

**Written Testimony of Kim Lewis, Managing Attorney, National Health Law Program**

**Joint Assembly Health and Senate Health Committee  
Informational Hearing on the *Medi-Cal Mental Health Delivery System*  
Assemblymember Wood, Senator Pan, Chairs  
March 5, 2019, 1:30 p.m. - State Capitol, Room 4202**

**Questions to be addressed by the panelists:**

- 1. What works well in the Medi-Cal mental health benefit?**
- 2. What needs improvement in the delivery of the Medi-Cal mental health benefit and how?**
- 3. What should be done to better integrate the delivery of physical and mental health benefits in the overall Medi-Cal health care delivery system?**
- 4. What should the Medi-Cal mental health delivery system look like in 5, 10 or 15 years?**

Good afternoon Chairs Wood and Pan, and members of the Committee, my name is Kim Lewis, and I am the managing attorney of the California office of the National Health Law Program. It is my privilege to be here today to talk to you about improving the delivery of mental health services in Medi-Cal. By way of background, I am very familiar with California's mental health system as I have worked on these issues for almost 30 years. I worked for a decade in a county patients' rights program in San Diego County where I was directly responsible for addressing the rights of children, youth and adults in the county mental health system. I also was lead counsel in a class action settlement (*Katie A.*) with DHCS and CDSS to develop and implement Medi-Cal home and community based mental health services for children and youth under the federal EPSDT entitlement. And I work directly with legal services and other health care advocates throughout the state who provide direct advocacy assistance to Medi-Cal beneficiaries who are seeking mental health care from the system. There were 4 questions the panel was asked to address and given the limitation of time, I will focus on two of them:

**What needs improvement in the Medi-Cal mental health delivery system?**

To answer this question, let me cite a current case example that I believe will help illustrate what is wrong with the current system:

*A 15 year old girl with mental health diagnoses of an eating disorder (ED), depression, suicidal ideation and obsessive compulsive disorder, as well as a substance use disorder was getting care from an ED specialist through her health plan. She also got care from a psychiatrist with the county mental health plan. Her condition became worse in the fall of 2018. At that time both her pediatric ED specialist and her psychiatrist wrote letters stating the youth needed residential treatment. In November 2018 she got a written denial from her health plan and was told to seek care from the county. When her mother contacted the county, she was told the county could not provide the services and she should call her health plan. Despite filing a grievance with the health plan, and even after seeking the help of a legal aid attorney, this*

*youth has still not received the care she needs over 3 months later. Meanwhile, she has lost about 15 pounds, has been involuntary detained and taken to the ER on multiple occasions.*

These kinds of cases are not atypical. The current bifurcated system is fragmented, and it financially incentivizes limiting or denying care, and instead sending the beneficiary elsewhere for services (since the plan will not be responsible to pay for it). It is not a system designed with the beneficiary at the center. Statewide, there are 56 mental health plans and 22 health plans, some of which operate in multiple counties. While DHCS is responsible to oversee and monitor all of these plans, it has limited resources to do so adequately. Mental health plans are only audited triennially, which is not sufficient to ensure compliance with the many state and federal laws that are in place to protect consumers and ensure appropriate access. So beneficiaries are often left on their own to navigate these complicated systems, and multiple plan types, when they need mental health treatment.

The primary issues that make this bifurcated system even more challenging for beneficiaries are: 1) the absence of referral tracking, 2) inadequate coordination and 3) the lack of continuity of care. Let me briefly describe each of them:

1. Absence of Referral tracking.

With a few exceptions, health and mental health plans do not track referrals when their mutual enrollees need mental health services that the other plan is responsible to provide. This in large part due to the fact that there is no requirement that they do so, and the fact that their data systems are not compatible so they cannot share data or use an automated tracking system. Those plans that do track these referrals must accomplish it manually. Given this, they often do not know what mental health services their members are getting outside of their plan.

2. Inadequate coordination.

Despite the fact that all health plans are required to have Memorandums of Understanding (MOU) with the mental health plans in their county, the amount and type of coordination between these plans varies dramatically from plan to plan, as all MOUs are different. And while there are some state regulations on the books as to what the content of the MOUs should be, our experience is that the written agreements are not followed and there is no oversight of this practice by the Department. The result is that, even with the MOUs in place, there is little to no coordination actually occurring for these shared enrollees. The earlier example highlighted this problem and this practice is quite common. Again, there are exceptions where particular plans engage in best practices for their members.

3. Lack of continuity of care.

Continuity of care is a serious concern when it comes to mental health services. Again this is in large part due to the lack of effective tracking and coordination between the plans for individual members as well as due to the fact that has been no clear guidance or expectation by the Department that this must occur. Therefore, when a beneficiary is in need a treatment that

the other plan is responsible to provide, services may be stopped and the beneficiary is simply referred to the other system for care. In cases where there is a dispute between the plans as to which plan is responsible, such as in the earlier example, services may not be provided by either plan. This is particularly problematic because of the lack of overlapping provider networks. So if one plan no longer authorizes a service, the beneficiary would be forced to stop care, and start over with a new provider, such as with psychotherapy. This is hardly considered an appropriate standard of care. Finally, while the state created scheme of impairments being characterized as “mild, moderate, and severe” is not consistent with the EPSDT federal mandate, and should not be applied to children and youth, it nevertheless is routinely used by mental health plans to screen out children and deny mental health services to a child or youth even when the service is medically necessary and they are entitled to it.

### **How can services be better integrated in the Medi-Cal delivery system?**

While I believe that Medi-Cal beneficiaries will ultimately be best served by a fully-integrated health care delivery system, such a major shift in the delivery system structure in California will take time, careful planning with stakeholder input, and will need to be implemented with safeguards and readiness standards. The services that children and youth in particular need and have a right to under EPSDT are not typical “medical model” services that are provided in private or employer health care coverage, and are not provided in an office or in a clinic setting. They are rehabilitative at their core and at times may be very time intensive, and must be provided with adherence to a fidelity model of practice in order to be effective and have good outcomes. This is not the type of services health plans are familiar with so existing providers that know how to do this must be maintained in the network.

But there are things that can be done now, without waiting for such a fully integrated system to be realized. Legislation on referral and tracking, data sharing, more specific coordination and continuity of care requirements must be put in place now. And the Department must allocate more resources to monitoring the health and mental health plans with respect to this benefit. No child or youth should ever be denied services because of their “level of impairment”.

Finally, for more details on the challenges and recommendations for improvements that the state should implement, I refer you to our recent November 2018 report, *Navigating The Challenges of Medi-Cal’s Mental Health Services in California: An Examination of Care Coordination, Referrals and Dispute Resolution*, which can be found on our website at [healthlaw.org](http://healthlaw.org).