanta, Georgia 30334

Dear Governor Deal:

The GAMHPAC is appreciative of the opportunity to provide comment on the state's Medicaid Redesign Initiative as outlined in the recent Navigant Report. In addition to providing comment, the GAMHPAC requests the Governor expand the process of the Medicaid Redesign to include mental health professionals, particularly, the Georgia Mental Health Planning and Advisory Council.

What is the Georgia Mental Health Planning and Advisory Council?

Mental Health Planning and Advisory Councils (PACs) exist in every state and U.S. territory because of the passage of federal laws 99-600 in 1986, continuing through Public Law 101-639 and Public Law 102-321 in 1992. These federal laws require States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds. These laws further require that stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership in the PAC.

The GAMHPAC is charged with serving as an advocate for adults with a serious mental illness, children with serious emotional disturbance, and other individuals with mental illnesses. The membership requirements of PACs are designed to ensure broad stakeholder representation and input into the planning, evaluation, and monitoring of mental health services. Many stakeholders are motivated by their own or a family member's involvement with the mental health system. The planning council provides a forum for a variety of advocacy interests to work together to effect change.

GAMHPAC Affirmations of Navigant Findings/Recommendations

The GAMHPAC applauds the effort to prepare Georgia for the predicted growth of Medicaid enrollees in a fashion that is fiscally sustainable, promotes appropriate service utilization and improves outcomes for Medicaid beneficiaries. The lagging economy and increased demand for publicly funded supports provides incentives for reducing system fragmentation, utilizing technology and focusing on better care and cost containment for special needs populations like the dually eligible or individuals with mental illness and addictive diseases. Toward these ends the Council affirms the report findings and/or recommendations related to:

- Electronic Health Records
- Primary Care Medical Homes
- Risk Based Capitation reimbursement
- Consumer Education and Options Counseling

GAMHPAC Concerns Related to the Navigant Report

The MHPAC does have several concerns related to the Navigant Report:

- The Report is payment oriented and does not adequately address the service system. For example, a major glaring omission is the non-inclusion of a recovery model for behavioral health;

- Changes to the delivery of Medicaid services have the potential to upset the negotiated settlement between the Department of Justice and the state of Georgia, which is to continue until 2015;

- The process is moving too fast and has not been inclusive of advocates who need to be at the table and participate in planning decisions related to capitation rates, implementation monitoring, and the development of performance outcomes;

- The perspective of Navigant offers a macro level outline which has insufficient implementation details and many feasibility problems. Without additional information it is impossible to fully understand or choose between the options offered;

- Build upon the strengths of Georgia's health infrastructure. There needs to be greater inclusion of those Georgia programs and services that are recognized as best practices and have a track record of positive performance outcomes. Examples include the DBHDD Peer Support Program; Supportive Housing; the Wellness Initiative; the Gateway Data Management System; and Georgia's statewide Aging and Disability Resource Center network;

- Recognize that one size does not fit all. It is not plausible that one system can meet the needs of multiple special populations. Individuals with disabilities have co-occurring diseases and multiple chronic conditions that are unique in nature. These groups cannot be lumped together. The needs of children with behavioral health disorders needs are very different from those of adults or older adults;

- Caution should be exercised in thinking that the approaches of many of the cutting edged states who have already moved ahead with managed care and are cited in the Report can be readily translated to Georgia. State specific values, state administrative structure, state agency organization, provider availability and politics vary widely.

GAMHPAC Thoughts and Suggestions

Consistent with the New Freedom Initiative, the Olmstead Decision, the DOJ Settlement, and CMS grant opportunities, it is imperative that resources continue to be shifted out of institutions and into home and community based settings. Rebalancing long term care is not only a national goal but a trend that has also been occurring in Georgia. It should be a guiding principle for all of the proposed options.

In any effort to design Behavioral Health options it is critical that a Recovery Model drive the system. It is also important the mental health professionals and consumers who have the expertise and understanding of a recovery system of care be involved. Intrinsic to the adoption of any Medicaid managed care capitation option is the fear that bottom line economics may adversely impact quality of care and access to services. Assurances should be required that cost shifting or under utilization of services do not occur.

Behavioral health managed care has met with limited success in Georgia as judged by the performance of existing behavioral health managed care organizations. Adopting managed care delivery programs may not meet expectations. It is important to note as stated in the Navigant report there is little documentation that managed care will lead to direct cost savings. Tennessee, one of the states cited as an early adopter of Medicaid managed care, had a disastrous experience implementing its TennCare program. The Medicaid Redesign Initiative process should not move too hastily in making decisions; nor move too quickly, especially in light of court challenges to the Affordable Care Act.

Moving to a consistent funding stream for all children and adolescents covered by Medicaid is a favorable option. However, given the current state of the Care Management Organizations and the fragmentation that having a CMO coverage causes families and providers, it is preferable that mental health care be "carved out" of a carve in (i.e. the carve in goes to a CMO, which in turn contracts out the mental health care) which further removes the child or adolescent from the paying source. Finally, by adding the current MRO population to the existing CMO population and putting the care under the new Department of Behavioral Health and Developmental Disabilities, this would provide the single point of accountability that parents and advocates have been requesting since 1999.

The capacity of the Department of Community Health to plan, develop and implement redesign approaches would be immeasurably improved by meaningful input of all stakeholders. The GAMHPAC as well as advocacy groups need to be actively engaged and sit as the table as the Medicaid Redesign Initiative process moves forward.

We the membership of the GAMHPAC, as mental health experts, would welcome the opportunity to be involved in any future planning.

Sincerely,

Marqi C. Baeszler, LCSW

Marquis Baeszler, LCSW
GAMHPAC, Chair

C: GAMHPAC listserv; Sherry Jenkins Tucker, Vice Chair, GAMHPAC; Pierluigi Mancini, Past Chair, GAMHPAC; Commissioner David Cook, DCH; Frank Shelp, Commissioner, DBHDD; Danton Sealy, Administrative Assistant, GAMHPAC