



Assembly and Senate Health Committees

Joint Hearing on Improving the Medi-Cal Mental Health Delivery System

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Chairman Pan, Chairman Wood, members of the Senate and Assembly Health Committees, my name is Sarah Arnquist, and I am a Vice President at Beacon Health Options (Beacon). I live in San Francisco and oversee our business relationships on the West Coast, including California and Washington State. Before my tenure at Beacon, I was lead author on a paper published by the California HealthCare Foundation in 2014 on the financing of California's public mental health system.¹ Thank you for the opportunity to testify before the Subcommittee today regarding the Medi-Cal mental health system and benefit.

About Beacon Health Options

Beacon is the largest, independently owned mental health specialty company in America. Across the country, Beacon serves 47 million people in all 50 states, including more than 13 million Medicaid and other publicly funded program members across 26 states and the District of Columbia through direct to-state contracts and 50 health plan partnerships.

Beacon is a mission-driven company, organized to help our members – often those with the most complex behavioral, developmental and substance use needs – get the services they need to live their lives to the fullest potential.²

In California, we work with eight Medi-Cal managed care plans to manage mild to moderate mental health services for nearly one in three Medi-Cal beneficiaries. Our network of nearly 4,000 independent Medi-Cal providers spans 25 counties from San Diego to the Oregon border. We also contract directly with some counties supporting their access and triage lines and doing medical necessity reviews to help them meet their compliance and service goals with respect to mental health parity and Drug Medi-Cal implementation.

What works well in the Medi-Cal mental health delivery system?

Undoubtedly, more Medi-Cal beneficiaries have access to mental health services today than they did five years ago before the implementation of the Affordable Care Act. Beacon works hand-in-hand with our eight Medi-Cal plan partners, all of which are members of the Local Health Plans of California, and our focus from the beginning of the benefit has been increasing access and utilization of mental health services.

¹Arnquist, Sarah and Peter Harbage. "A Complex Case: Public Mental Health Delivery and Financing in California." July 16, 2014. The California HealthCare Foundation. <https://www.chcf.org/publication/a-complex-case-public-mental-health-delivery-and-financing-in-california/>

² For more information, please visit <https://www.beaconhealthoptions.com/who-we-are/our-values/>



In 2018, 140,000 unique beneficiaries accessed services through Beacon’s network. In some counties, more than one in 10 adult Medi-Cal beneficiaries accesses mild to moderate mental health services. We continue addressing critical provider shortage areas where access remains challenging. We struggle to find providers in certain geographic areas and providers with specific capabilities, such as pediatric psychiatrists and non-English speaking providers. A key tool to address these shortages is telehealth. Our telehealth services quadrupled between 2016 and 2018 with about 4,000 beneficiaries using telemental health services last year.

Beacon appreciates the strong collaboration with representatives from the county behavioral health departments where willingness to collaborate and do what’s right for beneficiaries is the norm. However, the structural barriers of the system design challenge even the best of intentions.

What does not work well in the Medi-Cal mental health delivery system?

As explained in the background documents³ prepared by legislative counsel to help inform the committees and stakeholder parties, California’s coverage for mental health is very complex, with myriad financing options, and many different populations seeking services from a variety of providers and programs in a hard-to-navigate system.

The bifurcation of the Medi-Cal mental health delivery system based on impairment level creates extra administrative burdens and cost. In 2018, Beacon screened roughly 40,000 Medi-Cal beneficiaries for impairment level at our call center. Of those screened, approximately 94% were referred to a provider in our mild to moderate network. For the 6% who met criteria for specialty mental health services, we coordinated their referral to the county for further assessment and linkage.

Beacon works in 25 counties, and none of them have the same processes for coordinating referrals or for their impairment criteria for acceptance. The same individual may be accepted into services in one county and not another. Beacon has set up best in class processes for counting and tracking these screenings and referrals, according to the National Health Law Program,⁴ but the substantial administrative energy expended on this process could otherwise be spent linking the individual directly to services.

This split system creates additional barriers to data sharing because of concerns over data privacy, even when such data sharing is permitted under treatment, payment and operations per HIPAA regulations. Historically, California has deferred to local county counsels to interpret privacy laws and permissibility

³ Background document for February 26, 2019 - <https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Final%20February%2026%20Medi-Cal%20Mental%20Health%20Background%202.pdf>

⁴ Kimberly Lewis, Abigail Coursolle, Héctor Hernández-Delgado, Hayley Penan, and Alexis Robles. “Navigating The Challenges of Medi-Cal’s Mental Health Services in California: An Examination of Care Coordination, Referrals and Dispute Resolution.” November 2018. The National Health Law Program. <https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/11/NHeLP-BSCF-Report-11-2-18-1.pdf>

of behavioral health data sharing. The result is wide variation across the state in the types and quality of data counties share with plan partners and providers who are trying to provide the best services for beneficiaries. The data sharing and collaboration can also be difficult for counties because in some cases there are multiple health plans to deal with, each with its own processes. Los Angeles has six plans and San Diego has seven. That's not easy either.

Most importantly, dividing the Medi-Cal mental health delivery system between payers based on impairment level negatively impacts beneficiaries by creating a confusing maze of programs. This division makes delivering person-centered much more challenging because the financing dictates the provider and care setting, as opposed to an individual's needs. For example, health plan and county networks mostly do not overlap. This means beneficiaries often cannot stay with their treating physician as they get better and no longer qualify for county level of care, or, conversely, the system forces them to seek a different provider under a different program should their condition worsen over time. Another complicating factor is that such a system discourages collaboration for creative network access solutions between counties and plans. All parties involved are competing for the same limited pool of behavioral health workforce within their limited geographies.

A Case Study Example:

The challenges in the Medi-Cal mental health system can best be understood through the lens of a typical person accessing services. Our data shows a common profile of someone accessing mild to moderate services is a woman, usually white or Latina, between the ages of 25 and 45, who is seeking help for her depression or anxiety. Let's call her Sonja.

At a recent PCP visit, Sonja revealed that she was feeling agitated, was withdrawing from her friends and family and was having difficulty sleeping. Her PCP prescribed an antidepressant and told her to call Beacon at the number on the back of her insurance card. When Sonja called, per state requirements she underwent a brief screening to determine if her impairment fell into the "mild to moderate" or "moderate to severe" category. Sonja screened "mild to moderate." Beacon referred her to an in-network therapist, and she began attending weekly sessions.

After a month or so of therapy an episode of domestic violence occurred, that resulted in her husband going to jail. This triggered Sonja to spiral into deeper depression with increased feelings of worthlessness and hopelessness. Her anxiety spiked because her husband might lose his job, and the income loss would be detrimental to her family. During a phone call with her sister, she described a plan to take her life. Alarmed, her sister called 911 and Sonja was admitted to a psychiatric facility for a few days.

Neither Beacon nor her therapist, PCP or health plan had any idea Sonja was hospitalized because that service is paid for and managed by the county. Each county's process for intake following a hospitalization is different, but most likely Sonja would not be reconnected with

her therapist, who is outside the county's network. She must start over on her treatment journey.

There are times, however, when a beneficiary is discharged from inpatient directly back to the mild to moderate provider. If this were to happen to Sonja, she would not be able to receive intensive case management and rehabilitation services, such as support with financial resources and restraining orders, because those services fall outside of the current Medi-Cal managed care plan benefit package. Without this extra support, our ability to maintain people at the mild to moderate level becomes more tenuous.

The third scenario that we could see is that Sonja could engage in county services, continue seeing her Beacon therapist, and still be prescribed her medications from her PCP. Sonja is doing her best to follow all of these treatment plans, each of which may be vastly different. In this scenario, both the county and the plan are paying for services without any coordination, and Sonja appears to be gaming the system. But how is she supposed to know she shouldn't be receiving care funded by her health plan and county at the same time?

What should the state do to improve the mental health plan benefit?

Based on our experience working in many states, we believe that a beneficiary should be able to access all allowable benefits and services across full continuum of care from a single, cohesive provider network regardless of level of impairment or payer responsibility.

We offer the following recommendations that are feasible within existing regulatory constraints to enhance the existing benefit structure to more effectively support prevention and early intervention.

1. **Strengthen crisis systems as a key element of regional and state-wide infrastructure.** A key element that makes behavioral health different than the rest of the Medicaid health care system is that a crisis system of care must exist for entire communities regardless of health insurance status. Today, in California, an individual experiencing a crisis is going to have a vastly different experience depending on where they live. The state should consider creating some baseline expectations for crisis system design that should include law enforcement, criminal justice, education and the child welfare systems, along with the managed care plans, to explore opportunities for better coordination, prevention & early intervention. California could learn from other states Beacon works with that have focused on improving their crisis system for the future to create one that is integrated, more equitable and better oriented toward prevention, early intervention and diversion.⁵

⁵ <https://www.hca.wa.gov/about-hca/healthier-washington/integrated-physical-and-behavioral-health-care>

- 2. Support virtual collaborative care models with real-time psychiatric consultation programs to improve access and quality.** Upcoming mandated screening requirements for maternal mental health and adverse childhood events (ACEs) have the potential to flood an already overwhelmed mental health service delivery system. To address this, we recommend California invest in a large-scale psychiatric consultation program like the Massachusetts Child Psychiatry Access Program (MCPAP)⁶ which creates real-time access for a pediatrician or primary care providers to speak with a pediatric psychiatrist, thus increasing competency and capability for managing patients at the primary care level. This program has successfully been expanded to consultation for perinatal mental health and opioid use disorder treatment, thereby allowing the primary care system to appropriately designate patients for the level of care and coordination they might need.

Recently, AB 1676 was introduced to require Knox-Keene licensed plans to stand up psychiatric consultation programs.⁷ Beacon would urge the legislature to consider not making this a plan-specific requirement. Resources would be better aligned if California focused on creating regional models that are payer agnostic and could be supported by funding sources, such as Proposition 56 or the Mental Health Services Act.

- 3. Expand the array of services that Medi-Cal health plans may purchase.** Ideally, mild to moderate services should be prevention-oriented services to help individuals not escalate up to needing county-level of care. However, our ability to maintain individuals at the moderate level is hampered by the constraints on the types of services and providers we can pay for. For example, to effectively treat young children who screen positive for ACEs, we must treat the entire family unit. Today, Medi-Cal plans cannot pay providers for interventions like coordination with family supports, parental coaching or certain types of evidenced based therapies. Only the counties are allowed to pay for these services for people who already have significant impairments. Furthermore, the Medi-Cal plans are not able to pay for services rendered by non-licensed individuals and people with lived experience – both peers and family partners. Evidence shows unambiguously that these person-centered, culturally competent services promote recovery, help address critical access shortages and are cost-effective.
- 4. Create pilot programs to fully explore integration, either within managed care or within county-based systems, to see what works best for Californians.** Understanding that the current system is incredibly complex, and that better coordination can help improve services and outcomes in the long term, several organizations have started to suggest a single system might be the answer. Consolidating financial management and aligning the full continuum of

⁶ <https://www.beaconhealthoptions.com/beacon-health-options-recognizes-pcps-role-in-behavioral-health-care-during-national-depression-and-mental-health-screening-month/>

⁷ <http://analyses.chbrp.com/document/view.php?id=1386>

behavioral health services under a single payer could improve incentives for early intervention and coordinated patient care both across the mild to severe continuum and between behavioral and physical health.⁸ In the spirit of finding what works best, California could pilot benefit consolidation a certain population or geography. One idea is to start with the dual eligible population enrolled in Cal MediConnect, allowing the managed care plans to pay for the full continuum of Medi-Cal rehabilitation options and targeted case management services. Another is to move to a managed care model through the Medi-Cal managed care plans.⁹ In all cases, we would encourage a system that reduces complexity, allows the beneficiary seamless access to services, ensures continuity of care at appropriate levels of care, and improves quality and outcomes in the long term. In creating such a system, the state could measure overall impact on key performance outcomes and total medical expenditures to decide what works best.

What should the state do to better integrate mental health care and physical health care (administration, financing, clinical integration)?

As stated above, Beacon currently administers behavioral health services for Medicaid in 26 other states. Each system of care has strengths and weaknesses. Below are a set of principles we recommend California keep in mind as it contemplates the future of its behavioral health system:

1. **Standardize screening tools.** If the current mental health delivery system bifurcation remains, DHCS should develop and require statewide use of a standardized screening tool that uses consistent and clinically supported medical necessity standards.
2. **Standardize data sharing permissibility.** DHCS should provide directive, permissive guidance on sharing Medi-Cal funded mental health data between plans, providers and counties to improve coordination of care. Beacon has been a proponent of appropriate, private, secure, data sharing to help improve the services we provide to all beneficiaries we cover.¹⁰
3. **Move toward value-based purchasing.** DHCS should set required targets and timelines for transforming county purchasing away from cost-reimbursement methodologies and toward value-based contracting.
4. **Develop a rate setting methodology.** Today counties are responsible for providing the non-federal match for all Medicaid eligible specialty mental health services through myriad funding streams. Importantly, this is unlike the rate setting process used to pay the Medi-Cal health plans for all medical services. DHCS should invest in an exercise to develop a rate setting

⁸ http://static1.1.sqspcdn.com/static/f/675504/27611440/1498768966757/BSCG_BSCF_Behavioral_Health_Integration_Report_May_2017.pdf?token=N6yqslhjaLLDGrO88Ql5PkcaNzg%3D

⁹ <https://www.chcf.org/publication/behavioral-health-integration-medi-cal-blueprint/>

¹⁰ <https://www.beaconhealthoptions.com/beacon-health-options-urges-house-to-support-ops-act-that-modernizes-federal-privacy-laws-to-combat-opioid-epidemic/>

methodology for global capitation for adults with SMI and youths with SED. This would support any future changes mental health financing and administration.

5. **Promote transparency around uniform performance standards.** Look to other states, such as Washington or New York, that have integrated mental health for measures related to early system warnings and long-term effectiveness. Publish county and plan performance standards on the established metrics.
6. **Regional procurement.** DHCS should consider regional procurement for behavioral health services. Many providers cross over county lines and many beneficiaries move between counties. Regional structures may streamline contracting, reduce administrative burden and support better care coordination.

In closing we believe that California has opportunities to modify and improve the organization of its public mental health system to draw down more federal reimbursement, increase access to high quality care, and ultimately deliver better client outcomes.

I appreciate the opportunity to provide comments before the Committee and welcome your questions.



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