



***Pre-Convening Paper: Overview of Medi-Cal’s Behavioral Health System
& Necessary Safeguards for an Integrated System***

I. Introduction

Medi-Cal is the primary payer of behavioral health care in California, providing coverage to one-third of all California residents. A significant number of Medi-Cal beneficiaries have a mental health condition or illness, a substance use disorder (SUD), or co-occurring mental health and SUD conditions. However, a majority of Medi-Cal beneficiaries with behavioral health needs are currently not receiving treatment due, in part, to a fragmented delivery system under which beneficiaries receive mental health and SUD treatment from up to three different entities, depending on the severity of the condition. In anticipation of potential proposals to create a more integrated Medi-Cal behavioral health system, this paper provides an overview of the current trifurcated delivery system, evaluates strengths and weaknesses of the current system, and discusses necessary protections and safeguards that a transition to an integrated system must ensure.

II. Mental Health Services

Under California’s 1915(b) waiver, the state provides mental health services for adult beneficiaries with mild to moderate conditions through managed care plans (MCPs) and specialty mental health services (SMHS) through County Mental Health Plans (MHPs). For beneficiaries under age 21, the division is more complicated, as children under age 21, under Medicaid’ Early and Periodic Screening Diagnostic and Treatment (EPSDT) mandate, are entitled to any mental health services that are medically necessary to correct or ameliorate their mental health condition, regardless of the severity of it. Therefore, most of the mental health services available to children and youth in California are available as SMHS. In addition, while SMHS have been carved out of MCPs’ contracts with the Department of Health Care Services (DHCS), MCPs are still required to coordinate access to these services. In particular, MCPs must enter into a memorandum of understanding (MOU) with MHPs at the county level that must address coordination of beneficiaries’ care; referral protocols; clinical consultation; care management; information sharing; provision of prescription drugs, laboratory services,



emergency care, and transportation; coordination of physical and mental health care; a dispute resolution process; and the provision of medically necessary services pending resolution of a dispute.

SMHS are available through County MHPs and include: mental health services (which includes assessment, plan development, rehabilitation, collateral, individual and group therapy); crisis intervention; crisis stabilization; day treatment intensive; day rehabilitation; medication support; adult residential treatment; crisis residential treatment; targeted case management; psychiatric health facility services; psychiatric inpatient hospital services. Additional SMHS available to beneficiaries under age 21 include: therapeutic behavioral services, intensive care coordination, intensive home based services, and therapeutic foster care services. SMHS are available to beneficiaries who meet the medical necessity criteria. For adult beneficiaries, the medical necessity criteria for SMHS is met if the beneficiary has been diagnosed with one or more of the conditions listed in Cal. Code Regs., tit 9, § 1820.205(a)(1); the beneficiary has either a) a significant impairment in an important area of life functioning OR b) a reasonable probability of significant deterioration in an important area of life functioning; and the beneficiary meets the intervention criteria (that is, the focus of the proposed intervention is to address the impairment or condition identified; AND the expectation is that the proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning; AND the condition would not be responsive to physical health care based treatment). The medical necessity criteria for SMHS for beneficiaries under 21 is less stringent because of the EPSDT mandate, which provides that services must be provided when necessary to *correct or ameliorate* a mental illness or condition. This medical necessity standard has recently been enacted in state law.

All benefits that are not part of SMHS but are included as part of the state's Medicaid State Plan continue to be the responsibility of the MCPs, including the limited mental health services for beneficiaries who do not meet the medical necessity criteria to receive SMHS. As part of that obligation, the mental health services required by contract to be provided by MCPs include: individual and group mental health evaluation and treatment (psychotherapy) and psychiatric consultation; psychological testing when clinically indicated to evaluate a mental health condition; outpatient laboratory, drugs, supplies, and supplements; outpatient services for the purposes of monitoring drug therapy; and any other behavioral health service that falls within the primary care physician's scope of practice. MCPs are required by contract to provide the above listed services to adult Medi-Cal enrollees when they are medically necessary to treat a *mild to moderate* impairment of mental, emotional, or behavioral functioning. For children, the level of impairment cannot dictate what they are entitled to under EPSDT. This has resulted in a great deal of confusion as to when children should receive mental health services from the MCP and when they are entitled to receive SMHS from the MHP. Because there is an area of overlap between the services children and youth can

receive from the MCP and MHP, children and youth will generally receive the limited MCP contracted services only when they have a mild condition. If the child or youth's condition is "moderate to severe or the child/youth needs SMHS not covered by the MCP limited contract, regardless of their impairment level, the child/youth is entitled to receive SMHS. This confusion, and DHCS' failure to clearly explain or provide adequate guidance to plans concerning EPSDT mental health services, has resulted in statewide confusion that has caused children and youth to be denied access to medically necessary mental health services from both plan types.

MCPs are also responsible to provide psychiatric prescription drugs that have not been carved out of managed care contracts. Currently, California carves out approximately 40 psychiatric medications from MCP contracts. These prescription drugs are authorized and provided by DHCS on a fee-for-service (FFS) basis and separate from the SMHS delivery system.

III. Substance Use Disorder Services

Medi-Cal SUD treatment services are generally provided through County Alcohol and Drug Programs, as most SUD services have been carved out of MCP contracts. SUD benefits provided by counties include those that are covered under the Drug Medi-Cal (DMC) program, which are all SUD services in the Medicaid State Plan and state plan amendments (SPAs), as well as those covered under California's 1115 waiver's Drug Medi-Cal Organized Delivery System (DMC-ODS) program.

DMC services include: methadone maintenance treatment (MMT) at Narcotic Treatment Programs (NTPs); outpatient drug free treatment; intensive outpatient treatment; perinatal residential SUD services; and naltrexone treatment services. Each of these services have specific components (such as intake, body specimen screening, admissions physical exams and laboratory tests, treatment planning, and medical direction) and also have specific eligibility criteria and coverage exclusions arising from federal and/or state law. DMC-ODS services, which are only available for beneficiaries residing in counties participating in the waiver program, include all of the DMC services plus the following services: buprenorphine, disulfiram, and naloxone treatment at NTPs; residential services for all beneficiaries meeting the ASAM medical necessity criteria for residential treatment; withdrawal management or "detox" services; recovery services; case management; physician consultation; partial hospitalization; and additional medication-assisted treatment (MAT) (ordering, prescribing, administering, and monitoring of methadone, buprenorphine, and naltrexone treatment).

As with psychiatric prescription drugs, most medications for treatment of SUD have been carved out of MCP contracts. DHCS pays for these medications on a FFS basis and, depending on the setting in which the medication is administered; the medications may be covered under the Medicaid benefit of physician services or under the

prescription drug benefit. There are no statewide separately covered SUD services for children and youth under EPSDT in either the waiver or non-waiver counties, despite the fact that all county SUD programs are legally required to provide any SUD services that are medically necessary under the EPSDT federal obligation. This topic warrants further discussion and analysis that we will not address in this paper.

IV. Strengths and Weaknesses of the Carved-Out System

The current fragmented Medi-Cal behavioral health system presents some strengths, particularly when compared to the system that preceded it. When first implemented in California in 1995, the carved-out system for both SMHS and SUD ensured that beneficiaries with serious behavioral health conditions could get, for the first time, access to services from specialized providers outside of the Medi-Cal fee-for service system. These separate prepaid inpatient plans (PIHPs) in each county have managed and provided behavioral health services for Medi-Cal beneficiaries and contract with a certified diverse network of behavioral health providers qualified to address mental health and SUD conditions. This expertise makes it easier for low-income beneficiaries to be directed to appropriate providers and available services. Medi-Cal Managed care plans, on the other hand, have not historically had the expertise or experience, nor the provider network in place, to effectively treat and manage these conditions and provide the array of services that are part of the Medicaid Rehabilitative Option (MRO). MRO services include community-based mental health care for individuals with serious mental illness, youth with serious emotional disturbance, and/or individuals with substance use disorders. MRO services may be provided in the member's home, school, workplace, residential facility, emergency department, or wherever needed.

Despite the expertise and specialized knowledge of MHPs or DMC programs (including their specialized capacity to coordinate services among behavioral health providers and other county social services agencies), carving out behavioral health services from the larger Medi-Cal managed care system also presents significant problems. For example, a carved-out system creates widespread confusion among beneficiaries. This is particularly true for beneficiaries who need services from more than one plan. Beneficiaries are often confused about where they should go or call to apply for SMHS or SUD services. Where there is a lack of communication between MCPs and MHPs or DMC programs, beneficiaries who are referred from one plan to another, are also left to navigate the system and communicate with plan representatives on their own before being able to access the necessary services. Even when beneficiaries are able to access the services, navigating the trifurcated system results in delays to care to the detriment of their health and mental health or SUD service needs.

Moreover, MCPs have been unable to properly coordinate referrals and provision of services with MHPs and DMC programs. As a result, many beneficiaries with behavioral health needs continue to experience difficulty accessing specialized behavioral health

services. For example, while most MCPs have established screening procedures to evaluate the behavioral health needs of beneficiaries, as well as referral protocols to refer beneficiaries to MHPs or DMC programs, these procedures are often not properly followed and beneficiaries in need of SMHS or SUD services may not be referred to the appropriate plan and/or provider. Also, when MCPs refer beneficiaries to the MHPs or DMC system, the referring plan rarely maintains communication with the receiving plan or program to follow up and make sure that the beneficiary was in fact evaluated and received the necessary services.

In addition, disputes often arise between the plans as to whether the beneficiary is eligible for SMHS or SUD services. Similar disputes also arise when plans disagree regarding their respective responsibilities to pay for medically necessary services. This situation is common when the beneficiary has been diagnosed with co-occurring physical health and mental health or SUD conditions and need services simultaneously from more than one plan or provider. While California law clearly states that plans must have a dispute resolution in place and that beneficiaries must continue receiving medically necessary services pending the resolution of the dispute, plans often deny the services in these situations until one plan or the other agrees to pay for them.

Finally, the carved-out system has been ineffective in providing for proper communication to coordinate services between plans, particularly after the services have been approved. Most plans lack an appropriate mechanism to share information and beneficiary data, even though MOUs between MCPs and MHPs or DMC programs must specify agreements to share beneficiary information. Sharing of data is essential for provision of appropriate services, since information may be crucial to determine the clinical course of action. This problem is exacerbated by the fact that there are totally separate and misaligned plan funding systems and provider payment mechanisms. This makes it difficult, if not impossible, to align provider networks so beneficiaries can maintain continuity of care when moving between plans for behavioral health services.

V. Safeguards for a Transition Toward Behavioral Health Integration in Medi-Cal

As California takes steps to consider greater efforts toward an integrated delivery system for Medi-Cal behavioral health services, the state must put into place appropriate safeguards to protect consumers, especially during any transition period where responsibility for providing behavioral health services moves between entities.

Over the last decade, California's Medi-Cal program has gone through several major structural changes that can provide valuable lessons about the kinds of challenges that can arise during such transitions. Specifically:

- *Transition of Seniors and People with Disabilities (SPDs) into managed care:* Pursuant to California's 2010 1115 Medicaid Waiver, Bridge to Reform, California transitioned SPDs in 16 counties from the Medi-Cal fee-for-service (FFS) delivery system into the managed care delivery system between June 2011 and May 2012.
- *Rural Managed Care Expansion:* California transitioned Medi-Cal beneficiaries in 28 rural counties from the Medi-Cal fee-for-service (FFS) delivery system into the managed care delivery system between 2013 and 2014.
- *Healthy Families transition:* California moved children enrolled in its separate CHIP, called "Healthy Families," into Medi-Cal in 2013.
- *Low Income Health Program (LIHP):* Pursuant to California's (2010) 1115 Medicaid Waiver, Bridge to Reform, California counties operated county-based expansion programs for adults not otherwise eligible for Medi-Cal starting in 2011 through 2013 at which time enrollees were moved into the Medi-Cal expansion program or Covered California, starting January 1, 2014.
- *Expansion of non-specialty mental health services:* California significantly expanded the scope of non-specialty mental health services available to Medi-Cal beneficiaries through either FFS Medi-Cal or Medi-Cal managed care, beginning January 1, 2014.
- *Transition of Behavioral Health Treatment (BHT) from Regional Centers to FFS and Medi-Cal managed care:* California moved responsibility for providing behavioral health treatment for children with autism spectrum disorders from the Regional Centers into regular Medi-Cal through FFS or Medi-Cal managed care starting in 2014.
- *Cal MediConnect Duals Demonstration:* Pursuant to a memorandum of understanding with the federal government and California state law, California permitted people eligible for both Medi-Cal and Medicare to enroll in a single plan that administers both their Medicare and Medi-Cal benefits in eight counties - Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara - starting in 2014.
- *1915b waiver renewal:* California renewed the federal Medicaid waiver that governs Mental Health Plans (MHPs) that deliver specialty mental health services to Medi-Cal beneficiaries starting in 1995, with the last waiver renewal in 2015. As part of the 2015 renewal, MHPs began to measure timely access for the first time.
- *Drug Medi-Cal Organized Delivery System:* Pursuant to California's 1115 Medicaid Waiver, Medi-Cal 2020, California counties were able to draw down federal funding to reorganize their SUD treatment system using a continuum of care modeled on the American Society of Addiction Medicine criteria for SUD treatment starting in 2017.

Drawing from our experience working as consumer advocates through each of these transitions, we recommend that California implement consumer protections in key areas, to ensure continuity of care and access to behavioral health services during a transition from the current fragmented system to a more integrated one. The key areas that safeguards are needed include: (1) stakeholder engagement in transition, (2) extended continuity of care, (3) network adequacy, (4) adequate notices and informing materials, (5) data-sharing, and (6) care coordination with other services.

1. Stakeholder engagement: The State must meaningfully engage stakeholders in any transition that it implements. Stakeholders should be involved and invited to give feedback at all stages of the transition. It should make a concerted effort to involve key stakeholder groups (including consumers, consumer advocates, providers, and plans) and keep them apprised of transition plans, as well as seek their input throughout the transition process. The process should be as transparent as possible, with adequate time built-in for multiple rounds of stakeholder feedback at major junctures. In addition, the state should consider addressing specific planning and transition issues at the regional level, as appropriate.

2. Continuity of care: The State should provide for extended continuity of care for a period of time after any transition is effectuated. The continuity of care protection should ensure that beneficiaries maintain access to current providers and services approved. In addition, continuity of care should provide for the continuation of existing treatment plans, including the hours or intensity of services, for at least a set period of time, and set forth a process for beneficiaries to transition their treatment to a new provider when appropriate and necessary.

3. Network adequacy: Any transition must also ensure that the receiving entity has adequate provider networks to deliver the full range of covered benefits. The State should establish a time period by which the responsible entity must certify a network for any services it has not previously covered, including certification that network providers have the appropriate qualifications and expertise to deliver covered services. As appropriate, the state should ensure the network includes non-traditional providers such as non-clinical staff and paraprofessionals as part of the provider networks where appropriate to delivering necessary services and supports. The state should also make explicit requirements, as well as develop incentives, to bring providers into the networks.

4. Notices and informing materials: The State must ensure that beneficiaries receive adequate notices and other informing materials before and throughout the transition

period. This should include noticing early and often to be sure that beneficiaries are aware of the transition and any steps they need to take (ideally starting at least 6 months in advance). The state should also use other methods of informing besides paper notices. The state must engage in a robust stakeholder process to review notices and ensure they are understandable, comprehensive and culturally competent, as well as translated into all threshold languages.

5. Data-sharing: The State must provide adequate lead-time to facilitate data-sharing necessary during the transition, while also establishing safeguards to protect beneficiary privacy. This should include protocols set-up in advance to allow data-sharing pre-transition to ensure that the receiving entity has information necessary to facilitate continuity of care and coordination of all services. The state must also ensure that the receiving entity is able to obtain data from out-of-network treating providers for ongoing continuity-of-care and coordination.

6. Care coordination: The State must provide for coordination with other services during any transition. We recommend that the receiving entity be tasked with coordinating behavioral health services with physical health services, and for providing robust care coordination/management for transitioning beneficiaries. At the same time, these requirements should ensure the continuation of existing targeted case management, including intensive care coordination for children and youth, as a medically necessary SMHS. The receiving entity must also be responsible for coordinating services with other systems, including child welfare, criminal justice, schools, and regional centers.

Appendix A: Summary of Medi-Cal Behavioral Health Service Delivery

The table below summarizes how Medi-Cal currently delivers behavioral health services:

Covered by County Alcohol & Other Drug Program	Covered by County Mental Health Plan	Covered by Managed Care Plan*	Covered on FFS Basis
		All behavioral health services within PCPs scope of practice (including screening services under EPSDT)	
Outpatient drug free treatment (group therapy and limited individual therapy) & counseling incident to treatment with naltrexone, methadone or buprenorphine	Mental health services including assessments, plan development, therapy, rehabilitation and collateral services, intensive care coordination, intensive home based services, therapeutic behavioral services, and therapeutic foster care	Individual and group mental health evaluation and treatment (psychotherapy) & psychiatric consultation	
Physician Consultation**	Mental health assessment	Psychological testing, when clinically indicated to evaluate a mental health condition & alcohol misuse screening and brief Intervention for adults	
Monitoring of treatment with naltrexone, methadone or buprenorphine Additional MAT Services**	Medication support services	Outpatient services for the purposes of monitoring drug therapy	

Covered by County Alcohol & Other Drug Program	Covered by County Mental Health Plan	Covered by Managed Care Plan*	Covered on FFS Basis
Naltrexone, methadone & buprenorphine		Outpatient laboratory, drugs, supplies and supplements (excluding carved out psychotropic medications used for the treatment of alcohol and SUDs)	Psychotropic medications & medications used for the treatment of alcohol and SUDs
Intensive outpatient treatment	Day treatment intensive & day rehabilitation services		
Withdrawal Management**	Crisis intervention & crisis stabilization		
Perinatal Residential SUD Services Other Residential Services**	Adult residential treatment services & crisis residential treatment services		
	Psychiatric health facility services	Any physical health components of facility services	
Partial Hospitalization**	Acute psychiatric inpatient hospital services & psychiatric inpatient hospital professional services	Any physical health components of hospital services + inpatient services in out-of-network hospitals	Voluntary inpatient detox in a general acute care hospital
Case Management**	Targeted case management services & Intensive Care Coordination	Care coordination	
Recovery Services***			

* For beneficiaries enrolled in a Medi-Cal managed care plan. For beneficiaries in Medi-Cal fee-for-service, these services are covered on a fee-for-service basis.

** Only available in DMC-ODS pilot counties, except for services for children under 21 under the EPSDT mandate.