



INFORMATIONAL HEARING

Assembly and Senate Health Committees

Improving the Medi-Cal Mental Health Delivery System

Tuesday, March 5, 2019 ♦ 1:30 p.m.

State Capitol ♦ Room 4202

BACKGROUND

INTRODUCTION

On February 26, 2019, the Assembly and Senate Health Committees held an informational hearing entitled “The Medi-Cal Mental Health Delivery System” where an overview of the current Medi-Cal mental health delivery system was provided by the Department of Health Care Services (DHCS) and the County Behavioral Health Directors Association (CBHDA). The hearing provided an overview of the prevalence of mental health conditions in California with a focus on the Medi-Cal population. DHCS and CBHDA then described what the Medi-Cal mental health benefit consists of, how mental health services are delivered, administered, and financed, and how quality is measured and ensured.

The focus of today’s hearing is to evaluate the delivery of the Medi-Cal mental health benefit and whether it is meeting the needs of consumers. The Committees will hear from DHCS and CBHDA on their vision for the Medi-Cal mental health delivery system over the next five to 15 years, with a focus on the following questions:

- What works well in the delivery of the Medi-Cal mental health benefit?
- What needs improvement in the delivery of the Medi-Cal mental health benefit, with a focus on how to improve the delivery of services?
- How to better integrate the delivery of physical and mental health benefits in the overall Medi-Cal healthcare delivery system?
- What should the Medi-Cal mental health delivery system look like in five, 10, or 15 years?

The Patient Protection and Affordable Care Act (ACA) and the state legislation expanding eligibility and the scope of benefits for Medi-Cal have resulted in an expansion of the number of individuals receiving coverage through the program and an expanded mental health benefit through Medi-Cal managed care (MCMC) plans that are in addition to the benefits available through county specialty mental health plans (MHPs). The issues described below are some of the areas raised by multiple different stakeholders regarding the Medi-Cal mental health delivery system.

DELIVERY SYSTEM

The Specialty Mental Health Plan “Carve Out”

Medi-Cal mental health benefits are delivered through two separate systems. MHPs provide a broad range of specialty mental health services (SMHS) to individuals with more severe mental illnesses, while MCMC plans provide non-SMHS. The delivery of SMHS through MHPs is commonly referred to as a “carve out,” as is the coverage of anti-psychotic prescription medication through fee-for-service (FFS) Medi-Cal (described further below). A “carve out” is when services covered by the Medi-Cal program are delivered outside of a MCMC plan. Services for physical and behavioral health (which includes mental health and substance use disorders (SUDs)) historically have been financed and delivered under separate systems (the Drug Medi-Cal benefit is also delivered outside of MCMC plans).

MHPs are responsible for providing SMHS to Medi-Cal beneficiaries who meet SMHS medical necessity criteria. SMHS are delivered through 56 county mental health plans (Placer and Sierra Counties and Yuba and Sutter Counties operate two separate dual-county combined MHPs). Medi-Cal beneficiaries that meet medical necessity criteria for SMHS are entitled to receive medically necessary SMHS from their county MHP, regardless of whether or not they are enrolled in a MCMC plan.¹

MCMC plans are responsible for providing non-SMHS, and are responsible for prescription drug coverage for mental health conditions, except for approximately 40 anti-psychotic medications. These medications are contractually carved out of nearly all MCMC plan contracts and instead reimbursed through Medi-Cal FFS.² Over 24 contracting MCMC plans and their subcontracting providers and plans deliver services. MCMC plans cover 82% or 10.2 million of Medi-Cal’s 13.2 million beneficiaries projected to enroll in the program each month in fiscal year 2019-20. Medi-Cal beneficiaries who are not enrolled in MCMC plans receive non-SMHS through Medi-Cal FFS.

MCMC plans deliver their scope of mental health coverage in different ways. For example, some MCMC plans use a specialized healthcare service plan to administer their mental health benefit (major specialized mental health plans include Beacon and MHN), while other plans manage the benefit directly, and one plan (Health Plan of San Mateo, whose CEO is testifying today) contracts with its county behavioral health department. The chart below shows the scope of mental health benefits provided by MCMC plans and MHPs:

SERVICES	MCMC Plan	MHP - Outpatient	MHP– Inpatient
	<p>Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:</p> <ul style="list-style-type: none"> • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications,* supplies, and supplements • Psychiatric consultation 	<ul style="list-style-type: none"> • Mental Health Services <ul style="list-style-type: none"> ○ Assessment ○ Plan development ○ Therapy ○ Rehabilitation ○ Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential Treatment • Adult Residential Treatment • Crisis Intervention • Crisis Stabilization • Targeted Case Management • Intensive Care Coordination • Intensive Home-Based Services • Therapeutic Foster Care • Therapeutic Behavioral Services 	<ul style="list-style-type: none"> • Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service (FFS) hospital

Source: DHCS All Plan Letter (APL) 17-018.

*Approximately 40 psychiatric drugs are contractually excluded from coverage from MCMC plans and reimbursed through FFS Medi-Cal. The list of carved out drugs is in APL 17-08.

The Medi-Cal carve out is not unique to California as, historically, Medicaid services for physical health and behavioral health have often been financed and delivered under separate systems. Medicaid enrollees with behavioral health conditions often find themselves interacting with multiple public and private agencies and receiving care from myriad providers funded from different sources. In addition, a separate plan administrative structure is not unique to Medi-Cal, as carve outs exist in the private market, except in the private market, the health plan is ultimately responsible for the entire benefit. Critics of carve out arrangements make the following criticisms:

- Fragmented care as patients are forced to navigate two different administrative structures and potentially two different delivery systems to access care;
- A financial incentive for payers to cost-shift patients from one system to the other;
- Patients crossing delivery systems if their mental health condition improves or worsens;
- A lack of incentive for MCMC plans to manage lower levels of mental illness because the costs of higher levels are borne by a separate payor;
- Diffused responsibility for the entire patient’s health;
- Problems with sharing of medical information across different electronic health records (EHRs) and data systems; and,
- An inability for plans to coordinate the entire patient’s health, particularly when a beneficiary’s physical health condition is made worse by severe mental illness.

“Carve Out” of Anti-Psychotic Medications

Existing law authorizes DHCS to require MCMC plans to cover mental health pharmacy benefits to the extent provided in the contracts between DHCS and the MCMC plans.³ MCMC plans are responsible for providing non-SMHS, and prescription drug coverage for mental health conditions, except for approximately 40 anti-psychotic medications. With a few exceptions, these medications are contractually carved out of nearly all MCMC plan contracts and instead reimbursed through Medi-Cal FFS.⁴ Total spending on these prescription drugs was \$1.1 billion (\$425 General Fund) in fiscal year (FY) 2017-18. DHCS provides information on carved out drugs dispensed to MCMC plans that are paid for by Medi-Cal FFS on a monthly basis. However, there have been several criticisms of the carve out of anti-psychotic drugs. MCMC plans also indicate that the information on carved out anti-psychotics prescriptions provide is by DHCS only once a month is not timely for purposes of managing a patient’s condition, that the monthly data is sometimes furnished late, and one plan indicated it had to manually merge the data and search the DHCS data file and their own databases to match the data. The carve out of prescription drugs in Medi-Cal is proposed for expansion by Governor Newsom.⁵ Starting no sooner than January 2021, DHCS is proposing to carve out all pharmacy benefits from MCMC plans and return them to a fee-for-service benefit statewide.⁶

County-Based Mental Health Plan Delivery System

SMHS are delivered through 56 county MHPs (two of which are dual-county combined MHPs). As managed care plans, MHPs and MCMC plans share common core functions, including establishing networks, operating toll-free lines for patients, paying claims, utilization review, and providing information to beneficiaries. In MCMC, the smaller rural regional counties are served by a single plan or two plans that serve multiple counties. For example, the rural expansion of Medi-Cal managed care has two plans serving 18 counties, and Partnership Health Plan serves 14 Northern counties. The MCMC regional approach provides for economies of scale for rural and frontier areas with smaller population size and density, and geographic features that make travel and communication difficult. Existing law authorizes counties to opt out of being an MHP, and to be served by another plan, and at one point Solano County had Partnership Health Plan administer the SMHS benefit, and Kaiser in Marin and Sacramento have SMHS carved in for Kaiser enrollees. Regional MHPs, or having the MCMC administer the SMHS benefit (and contract with the county as a provider), could improve administrative efficiency and reduce duplication, leverage existing MCMC plan or MHP function, and free up revenue for beneficiary care.

MHPs Part of Broader County Mental Health Delivery System

Counties are responsible for mental health-related duties in addition to the MHPs they administer, and the fund sources used to fund the SMHS benefit in Medi-Cal (1991 and 2011 Realignment and MHSA funds) also fund other services and duties. For example, under California’s realigned community mental health system⁷, counties provide community mental health services, to the extent resources are available. Under Proposition 63, counties are required to use Mental Health Service Act funds for prevention and early intervention services⁸ for populations and services Medi-Cal may not cover. Counties are also required to designate mental health treatment facilities for involuntary commitments⁹

(e.g., 72 hour “holds” per Section 5150 of the Welfare and Institution Code), and to present allegations that a person is a danger to self or others or is gravely disabled as a result of a mental disorder in any judicial proceeding under the Lanterman-Petris-Short Act.¹⁰

MENTAL HEALTH SERVICE UTILIZATION

Utilization of the Expanded Mental Health Benefit in MCMC

Existing law requires MCMC plans to provide mental health benefits covered in the California’s Medicaid State Plan, excluding those benefits provided by MHPs under the Section 1915(b) waiver.¹¹

Prior to 2014, Medi-Cal beneficiaries with mental health conditions that did not meet the criteria for SMHS only had access to limited outpatient mental health services delivered by MCMC plan primary care providers, or a limited network of FFS mental health providers. SB X1 1 (Hernandez and Steinberg) was one of two bills implementing the ACA Medicaid changes and expanded the benefit package for mental health and SUD. AB X1 1 (John A. Pérez) implemented the Medicaid expansion established under the ACA, and SB X1 1 included the expanded benefit package for mental health and SUD services. As a result of SB X1 1, MCMC plans became responsible for delivering an expanded set of mental health services, including individual and group psychotherapy, psychological testing, psychiatric consultation, and medication management.¹²

Under the SB X1 1 benefit expansion, MCMC plans must provide specified services to adults diagnosed with a mental health disorder (as defined by the current Diagnostic and Statistical Manual of Mental Disorders or DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning.¹³ This adult benefit is commonly referred to as the “mild to moderate” benefit. MCMC plans must also provide medically necessary non-SMHS to children under the age of 21. MCMC plans must also deliver the outpatient mental health services specified in their MCMC contracts, whether they are provided by primary care providers (PCPs) within their scope of practice or through the plan’s provider network. MCMC plans are also responsible for the arrangement and payment of all medically necessary Medi-Cal-covered physical health care services, not otherwise excluded by contract, for plan beneficiaries who require SMHS.

While the utilization of mental health services in MCMC has increased over the last three years, the number of Medi-Cal beneficiaries receiving services falls below estimated prevalence rates for mental illness for adults in the population. This is commonly referred to as the penetration rate, which is a parameter used to measure access to SMHS for the Medi-Cal population.¹⁴ The penetration rate is calculated by dividing the number of beneficiaries served each year by the number of enrollees. DHCS indicates that in FY 2014-15 (the first year of the mild to moderate expansion), 32,865 adult beneficiaries received psychosocial services through MCMC plans. In 2016-17, the number of adult beneficiaries receiving these services increased to 187,152. To put these numbers in context, an estimated 4.3% of adults have a serious mental illness (SMI), and 15.6% of adults have any mental illness, so a rough estimate of the MCMC plan responsibility for mental health services would be 11.3% of adult Medi-Cal beneficiaries who have a mental illness that is not a SMI.

In FY 2014-15, 12,956 children/youth received mental health services from a MCMC plan, and that number increased to 73,906 children/youth in FY 2016-17. An estimated 7.4% of children have a serious emotional disturbance (SED),¹⁵ but the prevalence estimates do not distinguish between a SMI and any mental illness for children in the way the estimates do for adults.

The numbers of beneficiaries receiving services from MCMC are far fewer than the number of adults and children receiving SMHS from MHPs.¹⁶ For example, in FY 2016-17, while 73,906 children received services from a MCMC plan, 259,870 children received services from a MHP. For adults in FY 2016-17, 187,752 adults received services from a MCMC plan, while 341,362 adults received services from a MHP. The percentage of people receiving services varies widely by MCMC plan, from a low of 5.75 visits per 1,000 member months to a high of 50.63 visits per 1,000 member months, as shown in the chart below:

Mild to Moderate Mental Health Visits per 1,000 Member Months			
Plan Parent	2016	2017	% Change
Alameda Alliance for Health	19.30	25.60	6.30
Anthem Blue Cross	13.36	16.33	2.97
California Health and Wellness Plan	21.02	25.25	4.23
CalOptima	17.27	20.77	3.50
CalViva Health	7.44	11.98	4.54
Care 1st Health Plan	19.09	27.07	7.98
CenCal Health	21.69	32.98	11.30
Central California Alliance for Health	17.58	22.94	5.36
Community Health Group	18.24	24.24	5.99
Contra Costa Health Plan	17.69	19.08	1.38
Gold Coast Health Plan	19.11	24.21	5.10
Health Net Community Solutions, Inc.	8.20	9.09	0.89
Health Plan of San Joaquin	15.10	18.36	3.27
Health Plan of San Mateo	27.79	28.40	0.61
Inland Empire Health Plan	6.61	8.54	1.93
Kaiser Permanente	23.15	21.54	-1.61
Kern Health Systems	6.81	8.67	1.87
L.A. Care Health Plan	12.22	14.75	2.53
Molina Healthcare of California	15.16	18.54	3.38
Partnership Health Plan of California	40.40	50.63	10.24
San Francisco Health Plan	10.81	14.76	3.96
Santa Clara Family Health Plan	4.35	5.75	1.40
United	-	30.78	-

NOTE: Mild to Moderate Mental Health Visits capture the number of visits per month related to selected Psychotherapy Services and Diagnostic Evaluations. The selected procedure codes aim to capture mild to moderate mental health visits. A visit consists of a unique combination between provider, member, and date of service.

Utilization of Mental Health Benefit in MHP Plans

DHCS Medi-Cal Statewide Aggregate Specialty Mental Health Services Performance Dashboard (Dashboard) provides data on how many children and adults are receiving SMHS in a year, the year-over-year change from FYs 2013-14 to 2016-17, by race, age and gender. In addition, the Dashboard has the number of children and adults receiving at least one SMHS service, and children and adults receiving five or more services. The five or more visit benchmark provides a measure of the number of children and adults receiving on-going SMHS. The chart below shows the number of children receiving one or more services or five or more services has grown slightly, while the penetration rate has declined slightly each year. For adults, the number of individuals receiving services or five or more services increased nearly 15% in FY 2015-16 as a result of the ACA expansion, but the penetration rates have declined each year.

Fiscal Year	Children with 1 or More SMHS Visits	Percentage Change	Penetration Rate	Children with 5 or More SMHS Visits	Percentage Change	Penetration Rate
2013-14	257,643		4.4	191,647		3.3
2014-15	259,301	0.6%	4.3	191,249	-0.2%	3.2
2015-16	258,759	-0.2%	4.1	190,741	-0.3%	3
2016-17	259,870	0.4%	4.1	192,686	1.0%	3.1
Fiscal Year	Adults with 1 or More SMHS Visits	Percentage Change	Penetration Rate	Adults with 5 or More SMHS Visits	Percentage Change	Penetration Rate
2013-14	297,369		5.2	187,682		3.3
2014-15	341,797	14.9%	4.8	212,021	13.0%	2.9
2015-16	346,669	1.4%	4.4	214,035	0.9%	2.7
2016-17	341,362	-1.5%	4.2	209,648	-2.0%	2.6

Suicide Rates

While California's overall statewide suicide rate of 10.4% is slightly below the national average, the suicide rate in the Northern and Sierra region (21.1%) is nearly triple that of Los Angeles County, and the rate is significantly higher for males, particularly Native American and white males. While it is not clear what the source of insurance coverage is (if any) of people who die by suicide, the map below shows the regional variation in suicide rates in California:

California Counties Included in Regions



REGION	SUICIDE RATE	COUNTIES
Central Coast	11.8%	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
Greater Bay Area	9.8%	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
Inland Empire	10.4%	Riverside, San Bernardino
Los Angeles County	7.7%	Los Angeles
Northern and Sierra	21.1%	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
Orange County	10.0%	Orange
Sacramento Area	12.9%	El Dorado, Placer, Sacramento, Yolo
San Diego Area	12.6%	Imperial, San Diego
San Joaquin Valley	10.6%	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare

Disparities

Health and health care disparities refer to the differences in health and health care between populations.¹⁷ Disparities in “health” and “health care” are related, but not synonymous, concepts. A “health disparity” refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. A “health care disparity” typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care. Health and health care disparities often refer to differences that cannot be explained by variations in health needs, patient preferences, or treatment recommendations. Health inequality and inequity are also used to refer to disparities. There are multiple examples of health disparities and health care disparities in the broader mental health delivery system (including suicide rates referenced above) and the Medi-Cal mental health delivery system. For example, the lower penetration rates for services for Asian and Latino populations for SMHS has been cited over many years,¹⁸ there are differences by race in receipt of services following an inpatient hospital stay for mental health, and rates of depression vary by age and medical condition.

QUALITY MEASUREMENT

Measuring quality in MCMC and MHP plans

Federal Medicaid regulations require that each managed care plan establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes specified elements. Federal regulations also require states to review, at

least annually, the impact and effectiveness of the quality assessment and performance improvement program. States must also have a qualified External Quality Review Organization (EQRO) to perform an annual external quality review for each contracting plan. States are required to ensure that the external quality review results in an annual detailed technical report that summarizes findings on access and quality of care. DHCS selects measures of MCMC plan performance through what is known as the External Accountability Set (EAS).

For MCMC plans, the EAS performance measure consists of a set of Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance and the Consumer Assessment of Healthcare Providers and Systems survey. In addition to the HEDIS measures, the EAS performance measures may also include other standardized performance measures and/or DHCS-developed performance measures selected by DHCS for evaluation of health plan performance. The EAS performance measures are selected by DHCS for annual reporting by plans. In 2017, plans were required to report on 17 categories of health care service measures (for example, childhood immunizations, breast and cervical cancer screening, comprehensive diabetes care, controlling high blood pressure, depression screening).¹⁹ The one specific mental health measure for MCMC is depression screening and follow-up for adolescents and adults, but this measure was not included in DHCS' most recently published report. In addition, the percentage of women who delivered a live birth who completed a postpartum visit on or between 21 days and 56 days after delivery is a HEDIS measure, which is in part to determine the physical and mental health care needs of the mother following birth.

The current statewide EQRO report for MHPs for FY 2016-17 reports on a number of performance measures to access timeliness and quality of SMHS, plans to improve access to services, and to identify barriers to SMHS among MHPs. The EQRO report compares MHPs annually based on population size of the county, broken down into four categories and five regions.^A The EQRO reports on seven core measures, one of which is MHP outpatient follow-up rates and a second is the 30-day re-hospitalization rate. This measure is the percentage of beneficiaries who are seen outpatient follow-up after a psychiatric inpatient discharge, at seven and 30 days post-discharge. This measure has been reported on since 2012, and the most recent data available (2015) indicate 69.2% of beneficiaries received an outpatient follow-up visit within 30 days and 30.8% received such a visit within seven days. The psychiatric inpatient hospital 30-day rehospitalization rate was 14% in FY 2016-17. The other core EQRO MHP measures are as follows:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of Therapeutic Behavioral Services beneficiaries served compared to a specified benchmark; and,
- Total psychiatric inpatient hospital episodes, costs, and average length of stay.

^A The sizes are Large: >750,000; Medium: 200,000-749,999; Small: 55,000-199,999; Small and Rural: <54,999). The regions are Bay Area, Central, Los Angeles, Superior (Northern) and Southern.

The FY 2016-17 EQRO report indicates penetration rates have declined steadily across regions and MHP sizes from 2012 to 2015, decreasing from 5.9% in 2012 to 4.8% in 2015. The small-rural MHPs have consistently had the highest penetration rates across that timeframe, from 8.5% in 2012 to 7.8% in 2015. The lowest penetrations rates were in the Central region, which went from 4.8% to 4.1%. However, even though the small-rural MHPs have had the highest penetration rates, the urban areas have had a greater influx of new Medi-Cal beneficiaries than the small-rural MHPs, which directly affected the penetration rates of large and very large MHPs.

Compliance with State Network Adequacy Standards

In addition to the EQRO measures for access and quality of MHP delivery of mental health services, DHCS also measures network adequacy of MHPs. Under federal Medicaid managed care regulations, MHPs are considered Prepaid Inpatient Health Plans (PIHPs). PIHPs provide services to Medi-Cal enrollees under contract with the state, and meet specified criteria but do not have a comprehensive risk contract.²⁰ Under recent changes to these federal regulations²¹ and state law²² implementing these federal requirements, county MHPs have to meet new network access and appointment availability requirements in the same manner the health plans licensed under the Knox-Keene Act (the body of law regulating health plans by the Department of Managed Health Care).²³ According to DHCS, in the first year of implementation of these new standards, only two MHPs (Alpine and Mariposa) met network adequacy standards, while all other counties received a “conditional pass.”²⁴ The overwhelming reason for the “conditional pass” was a result of the inability to meet adult or child psychiatry ratios. In 2018-19, only nine MHPs passed this standard for children, and fourteen MHPs passed this standard for adults.

PROVIDER ISSUES

Provider Payment Differentials between MCMC Plans and MHP Networks

Several stakeholders report significant provider payment differentials between the county-based MHPs and the MCMC plans providing non-SMHS services. It is unclear if there is a data source or publicly available documentation for this observation or if it is a statewide issue, given that contract rates between MCMC plans and providers are generally proprietary, but it was cited in several stakeholder calls. While provider rates are a component of access, and higher rates from MHPs would likely increase the likelihood of providers treating the most severely mentally ill, a provider payment rate differential between public programs serving beneficiaries makes contracting with MCMC plans less attractive for mental health providers and makes it more difficult for MCMC plans and their subcontracting mental health plans to maintain a viable network.

Provider Documentation Requirements for Claiming SMHS

One of the persistent complaints made by mental health providers providing services through MHPs are the documentation requirements. Because MHPs are reimbursed on a cost-based certified public expenditure methodology and reimburse contracting providers on a FFS basis, documenting medical necessity (for example, the patient’s diagnosis, treatment plan, and progress notes) is required to draw down federal Medicaid funds. It is unclear if this is an area that has been published or studied in a

systematic way, or if the requirements can be reduced, either by a reduction in documentation requirements or by switching to an alternative payment methodology (such as capitation or case rates). Mental health providers cite that documentation take 30-50% of their work time. Stakeholders also cited the documentation requirements as a source of mental health provider burnout and low retention rates, and departing providers cite the paperwork burden in exit interviews with employers.

“Boarding” in Hospitals

One of the issues cited by hospital stakeholders and emergency room physicians are patients with a SMI being kept for multiple days, weeks, and in some cases months in hospitals. The boarding can occur in hospital emergency departments, when patients are waiting for a psychiatric bed or a community placement. While boarding is not reported to or tracked by California's Office of Statewide Health Planning and Development (OSHPD), the percentage of psychiatric beds that are occupied, as shown in the OSHPD data below, has increased since 2012, as has the Medi-Cal utilization of psychiatric beds:

Year	Percentage of Psych Beds Utilized	Percentage of Medi-Cal Psych Beds Utilized
2012	64.88%	14.78%
2013	69.93%	26.26%
2014	67.40%	23.37%
2015	63.71%	24.66%
2016	85.07%	20.58%
2017	84.54%	24.49%

Source: OSHPD Data

Integration of Mental Health, SUD and Primary Care Services

The integration of mental health care and SUD services into primary care settings is often cited as a way to help ensure that individuals with SMI or SED are identified earlier and connected with appropriate treatment sooner. In addition, integration is cited as critical for improving access to treatment for comorbid physical health conditions and SUDs that are common among individuals with SMI or SED. Integration can occur at the administrative level (e.g., one common health plan), at the funding level (a common funding stream) and at the clinical level, such as through co-located services, common electronic health records (EHRs), coordinated care models, and team-based care involving multiple providers.

Disincentives for FQHCs Participation in MCMC and MHP Networks

The core primary care network of MCMC plans are Federally Qualified Health Centers (FQHCs). The number of FQHCs has grown significantly over the last 15 years, in part because the cost-based Prospective Payment System (PPS) rate system with annual Medicare Economic Index adjustments is a significantly better payer as compared to FFS Medi-Cal primary care payment rates. There are approximately 1,040 FQHCs, and the number of FQHCs has grown significantly. In 2006, there were 476 FQHC service sites, which grew to 1,007 in 2015.

However, FQHCs that seek to participate in county MHPs’ networks and Drug Medi-Cal (either through DHCS or through Drug Medi-Cal Organized Delivery Systems (DMC-ODS) do so at lower DHCS FFS rates, or rates negotiated with each county for DMC-ODS (which are likely to be lower than their PPS rates). In addition, FQHCs seeking to bill for these services have to file a change of scope of service request with DHCS, which could result in a lower PPS rate for all the services the FQHC provides. Finally, FQHCs providing SMHS and SUD services have to separate the costs for MHP and DMC services from the costs incurred for the PPS rates. This means separate accounting for building space, documentation, record-keeping, and clinical and administrative staffing costs in order to comply with cost allocation requirements. Co-locating mental health and SUD providers with primary care would enhance patient access to services, encourage common EHRs, and reduce the stigma of receiving services in a building set aside for SUD or mental health services. One area worth exploring is whether there are additional non-Medicaid sources of money that could encourage co-location.

EHRs

Sharing clinical and other patient information can help care managers and health care providers from different disciplines communicate and coordinate care.²⁵ EHRs can give authorized individuals immediate access to patient data and support the transfer of knowledge and informed decision making among providers. For example, when a beneficiary with SMI or SED is being discharged from a hospital, the ability to share data between hospitals and community-based mental health providers would facilitate follow-up care. The ability to share data and fully integrate care delivery is dependent on provider ability to adopt EHRs. However, behavioral health providers often have limited working capital to invest in technology, and some behavioral health facilities and providers are ineligible to receive federal incentive payments to adopt EHRs. Furthermore, only certain providers working in behavioral health—physicians, nurse practitioners and certain physician assistants—are eligible for the Medicaid incentive payments. Of behavioral health providers who are eligible, few have been able to meet meaningful use standards.

The MHP EQRO report cites a lack of EHR interoperability as one reason for disparities in some MHP performance measures. According to the EQRO, only 91% of all MHPs have sufficient EHR software, which significantly lags behind physical health care systems. This is a serious barrier to care coordination between providers. Additionally, some of the smaller and more rural county MHPs have legacy EHRs, which do not allow for the updated data collection and sharing mechanisms that would improve interoperability as well as patient outcomes.

BENEFITS

Federal Medicaid Funding Availability for Medi-Cal Beneficiaries in IMDs

In November 2018, the Centers for Medicare and Medicaid Services (CMS) announced via a State Medicaid Director letter²⁶ opportunities for demonstration projects (waivers) under Section 1115 of the Social Security Act to improve care for adults with SMI and children with serious emotional disturbance (SED), referred to as the “SMI/SED demonstration opportunity”. Under Section 1115(a) of

the Act, the Secretary of the federal Department of Health and Human Services or Centers for Medicare & Medicaid Services (CMS), operating under the Secretary's delegated authority, can authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid Act. This SMI/SED demonstration opportunity will allow states, upon CMS approval, to receive FFP for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as Institutions of Mental Disease (IMDs) if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services.

Under existing federal law, an IMD is defined as any “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”²⁷ Services provided to beneficiaries in residential settings may be subject to the payment exclusion for IMDs,²⁸ which prohibits federal Medicaid payments for an individual who is a patient age 21-64 in an IMD. Under current federal Medicaid managed care regulations, states can receive FFP for monthly capitation payments paid to Medicaid managed care plans for coverage of Medicaid beneficiaries residing in IMDs when the enrollees that are inpatients in a hospital providing psychiatric or SUD inpatient care or in a sub-acute psychiatric or SUD crisis residential setting when the stay is for no more than 15 days during the period of the monthly capitation payment and certain other conditions are met.²⁹ Because inpatient SMHS are the responsibility of MHPs, and MHPs are not paid under capitation, California cannot use this option under its existing payment arrangements.

Under the CMS-proposed demonstration, FFP would be available for services for beneficiaries who are short-term residents in IMDs primarily to receive mental health treatment. This option could be used by county MHPs. While residing in those facilities primarily to receive mental health treatment, CMS indicates Medicaid beneficiaries should also be screened for co-occurring SUDs as well as physical health conditions. States with approved demonstrations could also receive FFP for Medicaid coverable services provided to otherwise eligible beneficiaries to treat any co-occurring SUD and physical health conditions while those beneficiaries are residing short term in IMDs primarily to receive mental health treatment.

CMS indicates it will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government. Further, CMS will consider a state's commitment to on-going maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project in order to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. CMS also strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, particularly crisis stabilization services.

FINANCING AND FUNDING

SMHS Financing from 2011 Realignment in State Constitution

MHPs are paid on an FFS basis by certifying their costs (known as CPEs). The primary source of funds used by counties to draw down federal Medicaid funds are 1991 and 2011 Realignment funds. DHCS utilizes CPEs made by counties for the state share of funding each type of payment made to an MHP.³⁰ MHPs pay for the total cost of services using non-federal funding sources and then submit a claim to the state for FFP reimbursement using the CPE process.

California's mental health system underwent two major changes to its fiscal and governance structure in 1991 and again in 2011 under what is commonly referred to as "realignment." Under the 2011 realignment,³¹ counties bear the full financial responsibility for the non-federal share of Medi-Cal SMHS, including the Early and Periodic Screening, Diagnostic and Treatment Program and mental health managed care, with the exception of newer mandated costs. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment applies to local agencies only to the extent that the state provides annual funding for the cost increase.³² Proposition 30 placed the 2011 realignment financing provisions and requirement that new state requirements imposed on local agencies in the State Constitution, thus requiring any changes to this dedicated revenue stream to go to the voters.

Lack of Information on County Expenditures by Specific Fund Source

Medi-Cal SMHS are provided by MHPs and funded through a combination of four of the major public community mental health funding sources: (1) 1991 Realignment and 2011 Realignment; (2) Mental Health Services Act (Proposition 63); (3) state General Fund; and, (4) federal Medicaid matching funds. The realignment and MHSA funds also support county-based mental health services outside of Medi-Cal, and as the Legislative Analyst's Office noted, counties generally have exercised wide discretion in allocating different portions of the funds for the various mental and other behavioral health services for which they are responsible. For example, counties receive 2011 Realignment funding for behavioral health services through a behavioral health subaccount. Counties use this subaccount to support both Medi-Cal mental health and SUD services, but have discretion over how much of the subaccount funds goes to each type of service. While there has been significant legislative attention to the fund balances involving MHSA funds, it is unclear how 1991 and 2011 Realignment funds are spent using existing state budget documents.

FEDERAL CONCERNS

CMS 1915b Waiver Approval

In approving the current Medi-Cal SMHS Waiver (effective July 1, 2015 through June 30, 2020), the federal CMS expressed an overarching concern with the state's program integrity monitoring and

compliance.³³ Because of this, CMS required adherence to Special Terms and Conditions (STCs) as a condition of approval, including the seven requirements below:

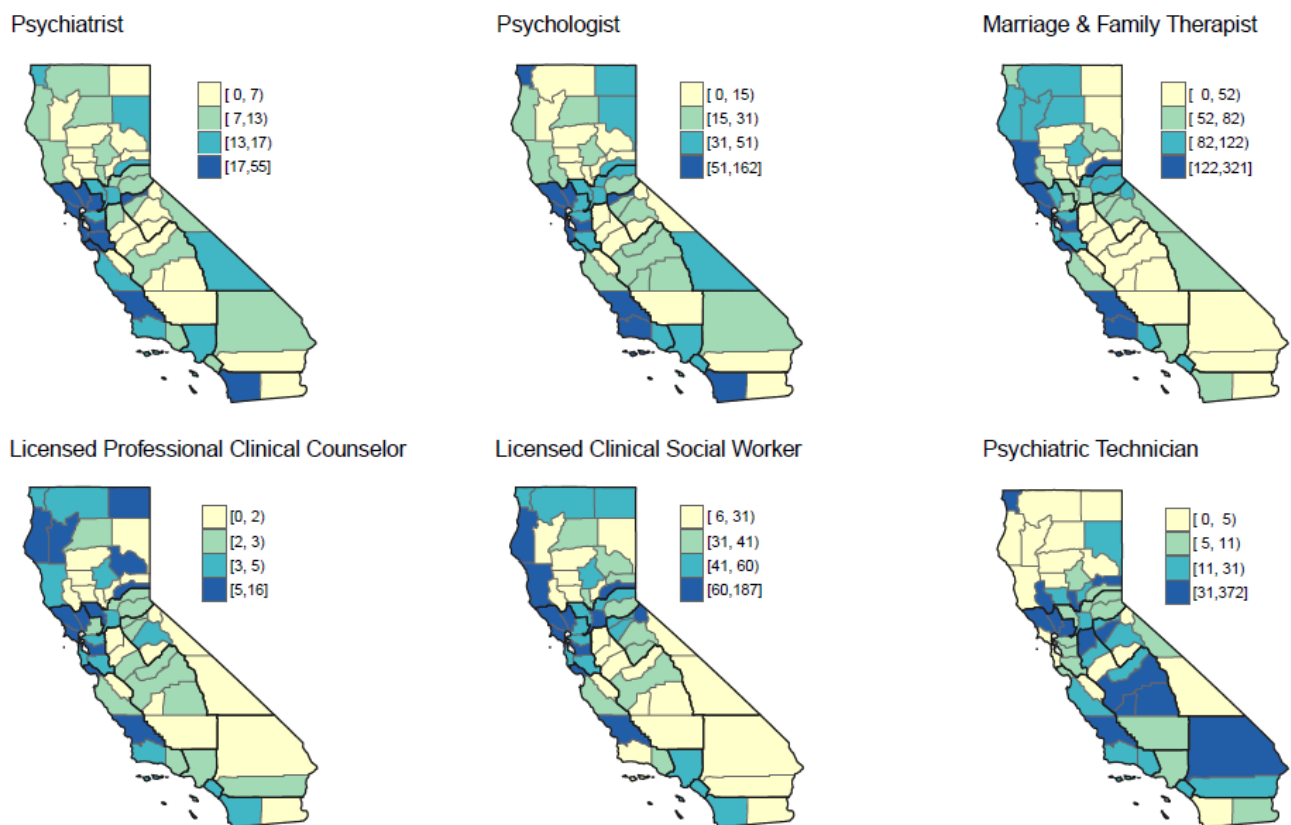
- 1) On an annual basis, the state must make readily available to beneficiaries, providers, and other interested stakeholders, a MHP dashboard that is based on performance data of each MHP included in the annual external quality review technical report and/or other appropriate resources. Each MHP dashboard must be posted on the state's and the MHP's website. Each dashboard will present an easily understandable summary of quality, access, timeliness, and translation/interpretation capabilities regarding the performance of each participating MHP;
- 2) The state must require each MHP to commit to having a system in place for tracking and measuring timeliness of care, including wait times to assessments and wait time to providers. The state needs to establish a baseline of each and all counties that includes the number of days and an average range of time it takes to access services in their county;
- 3) The state will provide the EQRO's quarterly and annual reports regarding the required Performance Improvement Plans to CMS, and discuss these findings during monthly monitoring calls;
- 4) The state will publish on its Website the county MHP's Plan of Correction as a result of the state compliance reviews;
- 5) The state will provide to CMS the annual grievance and appeals reports by November 1st of each year;
- 6) All information required to be published pursuant to these STCs will be placed in a standardized and easily accessible location on the state's website; and,
- 7) The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or Children's Health Insurance Program programs that occur during this waiver approval period, unless the provision being changed is expressly waived or identified as not applicable.

Office of Inspector General Report

An August 2018 federal Office of Inspector General (OIG) report found that California did not always comply with federal and state requirements when claiming federal reimbursement for SMHS expenditures.³⁴ On the basis of 500 sample service lines, OIG estimated that California claimed at least \$180.6 million in unallowable federal reimbursement. DHCS repaid the federal government in December 2018. DHCS indicates that, because the responsibility for SMHS was realigned to counties as a part of the 2011 Realignment, these disallowances will ultimately be repaid by the counties on a quarterly basis, over a period of four years beginning in the last quarter of FY 2018-19.³⁵

MENTAL HEALTH WORKFORCE

With the number of Medi-Cal eligible individuals increasing, the mental health workforce is not adequate to meet the needs of Californians (including Medi-Cal beneficiaries), particularly in rural areas, the Central Valley, and the eastern part of the state. As of 2016, California had over 80,000 behavioral health professions (UCSF Healthforce Center 2018). This existing workforce, however, is not distributed evenly across the state. The UCSF Healthforce Center reports that the greater San Francisco Bay area has the highest per capita number of behavioral health occupations except psychiatric technicians. By contrast, the Inland Empire and San Joaquin Valley had the lowest number of behavioral health professions in the state, as illustrated below:



From UCSF California’s Current and Future Behavioral Health Workforce Report. The above picture shows the ratios of different mental healthcare professions within each county; the different shares between counties represent the lowest quartiles (lighter colored, low ratio of providers to patients) to the highest quartiles (darker colors, higher ratio of providers to patients).

In addition to inequities between regions of California, there is also a pipeline issue in the behavioral health workforce. According to the California Future Health Workforce Commission, over 45% of psychiatrist and 37% of psychologist are over the age of 60, meaning that the current workforce shortage of mental health professionals is only projected to become worse without initiatives to recruit and train more individuals in these fields.

CONCLUSION

Mental health conditions affect a substantial number of people in the U.S. and are especially common among low-income individuals. As the major source of coverage for low-income Californians, Medi-Cal plays a key role in covering mental health care. The ACA and the state implementing legislation have resulted in an increase in the number of individuals receiving Medi-Cal coverage, and an increase in the scope of mental health benefits available through Medi-Cal managed care plans. However, access to care remains a challenge. There are significant areas for improvement in addressing mental health treatment rates. These include regional and racial disparities in care and differences in the rate of services provided by the different delivery systems. In addition, there are significant opportunities for better coordinating and integrating physical and mental health services. The purpose of these hearings is to provide an overview of the current Medi-Cal mental health delivery system and to look for ways to continue to improve the system so it effectively serves the most vulnerable Californians.

¹ Mental Health and Substance Use Disorder Services Information Notice 16-061, issued December 9, 2016.

² The list of nearly 40 carved out psychiatric medications is in APL 17-018. DHCS indicates Health Plan of San Mateo and Kaiser Permanente in Sacramento County have these drugs carved in.

³ Welfare and Institutions Code Section 14189, as added by SB X1 1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013.

⁴ The list of nearly 40 carved out psychiatric medications is in APL 17-018. DHCS indicates Health Plan of San Mateo and Kaiser Permanente in Sacramento County have these drugs carved in.

⁵ Governor's Budget Summary 2019-20, Health and Human Services, page 61-63.

⁶ 2019-20 Governor's Budget, Highlights, Department of Health Care Services, available at: https://www.dhcs.ca.gov/Documents/Budget_Highlights/FY2019-20-GB-Highlights.pdf

⁷ Welfare and Institutions Code Section 5600 et seq.

⁸ Welfare and Institutions Code Section 5892.

⁹ Welfare and Institutions Code Section 5008(n).

¹⁰ Welfare and Institutions Code Section 5114.

¹¹ Welfare and Institutions Code Section 14189.

¹² Welfare and Institutions Code Section 14132.03.

¹³ Department of Health Care Services All Plan Letter 17-081, issued October 27, 2017.

¹⁴ Medi-Cal Specialty Mental Health External Quality Review, Validation of Performance Measures, prepared for the California Department of Health Care Services by Behavioral Health Concepts, Inc., December 15, 2017.

¹⁵ Holzer, Charles and Nguyen, Hoang, Estimation of Need for Mental Health Services. Accessed from <http://charlesholzer.com/> on October 10, 2016. charlesholtzer.com

¹⁶ DHCS 2018 Statewide Aggregate Specialty Mental Health Services Performance Dashboard, p. 5 and 21. https://www.dhcs.ca.gov/services/MH/Documents/2018_SMHS_Dash_Combined_Report_non-ADA_7-18.pdf

¹⁷ Kaiser Family Foundation Disparities in Health and Health Care: Five Key Questions and Answers, by Kendel Orgera and Samantha Artiga, published by the Kaiser Family Foundation on August 8, 2018 and available at: <https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/>.

¹⁸ Medi-Cal Specialty Mental Health External Quality Review Validation of Performance Measures, prepared by the California Department of Health Care Services by Behavioral Health Concepts, Inc., December 15, 2017, p. 42.

¹⁹ Department of Health Care Services External Accountability Set (EAS) for Medi-Cal Managed Care Health Plans (MCPs) and Specialty Health Plans (SHPs) Measurement Year (MY) 2017 / Reporting Year (RY) 2018. Updated as of August 30, 2017

²⁰ Title 42 of the Code of Federal Regulations (CFR), Section 438.2.

²¹ Title 42 of the CFR, Section 438.68, 438.206 and 438.207.

²² AB 205 (Wood, Chapter 738, Statutes of 2017).

²³ Welfare and Institutions Code Section 14197.

²⁴ DHCS Annual Certification Report Summary, Network Certification Summary, available at: <https://www.dhcs.ca.gov/services/Pages/Mental-Health-Plan-Final-Rule-and-Parity-Information.aspx>.

²⁵ MACPAC Integration of Behavioral and Physical Health Services in Medicaid, Chapter 4.

²⁶ State Medicaid Director Letter # 18—011 from Mary C. Mayhew, Deputy Administrator and Director regarding Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, dated November 13, 2018, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

²⁷ Title 19 of the Social Security Act, Section 1905(i).

²⁸ Title 19 of the Social Security Act, 1905(a)(29) of the Act.

²⁹ Title 42 of the CFR, Section 438.6(e).

³⁰ DHCS 1915(b) Waiver Standard Funding Questions, March 24, 2015.

³¹ Section 30025 of the Government Code, as amended by SB 1020 (Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2012).

³² California Constitution, Article 13, Section 36, subdivision (c), paragraph (4), and DHCS November 2018 Medi-Cal Estimate, Base Policy Change Number 61.

³³ Letter from Hye Sun Lee, Acting Associate Regional Administrator, Division of Medicaid & Children's Health Operations of the Centers for Medicare and Medicaid Services to Mari Cantwell, Chief Deputy Director, California Department of Health Care Services, dated June 24, 2015, https://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf

³⁴ Department of Health and Human Services, Office of Inspector General, "California Claimed Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services," <https://oig.hhs.gov/oas/reports/region9/91502040.pdf>

³⁵ Medi-Cal November 2018 Local Assistance Estimate for Fiscal Years 2018-19 and 2019-20, Department of Health Care Services, Policy Change 115, PC Change 230-232.