Restructuring the Behavioral Health System in California
Joint Oversight Hearing of the
Assembly & Senate Health Committees &
Assembly & Senate Budget Subcommittees on Health and Human Services
Tuesday, February 21, 2012
3:30 pm ~ Room 4202

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Honored Members of the Assembly and Senate:

I. Introduction: My name is Dr. David Pating. I am a Kaiser Addiction Psychiatrist who serves as co-chair for the California Coalition for Whole Health—a coalition of the most prominent mental health and alcohol & drug associations in our state including the:

County Mental Health Directors Association
County Alcohol and Drug Program Directors
California Psychiatric Association
California Society of Addiction Medicine
California Institute of Mental Health and
Alcohol and Drug Policy Institute.

Together these organizations have come together for the purpose of improving behavioral healthcare through the mandated processes of Health Care Reform in our State.

II. The Business Case for Mental Health: The urgency to improve Mental Health and Addiction treatment in California has two quality and cost drivers:

1) 50% Comorbidity: We must recognize that over 50 % of chronic medical diseases (including asthma, hypertension, diabetes and cardiovascular disease) are co-morbidly worsened by mental health and/or alcohol and drug abuse. The result is: persons with mental health and addictions live 25 year shorter lifespan on average. This is a major health disparity.

2) Unreimbursed Costs: The cost of untreated mental illness and addiction is enormous. For every 1000 Californian's who are uninsured or receiving Medi-Cal, 118 will be alcoholic, 57 drug addicted and 12 will abuse pain medications—totaling 152 persons, just as many have mental illnesses. Annually, for substance abuse, this cohort costs our state $1.29B dollars. If only 10% of these individuals were treated, the state would save $400million, with a 20% reduction in medical burden and 15-20% improvement in employment.

III. Impact of Health Care Reform: For these reasons, CCWH carries this statewide mantra: "There can be no Health without Behavioral Health." Care for individuals with mental and physical disorders needs to be integrated.

With regards to improving Behavioral Health under Health Care Reform, the following needs to occur to make this happen:

1) Outreach and Enrollment needs to be adequate so that patients with mental health and addiction patients do not remain uninsured. Evidence from Massachusetts, where ACA like provisions are state-mandated, suggests that MH/SA clients are disproportionately represented among the uninsured and under-enrolled compared to expectations. In California, this outreach needs to particularly include unserved cultural and linguistically diverse communities.

2) Essential Health Benefits, mandate by the Affordable Care Act for mental health and substance abuse, needs to be robust and <u>must</u> assure that co-pays or day/dollar limits are at parity with other disorders. This creates challenges for the state, since current Medi-cal mental health and drug benefits are substantially lower than optimal essential benefits. DHCS is working on resolving this through 1115b waiver projects.

3) Workforce development, licensing and training assistance is needed to assure that mental health and addiction treatment workforce is competent to provide reimbursable services. Currently, much of the behavioral healthcare system involves programs and services that are traditionally non-medical or not insurance-based. This means, a whole sub-segment, e.g. residential treatment homes, may become extinct unless they are recognized as essential providers.

4) Evaluation needs to be comprehensive and involve evaluation for the whole Mental Health and Alcohol and Drug treatment system, not a fragmented evaluation of multiple systems. We must assure that state evaluation of Accountable Care Organizations or evaluations of the effectiveness of Essential Benefits is coordinated with statewide Mental Health Services Commission Evaluations—to provide Total System Competency, which will reduce overall cost while saving lives.

<u>IV. Effective Restructuring:</u> Based on these needs to prepare for Health Care Reform, our Coalition recommends that the following advice regarding restructuring the Departments of Mental Health and Alcohol and Drug Programs: *Keep the family together!*

To facilitate the complex roll out of HCR, including its many levels of outreach, service and program integration, parity implementation, licensing and evaluation, we recommend that the State:

1) Retain DMH and ADP functions under one authority.
2) Keep related state functions intact.
3) Plan for transition with stakeholder participation.
4) Build towards a seamless continuum of public and private mental health and alcohol and drug programs. Not a system that is fundamentally split: Mental Health versus Physical Health or Insured versus Non-Insured.

Do not proceed with reorganization that will place the Offices of Prevention or Multicultural Services in one department, the office of Licensing in another, and Evaluation units disconnected from either. Behavioral Health is a primary care specialty needing Full Integration. To address the huge service and engagement gaps that historically resulted in major public health costs from untreated mental illness and substance abuse, further Fragmentation is Not Recommended.

I am happy to accept questions if needed.

Thank You.