Hospital Council
of Northern & Central California

Excellence Through Leadership & Collaboration

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Hospital Council Behavioral Health Task Force

Final Report

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Contents

About Us

The Hospital Council of Northern and Central California is a nonprofit hospital and health system trade association established in 1961, representing 185 hospitals and health systems in 50 of California's 58 counties—from Kern County to the Oregon border. The Hospital Council's membership includes hospitals and health systems ranging from small rural hospitals to large urban medical centers, representing more than 37,000 licensed beds.

The Hospital Council works in partnership with CHA to influence state and federal legislation and regulatory issues. At the local level, the Hospital Council monitors County Boards of Supervisors, health departments and other agencies, and supports member involvement in local decision-making on such critical issues as health care workforce, the safety net, access to care, emergency medical services, reimbursement, patient safety, community benefits and more.

Hospital Council delivers services geographically through sections, each with specially designated staff. The structure provides members with opportunities to pursue common goals and efforts that may be county-specific and/or regional in nature. Section meetings occur routinely to timely address local issues.

This report focuses on adult behavioral patient needs and is intended to support conversations among interested stakeholders to identify existing resources and how those resources can be used most effectively to provide the right care at the right place at the right time with the right provider. The report is focused on local and regional advocacy opportunities. While we acknowledge the constraints of state and federal laws and regulations, we believe that much can and must be done within the existing constraints to advance behavioral health care for all residents.

Introduction

Throughout California and the nation, the number of people living with mental illness continues to increase, and this will require hospitals, communities, and other stakeholders to create innovative solutions to assist these individuals. The challenge that exists is not only the volume of individuals in need, but the complexity of these patients within a health care system that has limited resources and capacity. Finding sufficient space, funding and specialty-trained providers to effectively deal with presenting issues poses challenges to effective and efficient care. In addition, varied local and federal laws and regulations that govern treatment and coverage of these conditions often may impede timely and appropriate interventions.

In response to these challenges, the Hospital Council Behavioral Health Initiative was initiated. To prepare Hospital Council Regional Vice Presidents and to provide significant resources to our Sections, the Behavioral Health Task Force (BHTF) was created to advise staff, ensure coordination of association actions with existing hospital and system activities, and collaborate with government agencies and community groups in order to push forward behavioral health public policy priorities. The Task Force membership includes immense depth of expertise and a commitment to provide recommendations for action to improve behavioral health services.

Access to care, coordination of care and community resources, revenue and funding factors are universal issues in all health care systems. Which of these issues and how they are controlled or influenced by other factors, however, is unique to each county and each service delivery system that interacts within any given jurisdiction. Therefore, no one set of solutions or interventions will apply to the idiosyncrasies of our partner counties and hospitals.

To address the unique needs and issues in varied regions and political environments, a menu of prospective options has been created that local groups can review and select from, choosing those that fit their individual circumstances. The goal of this report is to provide a resource for policy considerations and advocacy. The challenges and opportunities highlighted are based on the unique perspective of Task Force members. The intent is to use the synthesized information to develop collaborative solutions for enhanced access to care, care coordination and community resources, and funding resources. The Hospital Council is committed to serving as a convener to develop locally responsive solutions to serve all residents with behavioral health care needs as effectively as possible.

The Hospital Council has developed this report consistent with its strong belief that all stakeholders, e.g., Mental Health Departments, hospitals, community resources, and state agencies, are necessary and have value to contribute to the programs, practices, and policies that impact care to our patients. In addition, we believe that all stakeholders can benefit from collaboration to better achieve their individual missions. We acknowledge that resources within the mental health systems are tight, such that collaboration can bring greater efficiencies and impact than individual efforts. These beliefs underline the Hospital Council's commitment to improve patient outcomes and experience by working together with other stakeholders for our common values and purpose, which are our patients. Together we are stonger, and and our patients and communities need us to move forward decisively.

The primary focus of this report is to provide insight into opportunities that strengthen the *Acute Ambulatory Model*. This paradigm shift replicates other fields of medicine by expanding the focus of care delivery to include settings outside of the hospital walls. Examples include Crisis Stabilization Units (CSU), Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP), integrated behavioral

health and medical health care within the primary care setting, telepsychiatry and other communication modalities, stand-alone clinics, mobile care units, and behavioral health care at home. Identifying collaborative opportunities within and across counties that leverage existing resources and funding streams will enhance successful program implementation.

This report is intended to support conversations among interested stakeholders to identify existing resources, and how those resources can be used most effectively to provide the right care at the right place at the right time with the right provider.

The report is focused on adult behavioral health needs. The Task Force acknowledges the importance of child and adolescent behavioral health care prevention, early intervention and treatment as a critical strategy for a healthy adult population. Additional work in this area is appropriate. The report also does not address substance use disorder treatment and the Task Force acknowledges that a significant number of ED patients present with substance use and/or behavioral health issues.

The report is focused on local and regional advocacy opportunities. The Task Force acknowledges the constraints of state and federal laws and regulations. The Hospital Council works closely with California Hospital Association to address state and federal behavioral health issues.

To support this work, the overarching recommendations include:

- Adopt an *Acute Ambulatory Model* approach by identifying alternative levels of care and integrated programs within and across counties.
- Standardize behavioral health personnel training for 5150 involuntary holds within and across counties to remove barriers to timely and appropriate access to care.
- Identify opportunities to share medical records within regions to allow for longitudinal case management for individuals requiring behavioral health services.
- Convene or support community collaboratives (counties, cities, agencies, elected roles, police, fire, EMS, physicians, hospitals, housing advocates and more) to identify solutions to access, care coordination and funding barriers to integrated care; secure resources; and execute implementation plans for those solutions.
- Integrate behavioral and medical health services at care delivery sites where appropriate and feasible.
- Leverage existing resources to expand and further integrate community resources with hospital-based programs.
- Reform reimbursement systems to allow for innovations and alternative care models such as telehealth modalities, emergent psychiatric services, and partial hospitalization programs to more efficiently and effectively treat the behavioral health population.

It is important to acknowledge that hospitals treat inpatients who have both medical and behavioral health conditions. The complexity of these patients is challenging and will require all members of the care team to explore best practices, such as Alameda Health System's John George Psychiatric Pavillion Campus and Contra Costa Health Services, that more fully integrate medical and behaviorlal health care services in the acute care setting as primary care practices are integrating these clinical services in outpatient settings.

Process

This report describes the findings of the Hospital Council Behavioral Health Task Force (BHTF). The Behavioral Health Initiative has the following goals:

1. To improve the working relationship with county behavioral health departments by becoming a knowledgeable partner and resource.

2. Position Hospital Council staff to have the relationships, knowledge and influence necessary to implement anticipated recommenations made by California Hospital Association's Leading the Way initiative at the local level.
3. Enhance collaborative partnerships between counties and hospitals to promote mutual accountability for accurate and prompt reimbursement for patient care services.
4. Partner with willing local behavioral health departments to implement solutions associated with identified opportunities.

The Hospital Council Behavioral Health Task Force met four times between August and November 2017. The Task Force membership list, including consultant support, is attached as Appendix B.

Access to Services

The demand for mental health services is growing at an astounding rate. The rate of mental health and substance abuse-related ED visits in the United States increased 44.1 percent from 2006 to 2014, with suicidal ideation growing the most (414.6 percent increase in number of visits). Among mental health/substance abuse-related ED visits, alcohol-related disorders were the most frequent diagnoses in 2014 (1.5 million visits).[1] With this increasing need, the access to psychiatric and behavioral health services has become challenging across the care continuum. These challenges include access to the appropriate services, delays in transitions to other services and providers, and the complexity of insurance coverage (or lack of coverage) for required services. Hospital EDs present a special opportunity to treat the whole person, both their physical and emotional needs, and to reduce the inequities in treatment the larger delivery sysyem contraints foster. This section presents the challenges associated with access to care, and discusses the opportunities for collaborative solutions across the behavioral health care continuum.

The Right Time, the Right Provider, the Right Level of Care

The primary health care shortage has contributed to the increasing need for timely behavioral health care in our communities. Currently, patients with mental health needs often present to already over-crowded emergency departments, where they may wait for long periods of time for evaluations, dispositions and/or referrals to lower levels of care or the community resources, or are sometimes admitted due to lack of alternatives. The fragmented and inconsistent interpretations and applications of the Lanterman-Petris-Short (LPS) Act by California's 58 counties contribute to this problem. LPS has led to a rising and often inappropriate dependence on hospital emergency departments to care for this population, without concomitant resources.[2]

Connecting patients with proper services and providers in a timely fashion can be challenging and convoluted. Community resources, if and when they are available, are not always seen as viable options, and there is a general lack of awareness of what resources exist and who might be eligible. Patients

living with chronic medical conditions are often denied access to behavioral health programs due to their medical needs, despite effective self-management of their illness. Furthermore, providing the right care by the right providers is impacted by the nationwide shortage of psychiatrists and other mental health professionals.

Variances for placing/discontinuing Involuntary Holds

The LPS Act currently lacks guidance for non-LPS designated facilities involved in an involuntary hold, resulting in wide variations in the application of the law across counties, cities, and even across hospitals. The LPS Act was created 48 years ago and set the precedent for modern mental health commitment procedures in the United States. However, many of these procedures no longer align with current care delivery models. While the California Legislature considered modernizing the LPS Act last year in Assembly Bill 1300, it ultimately did not enact that legislation. Accordingly, there continue to be ambiguities in various aspects of the LPS Act, which leads to variations in the interpretation of requirements.

Training and certification for 5150 involuntary placement and discontinuation has not been standardized, contributing to inconsistency by which these 5150 holds are placed and discontinued across care settings. Variations exist associated with the current process for LPS training. Variances may include in-person attendance requirements for training and extended timeframes to complete content. Scheduling LPS training can also be a protracted process. Hesitancy of ED physicians and providers to lift involuntary hold status may exist, despite completion of training and certification. The absence of psychiatric expertise can contribute to liability concerns for ED physicians and providers. It is important to note that a significant number of 5150 involuntary hold patients seen in EDs have substance use or substance use and mental health issues. This report does not cover substance use disorder treatment.

Service Delivery Challenges and Addressing Vulnerable Populations

Traditional behavioral health resources are often available to a limited subset of individuals with mental health illness and needs. In the current system, a large population of those experiencing mental illness also experience other conflicting priorities and issues and fall through the gaps in care. Populations that often get displaced in traditional care models include homeless patients with psychiatric needs, children and adolescents with psychiatric illnesses, the incarcerated population, and individuals with mild psychiatric conditions. The more complex the individual's personal situation, the more likely they are to fall through the gaps in care.

Local Advocacy Opportunities

Access to care opportunities for advocacy to explore may include:

Opportunity 1.1 Funding and Access to Emergency Services

1.1.1 The bifurcation of payment for emergency psychiatric services based on the severity of patient's mental health condition and whether the patient is admitted to an inpatient bed, among other factors, is outdated. This leads to disparities between payment for emergency psychiatric services and emergency medical services, which may violate a number of federal laws, such as the Mental Health Parity and Addiction Equity Act (MHPAEA) and federal Medicaid managed care rules. In addition, this byzantine system may create financial incentives for Medi-Cal managed care plans and County mental health plans to act in ways that preserve their resources

at the cost of the best interests of the patients. Three-way behavioral health contracts between providers, County mental health plans and Medi-Cal managed care plans may provide increased coordination of care while removing these financial incentives.

1.1.2 Hospitals and counties can align the provision of emergency-trained psychiatric providers to treat and stabilize patients suffering from an emergent psychiatric condition. The emergency psychiatry model can be created through a partnership between hospitals and counties. The space and staffing for the outpatient unit can be provided by the hospital. Reimbursement for crisis stabilization services can be considered by the county, utilizing the Medicaid crisis stabilization billing code. The availability and access to an emergency psychiatric evaluation, initiation of treatment, and effective medication management could lead to the discontinuation of involuntary hold status for many patients, providing the ability to successfully return to services in their community. This approach can contribute to a significant reduction in the need for inpatient admissions, resulting in an increase of available inpatient beds for patients that cannot be stabilized in the emergency setting. Immediate access to evaluation and treatment by a psychiatrist reduces ED boarding time, improves patient care delivery and contributes to county cost savings associated with reduced inpatient admissions.

Opportunity 1.2 Reduce Variance of 5150 Involuntary Holds

1.2.1 Currently, 5150 data tracking within hospitals is often a manual process. Data is not shared across regions, counties, outpatient programs nor primary care providers. There are opportunities for hospitals and counties to create standardized 5150 data tracking and exchange of patient care documents. Data sharing with community providers would contribute to customizing patient care plans and care coordination between hospitals and community services. See Opportunity 2.3 for additional details.

1.2.2 Federal EMTALA law defines hospital emergency department (ED) psychiatric patients meeting 5150 criteria as having an emergency medical condition just like heart attacks and car accidents, which requires a full screening examination and stabilizing treatment to the capability of that ED. Thus, the Emergency Physicians (EPs) in these settings have a federal requirement to evaluate and treat these patients. Hospital EDs and ED physicians are bound by federal EMTALA laws requiring a patient be stabilized prior to discharge, and therefore cannot legally discharge a patient in which they disagree with a decision made by a county outreach/mobile personnel on discharge of a mental health patient. Hospitals and counties could adopt 5150 policies to align hospital EMTALA obligations with 5150 requirements with respect to initiation, evaluation and discharge of holds, including a procedure which permits hospitals and providers to appeal a determination to a supervisory level.

1.2.3 Encourage counties to utilize alternatives to 5150 holds, such as 1799 holds, when possible. Under California Health & Safety Code section 1799.111, a licensed general acute care or acute psychiatric hospital (including its ED) that is not a county-designated facility under 5150 may hold a person that "presents a danger to himself or herself, or others, or is gravely disabled" for up to 24 hours while awaiting transition to an appropriate behavioral health care facility. Counties could permit designated ED physicians to initiate 5150 holds on patients whose 1799 holds are expiring when the standard county mechanism for 5150 initiation will not be available in a timely fashion.

1.2.4 Welfare and Institutions Code section 5121 authorizes county behavioral health directors to establish the procedures for the designation and training of professionals to perform functions under section 5150. However, this has resulted in a fragmented system in which designated staff in one county may not perform 5150 functions in a neighboring county. Counties could explore coordinating with neighboring counties to create uniform designation and training of professionals, so that professionals who have undergone training and received certification in one county can be authorized in the neighboring county. This can increase the coordination of care between the counties and expand the county's access to providers, thus improving the ability to provide the correct level of care.

1.2.5 Hospitals and counties can advocate for standardized application of the LPS law throughout California. Hospitals and counties could identify areas of ambiguity in the current LPS law that can be shared with their respective statewide associations to the extent that a legislative effort like AB 1300 is considered in the future.

Opportunity 1.3 Address Workforce Shortages

1.3.1 Given the recognized shortage of Psychiatrists across California, especially Psychiatrists well-trained in Emergency Psychiatry, one way to maximize emergency patient access to Emergency Psychiatrists is via telepsychiatry for examinations required under 5150 involuntary holds. A team of telepsychiatrists could potentially perform examinations as needed in many institutions throughout the state, across county lines, in a cost-effective fashion. However, presently this option is stymied by inter-county variances in regulations and authorizations, designations, and training requirements for psychiatrists to be involved in 5150 cases, as well as ambiguity as to whether telepsychiatry can constitute "personal observation" necessary to lift 5150 holds. There is an opportunity to pilot this model between inter-related counties and/or counties with limited access to psychiatrists. Securing reimbursement for telepsychiartry is also an opportunity.

1.3.3 Ensuring reimbursement for alternative behavioral health treatment modalities may also address workforce shortages. The California Mental Health Parity Act and federal Mental Health Parity and Addiction Equity Act require health plans and insurers in California to provide equivalent coverage for mental health and medical health benefits. Local providers may coordinate with health plans and insurers to educate them about the full spectrum of mental health services, how they connect to provide a full spectrum of services, and the resources required to render different levels of mental health services.

Care Coordination

There is an opportunity to streamline care coordination to support safe, efficient patient movement through various support services within the counties. In alignment with CHA's "Leading the Way" initiatives, the goal is care coordination to meet the needs of the patient at any point of entry, providing access to the right care, at the right time by the right provider.

Fragmentation of Medical and Behavioral Care Models

As discussed above, both state and federal law require parity between medical and mental health services. However, despite frequent co-morbidity between medical and mental health conditions, the

two delivery systems often operate separately. The shift to multi-disciplinary, integrated care that addresses both medical and behavioral issues is slow and difficult due to a variety of challenges, such as a lack of sustainable funding, infrastructural issues, and difficulty operationalizing behavioral health principles into a redesigned care system. The notion that behavioral health needs are different from, or secondary to, medical health needs remains at the center of these challenges.

Access to Patient Health Records

The lack of access to patient health records results in duplicative efforts in care delivery, prevents access to effective interventions and established providers and services, and ultimately contributes to lack of efficiency in care delivery and diminished patient outcomes. Research has shown that longitudinal case management for behavioral health patients leads to better patient outcomes. However, case management relies heavily on the tracking of pertinent information such as a summary of patient medical and medication history, visits, treatments started, etc. The inability for electronic medical records across hospitals and county programs to communicate with each other, and track these vital components of case management, creates significant barriers to effective care management. Currently, county mental health records, primary care and hospital health records are not generally shared or accessible to providers.

Aligning Behavioral Health Priorities

Another challenge to coordinating care is the alignment of behavioral health priorities across services. Hospitals and other stakeholders are inundated with the population of behavioral health patients presenting to hospitals that often do not have the capacity or resources to assess the population as a whole and determine what appropriate interventions look like. Long-term behavioral health strategies need to take more of a population health approach to identifying interventions. That is only possible with shared data on what types of patients are coming in, what their needs are, etc. This is different than the patient-level data discussed in the previous challenge because it focuses on identifying resource and intervention needs for the population as a whole. The county is in the best position to collect, house, and convene stakeholders to discuss impact of the data.

Providing Effective Communications for Limited English Proficient and Disabled Patients Seeking Mental Health Care

Under the Civil Rights Act of 1964 and section 1557 of the Affordable Care Act, and their respective implementing regulations, all mental health providers receiving federal funds are required to ensure effective access to limited English proficient and disabled patients through interpretation or other means. This can be a special challenge for mental health providers because of the perceived lack of qualified interpretation services specializing in mental health communications. Effective interpretation for these patients requires understanding the presentation of mental health and medical health conditions, as well as culturally responsive communication of information.

Local Advocacy Opportunities

Coordination of care opportunities to explore may include the following:

Opportunity 2.1 Medical and Behavioral Health Integration

In order to effectively treat the whole person, primary care must build high-functioning practice teams and seamlessly integrate behavioral health capacity into the team.

2.1.1 Create an integrated model for provision of medical and behavioral health care among hospitals, counties, payers and contracted primary care providers.[3]

2.1.2 Adopt new Medicare & Medicaid (CMS) Physician Fee Schedule codes that support integrated care. This provides an opportunity to identify primary care practices interested in performing behavioral health integration services for Medicare beneficiaries.[4] Provision of behavioral health services within primary care practices can contribute to ease of access for patients and increased occurrences of follow up for mental health needs associated with the trusting relationship established with the primary care provider.

Opportunity 2.2 Expanding Care Delivery

2.2.1 Counties are encouraged to consider "embedding" county crisis personnel within local hospital EDs with high mental-health emergency patient utilization for assistance with interventions and dispositions.

2.2.2 Consider use of Psychiatric Advanced Providers available on field transports, home visits, mobile clinics etc. The utilization of Advanced Providers in this capacity provides clinical expertise to evaluate and triage patients to the correct level of care prior to transporting to the ED, which promotes care delivery in the community setting, including at home.

2.2.3 Both County mental health plans and Medi-Cal managed care plans have care coordination obligations for Medi-Cal patients, especially for children. As part of the execution of these responsibilities, counties could consider facilitating "case conferences" between county mental health and hospital/ED personnel regarding high-utilizer individuals to create individual-specific care plans for future encounters. This will assist these individuals obtain the necessary services they require in the appropriate setting.

2.2.4 Continue to create Community Collaborative models involving hospital and county leadership, county providers, elected officials, law enforcement and jail representation as participants in the collaborative efforts. The broad range of stakeholders is vital to the success of these models. Through effective utilization of existing resources, shared data, and shared risk, countywide solutions for access to care and care coordination can be achieved. Collaborative models have been successful in Sacramento, Santa Clara, Solano, San Joaquin, Fresno, San Francisco, San Diego County, Orange County. Examples of other Community Collaborative efforts include Sacramento and San Luis Obispo counties. Innovation grant funds from the state Mental Health Services Oversight and Accountability Commission provide opportunities to pilot new care coordination programs.

2.2.5 Promote expanded funding for Partial Hospitalization Programs (PHPs) and Intensive Outpatient Programs (IOPs), which provide early intervention and wrap-around services to

support clients at a lower level of care and reduces reliance on EDs. Benefits include coordinated care with established providers to reduce potential emergent needs, improved coordination and integration of behavioral health services into the Acute Ambulatory Care Model.

2.2.6 Hospitals and counties can advocate for inclusion of wrap-around services in affordable housing initiatives. Combining affordable housing programs with wrap-around services that provide social services, wellness initiatives, and medical care increases the effectiveness of both programs. Opportunities for provision of care at home could result in a decreased volume of homeless individuals presenting to EDs to meet basic needs. Hospital systems have initiated funding housing options for homeless individuals.[5]

2.2.7 Promote the creation of sobering centers in all counties. Counties are encouraged to develop voluntary sobering centers for intoxicated individuals needing a safe environment to detoxify rather than utilizing acute emergency medical services. The centers can be a low-cost investment to provide an option for reduction in utilization of emergency room services for non-emergent needs. Full utilization of sobering centers may require approval by the Office of Statewide Health Planning and Development to allow ambulance transportation of non-emergent patients to sobering centers, consistent with medical standards and protocols.

2.2.8 Counties and health systems can co-sponsor staff training for agitation management, de-escalation, and treatment of behavioral health patients in all settings. In addition, counties and hospitals can promote the use of de-escalation training courses provided by the Hospital Council-endorsed business partner. Benefits would be realized by all parties caring for the behavioral health population. In addition, improving the method of care for patients with behavioral health needs will de-stigmatize perceptions about mental illness and promote new methods care delivery.

2.2.9 Develop a process to enable health plans and counties to share providers, allowing patients with moderate mental health conditions that need to move between the Medi-Cal Managed Care Plan (MMCP) and the Mental Health Plan (MHP) to stay with the same provider.

2.2.10 There is an opportunity for hospitals, counties and their communities to advocate for high school curriculum to include mental health education, prevention and mentorship focus. The School-Based Adolescent Mental Health Programs model actively engages educators, parents and students through early intervention, active family involvement and peer mentorship. Academic credits are provided to students enrolled in the program.[6]

Opportunity 2.3 Health Record Integration

2.3.1 Advocate for effective implementation of AB 1119, effective January 1, 2018, which permits hospital providers to promptly obtain County mental health records for patients who cannot provide consent, especially previous diagnoses and pharmacy records, and to speak directly with patients' mental health providers.

2.3.2 County and hospital involvement in HIE integration efforts allow interface exchange with county services, hospitals, primary care providers, payers, pharmacies, and patient portals as a tool for centralized care coordination including enhanced communication exchange between providers and clients. HIE integration can address inter-county needs associated with a population that is often mobile. In addition, an HIE would provide crucial information to inform all care providers regarding efforts to address the opioid crisis. Increased communication between behavioral health and medical health care teams may help reduce the stigma associated with mental illnesses, enable greater care coordination and impact effective management of comorbidities. Due to the magnitude of comprehensive integration, consider pilot models with selected counties and health systems, e.g. Sacramento's efforts.[7]

2.3.3 Health information exchange challenges between hospitals and county providers can be reduced through the use of tools such as the EPIC community portal or the Emergency Department Information Exchange (EDIE). EDIE is endorsed by the American College of Emergency Physicians (ACEP) due to its proven ability to improve patient outcomes by reducing the risk of emergency department visits and avoidable readmissions for high-risk patients with complex needs.[8] The functionality associated with EDIE includes provision of comprehensive patient health records, identification of current care providers, and can include specialized treatment plans identifying successful interventions to be considered for patient care. In addition, patient medication regime and prescription history are available within EDIE.

Key Funding Streams

A complicating factor to the expansion of behavioral health integrated services summarized above is the complexity of funding for integrated health services. The creation of a simplified funding process could augment efforts to enhance care coordination, providing an opportunity to address both medical and behavioral health needs and more effectively treat the whole person. The following section provides an overview to the funding challenges that exist with current models, and advocacy opportunities for optimizing funding streams.

Funding Challenges

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires states to provide certain services, including mental health services. As discussed above, the MHPAEA requires that California cover mental health services to the extent that comparable medical health services are covered. MHPAEA further prohibits a state from imposing quantitative and non-quantitative restrictions on mental health services that are not imposed on medical health services.

The current funding model is a bifurcated system that contributes to siloed care delivery. The system designates responsibility for the medical health and "mild-to-moderate" mental health conditions of Medi-Cal beneficiaries to Medi-Cal managed care plans (MMCPs) and responsibility for providing services for "severe mental illness" to county specialty mental health plans (MHPs). As with the Medi-Cal program, generally, these mental health services are funded by state monies matched by federal funds. MHPs are paid by the federal share of county expenditures. Counties derive the state share for MHP expenditures from a combination of State realignment funds; State managed care allocations, State General Fund (SGF), Mental Health Services Act (MHSA) funds, local county funds and other sources such as grants. MMCPs receive a capitation payment for each patient they serve, which is funded in part by fees imposed on managed care plans, hospitals and others.

Likewise, while both federal and state law require commercial health plans and insurers to provide parity for mental health services, many mental health providers continue to perceive that many health plans and insurers fall short of this requirement. This continues to be an issue investigated by enforcement agencies and pursued by patients and providers in litigation.

The reimbursement for mental health care provided to undocumented immigrants is another unique challenge. Uninsured immigrants have fewer choices, particularly for ongoing medical needs. Undocumented immigrants are not eligible to buy marketplace health coverage such as Covered California, or for premium tax credits and other savings on marketplace plans. Medi-Cal coverage for undocumented is limited.

Certain providers, including many primary care clinics and hospital emergency rooms, will render services regardless of ability to pay or immigration status. However, maintaining access beyond episodic care is challenging. Some people are able to get those services through individual physicians, safety-net hospitals, community health centers or other charitable organizations.[9]

Pay for Performance

The upcoming transition to reimbursement based upon pay for performance also contributes to the funding challenges. Highlights from CMS Medicare-Medicaid quality programs include:

- When finalized, the Outpatient Quality Reporting (OQR) Proposed Rule will include the new ED core measure "Median Time from ED Arrival to ED Departure for Discharged Psychiatric/Mental Health Patients" and will start being publicly reported as early as July 2018, utilizing 2017 Q4 data collection.
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) and (Hospital Based Inpatient Psychiatric Services (HBIPS) continue to add more measures focusing on transitions of care and readmissions:
    - (A) New for 2017: Transition record received by discharged patients
    - (B) New for 2017: Timely transmission of transition record (to follow-up providers)
    - (C) New for 2017: 30-day all-cause readmission measure (readmit to inpatient psychiatric facility or acute care hospital)
    - (D) Slated for 2018: Medication continuation 30 days post discharge for bipolar or schizophrenia patients.[10]

Understanding Memorandums of Understanding (MOUs) Between Counties and Plans

In each county, the MHP and Medi-Cal Managed Care Plans (MMCP) are required in their respective contracts with Department of Health Care Services to have a memorandum of understanding (MOU) specifying roles and responsibilities for coordinating the delivery of medically necessary mental health services. The MOU between the MHP and the MHP can be vague and overly general which contributes to the lack of clarity and direction. Consequently, coordination efforts between the plans has been limited.[11]

Local Advocacy Opportunities

Key funding stream opportunities to explore may include:

Opportunity 3.1 Funding

3.1.1 Local communities may explore additional sources to fund the state share for MHP expenditures. Federal law establishes strict requirements on using provider taxes or bona fide donations for the state share of Medicaid funding.

3.1.2 Any effort to consolidate the responsibility for delivering the full range of Medi-Cal mental health services, inclusive of mild, moderate and severe, within a single entity will have to address the source of state funds into a capitated approach. There could be benefits from integrating these programs, such as the integration of mild, moderate and severe mental health services as well as the integration of mental and physical health.[12]

3.1.3 If hospitals are willing to initiate and fund onsite emergency psychiatric programs such as hospital-based Crisis Stabilization units, County mental health plans may contract with hospitals for patients treated in these programs under Medi-Cal Specialty billing codes.

3.1.4 Mental Health Services Act (MHSA) funds can be utilized by counties for innovative projects, and are a relatively flexible funding source. MHSA funds are an opportunity to take advantage of opportunities for collaboration, including community involvement. MHSA funded projects require approval by the Mental Health Oversight and Accountability Commission. Approved projects must be time limited and can only be used for innovative programs, not for routine services. Within these restrictions, Counties could use MHSA funding to pursue integration strategies between counties, hospitals and other community stakeholders.

3.1.5 Implement "No Wrong Door: Pay and Chase" policies. Currently, neither MMCPs nor MHPs have a financial incentive to quickly resolve disagreements in coverage for a patient. Advocacy for this option prevents the patient from experiencing a protracted waiting period during a dispute between MMCP and MHP.[13]

3.1.6 Quantify the cost of services per patient in the continuum of care where care coordination is provided by the two systems, MHPs and MMCPs. Use this information to determine potential cost savings in a more coordinated system as well as appropriate reimbursements.

Opportunity 3.2 Alternative Payment Options

3.2.1 Identify financing and risk sharing models that align incentives between plans, counties, and hospitals. Combining these multiple funding streams into a single capitated payment to a hospital partnering with physicians may create more stability in the overall system and may create incentives to provide non-acute mental health services to reduce emergency room visits.

3.2.2 Rewards and penalties attached to performance metrics and data sharing requirements could encourage plans and counties to pay for warm hand-offs of mental health patients transitioning between MMCPs and MHPs.[14]

3.2.3 The public reporting of quality measures contributing to pay for performance offers an opportunity for partnerships between counties and hospitals to align interventions and care coordination. This option could also include MHP primary care providers, structured as a pilot.

Opportunity 3.3 Creating Programs within Hospital Walls

3.3.1 Consider designation of space within the hospital setting as a Medi-Cal Level 3 program, providing counties onsite work space in the hospital. This designation will allow for stabilized ED patients to have ease of access to step down services, allowing the locus of control at the hospital rather than dependence on responsiveness and availability of county resources. Services provided at the designated site can be reimbursed by Medi-Cal.

Role sharing between hospitals and counties can build enhanced working relationships between care teams, timely coordination of patient transitions to community services, the opportunity for efficient patient record sharing, and enhanced opportunity for patient/family education about medication management. Hospital space can be provided for county providers, offering ease of access to patients and families by bringing services to patients and enhancing effectiveness of wrap-around services. Hospitals can include county providers as ED team members, providing the ability to partner with ED and psychiatric providers to ensure timely initiation of patient stabilization, treatment and discharge.

Opportunity 3.4 Improve MOUs and Contracts between Counties and Plans

3.4.1 State law includes many requirements for memoranda of understanding ("MOUs") between MHPs and MMCPs, covering care coordination, referrals, information sharing, and dispute resolution between MHPs and MMCPs. However, many MOUs fail to include all the subjects legally required to be included.[15] Hospitals could advocate for MHPs and MMCPs to review their MOUs, utilizing a public process that informs stakeholders of policy decisions that affect them.

3.4.2 Counties may publish MOUs on the internet, so that hospitals are aware of the delineation of responsibility between MHPs and MMCPs.

3.4.3 MMCPs and MHPs may further amend MOUs to coordinate payment obligations, especially since it may not always be clear to a hospital which plan is responsible to pay for a specific patient's care. To the extent that a hospital sends a claim to an MHP or MMCP that the recipient believes is the responsibility of the other plan, the recipient can agree to forward the claim to the other plan, similar to the requirement on health care service plans at California Code of Regulations, title 28, section 1300.71(b)(3), and then notify the hospital that it has forwarded the claim.

Conclusion

The issues confronting hospitals and health care systems arising from the increasing numbers and the unique needs of mental health patients entering the system are well known and well documented. What is not known is how to most effectively deal with this growing population and the demands they create for our communities, hospitals, integrated treatment options, staffing, and funding sources. At the local level, these needs are difficult to address due to limited funding, competing needs, competition within

the mental health community, community apathy or resistance to mental health programming, and a myriad of complicating political environmental factors. The opportunities for advocacy presented in this report lay the foundation for targeted community discussions when convening community stakeholders focused on improving care delivery to people living with mental illness.

Appendix A: Resources for Integrated Care

INTEGRATED CARE	
Program Name & Contact	**Description**
Primary and Behavioral Health Care Integration (PBHCI) Program, Substance Abuse and Mental Health Services Administration (SAMHSA) ✉ integration@thenationalcouncil.org	Provides support to communities to coordinate and integrate primary care services into publicly funded, community based behavioral health settings. Specific health indicators are collected and monitored in order to improve health outcomes. Eight CA sites are PBHCI Grantees: ▪ Alameda County Behavioral Health Care Services ▪ Asian Community Mental Health Services ▪ Catholic Charities of Santa Clara County ▪ County of Sonoma ▪ Didi Hirsch Community Mental Health Center ▪ Kedren Community Mental Health Center ▪ Mental Health Services, Inc. ▪ Monterey County Health Department ▪ Native American Health Center, Inc. ▪ San Francisco Department of Public Health ▪ San Mateo County Health System ▪ Tarzana Treatment Center, Inc. [16]
Alameda Health Consortium ✉ information@ alamedahealthconsortium.org	The Alameda Health Consortium provides coordination, training, and technical assistance to community health centers that are integrating behavioral health care with primary care services.[17]
Alameda Health System Karyn Tribble, PsyD, LCSW, Chief Administrative Officer, Behavioral Health Services	The Alameda Health System works in partnership with Alameda County Behavioral Health Care Services to facilitate patient assessment and treatment on site at Alameda Hospital.
Whole Person Care Program ✉ 1115WholePersonCare@dhcs.ca.gov	Medi-Cal 2020 waiver initiative that allows for coordination between physical health, behavioral health, and social services in order to improve health outcomes by identifying target populations, sharing data between systems, and coordinating care.[18] Approved counties include: Santa Clara, Contra Costa, San Joaquin, Alameda, Marin, and Monterey.[19]
Police/Mental Health Coordination Project Tracie Bussi *Project Coordinator* ✉ tbussi@crisisservices.org	Collaborative effort in Erie County, New York to increase collaboration and communication between law enforcement and mental health agencies in an effort to improve the quality of services to individuals with mental illness. Originally funded through a grant from the New York State Office of Mental Health, the PMHCP now receives continued support from the Comprehensive Psychiatric Emergency Program of the Erie County Medical Center.[20]

ValueOptions of California (800) 228-1286	A health care service plan, regulated by California Department of Managed Health Care, that consists of a health/substance use disorder ("MH/SUD") and employee assistance program ("EAP") services.[21] Effective June 2014, ValueOptions entered into an agreement with Kaiser Permanente to provide an alternative resource for outpatient mental health services for Kaiser Permanente in the Northern California region. The agreement is intended to provide Kaiser Permanente the capacity to provide temporary additional access for member in selected locations and who are referred to ValueOptions after triage by Kaiser Permanente of Northern California.[22]
Orange County Coalition info@coccc.org	A consortium of safety net providers and key partners committed to supporting its members through service, education, advocacy and resources by increasing access to care, championing the role of community health centers, and raising the coalition's profile among policy makers.[23]
Improving Mood-- Promoting Access to Collaborative Treatment (IMPACT) Program uwaims@uw.edu	Primary-care based integrated approach to treating depression in older adults. A team consisting of a trained primary care provider, the patient, a care manager, and an embedded consulting psychiatrist screen patients and develop treatment plans based on evidence-based practices.[24]
PARTIAL HOSPITAL PROGRAMS	
Association for Ambulatory Behavioral Healthcare Paul Raines, RN, MSN *President, St. Joseph's Behavioral Health Center* paul.rains@dignityhealth.org	A conduit for best practices, advocacy, support, and networking built to promote Partial Hospitalization and Intensive Outpatient Programs as a vital component of the Behavioral Healthcare Continuum.
Adult Mood Program at El Camino Hospital (866) 789-6089	Provides short-term treatment, consisting of partial hospitalization (up to six hours a day) and intensive outpatient (three hours a day) treatment programs, for people experiencing significant mental health mood symptoms.
COMMUNITY RESOURCE	
Clubhouse International info@clubhouse-intl.org (212) 582-0343	Clubhouses offer people living with mental illness hope and opportunities to achieve their full potential. Programs include education, employment, and social activities. The personal stories of members and their families and an increasing body of research provide evidence that Clubhouses provide a holistic, inspiring and cost-effective solution to people living with mental illness. Northern California Clubhouse International: Putman Clubhouse, Concord, CA, www.putnamclubhouse.org California Clubhouse, San Carlos, CA, www.californiaclubhouse.org [25]

HOMELESSNESS & SUBSTANCE ABUSE	
Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States) ✉ homelessprograms@samhsa.hhs.gov	CABHI programs are competitive grant programs, jointly funded by the SAMHSA Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) that support state and local community efforts to provide behavioral health treatment and recovery-oriented services for the chronically homeless.[26]
California Proposition 47 ✉ Prop47@bscc.ca.gov	CA grant to provide people in the criminal justice system with mental health services, substance use disorder treatment, and diversion programs, as well as other community-based supportive services.[27] Counties and agencies are applicants for funding or have been rewarded funding, in order to improve their behavioral health services and programs. Counties and programs include: ▪ Alameda County Health Care Services Agency ▪ Butte County Probation Department ▪ Contra Costa Health Services Department ▪ Fresno County Depart of Behavioral Health and the City of Parlier ▪ Kern County ▪ Marin County Health and Human Services ▪ Monterey County Health Department, Behavioral Health Bureau ▪ Sacramento County Department of Health and Human Services, Division of Behavioral Health Services ▪ San Francisco Department of Public Health ▪ San Joaquin County Behavioral Health Services ▪ Santa Clara County ▪ Santa Cruz County Sheriff's Office ▪ Santa Cruz County Superior Court, Watsonville Police Department ▪ Shasta County Probation Department, ▪ Solano County Department of Probation ▪ Sonoma County Department of Probation[28]
No Place Like Home Program ✉ NPLH@hcd.ca.gov	California state initiative that assists local communities by investing in the development of permanent supportive housing for persons in need of mental health services experiencing homelessness. Counties compete with similar sized counties for up to $2 billion in bond proceeds for multiple funding rounds.[29]
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Reed Forman *Lead Public Health Advisor* ✉ Reed.Forman@SAMHSA.hhs.gov (240) 276-2416	An integrated approach to the delivery of early intervention and treatment services for persons with substance use disorders by primary care centers, hospital emergency rooms, trauma centers, and other community settings.
BayMark Health Services (415)552-7914	BayMark Health Services is a specialty health care organization providing evidence-based, individualized treatment services to individuals addicted to opioids. Site locations include the following:

	Antioch, Fairfield, Fresno area (multiple locations, Hayward, Menlo Park, Oakland, Richmond, Sacramento area (multiple locations, San Francisco (multiple locations), Stockton, Vallejo, Visalia.[30]
Aegis Treatment Centers ✉ info@aegistreatmentcenters.com ✆ (818)206-0360	Aegis Treatment Clinics utilize an evidence-based multi-disciplinary, holistic treatment model. Clinic services are located in 15 counties, 100 communities. Northern California locations: ▪ Aegis Redding ▪ Aegis Chico ▪ Aegis Modesto ▪ Aegis Fresno ▪ Aegis Roseville ▪ Aegis Stockton ▪ Aegis Marysville ▪ Aegis Manteca ▪ Aegis Lodi ▪ Aegis Stockton (5th Street) ▪ Aegis Stockton (California Street ▪ Aegis Redding (Hartnell Ave.) Central California locations: ▪ Aegis Santa Barbara ▪ Aegis Atascadero ▪ Aegis Bakersfield (Columbus Street) ▪ Aegis Delano ▪ Aegis Bakersfield (21st Street) ▪ Aegis Santa Maria ▪ Aegis Merced[31]
Bright Heart Health ✆ (844) 884-4474	Bright Heart Health is an example of mobile health care delivery, augmenting services provided in the ED setting. ED providers can safely administer the initial dose of Suboxone (buprenorphine and naloxone), follow up including rapid access to an Addiction Specialist for continued care in the setting most convenient for the client, via video conferencing. Federal funding for opioid interventions may be considered for mobile health care models.[32]
Project ECHO: University of New Mexico ✉ echo@salud.unm.edu ✆ (505)750-3246 (ECHO)	ECHO model™ is hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. Primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities. ECHO provides training in opioid addiction treatment at no cost, delivered to clinics. The ECHO program serves federally-qualified health centers, with a special focus on those that received the Substance Abuse Service Expansion awards.[33]

CHILD & ADOLESCENT SERVICES	
After-School Program Interventions and Resiliency Education (ASPIRE) Program (866) 789-6089	El Camino Hospital in Mountain View has launched an after-school program for teenage youths who are experiencing significant anxiety, depression, or other symptoms related to a mental health condition. The primary goal is to help adolescents achieve emotional wellness and reduce risk for unhealthy behaviors while also receiving school credit. ASPIRE is supported by donations to El Camino Hospital as well as reimbursement from payers.[34]
Project Advancing Wellness and Resilience Education (AWARE) NITT-TA@cars-rp.org (844) 856-1749	A grant program designed to help state and local education agencies promote youth mental awareness among schools and communities to improve connections to services for school-age youth.[35]
HEALTH INFORMATION EXCHANGE	
Behavioral Health Data Exchange Consortium John Rancourt *Deputy Director, Office of Care Transformation* John.rancourt@hhs.gov	Secure interstate exchange of behavioral health records among treating health care providers using Direct protocols.[36]
OCPRHIO info@ocprhio.org (714) 884-4441	Southern California community collaboration of health care providers to facilitate Health Information Exchange (HIE) exchange in California. Participants include hospital systems, medical centers, and federally qualified health centers (FQHCs) across California.[37]
Oregon Emergency Department Information Exchange (EDIE) OHIT.Info@state.or.us (503) 373-7859	Partnership between Oregon Health Authority and Oregon Health Leadership Council that provides emergency departments with real-time notifications and key care summaries for patients who visit the emergency department frequently, with the goal of reducing avoidable hospital utilization and improving health outcome at Oregon's 59 hospitals.[38]

PreManage ✉ info@orhealthleadershipcouncil.org	Complement's Oregon's EDIE (Emergency Department Information Exchange) that allows hospital event information (ED and Inpatient admissions and discharges) to be sent real time to health plans, CCO's (Coordinated Care Organization) and provider groups on a real-time basis for specified member or patient populations. Information sharing contributes to better patient outcomes, reduction in readmissions, and lower ED and laboratory costs.[39] Northern/Central CA hospitals and health systems utilizing EDIE: ▪ Anthem ▪ Adventist Health System ▪ Alameda Health Services ▪ Chinese Hospital ▪ Community Hospital of the Monterey Peninsula ▪ Contra Costa County ▪ Fairchild ▪ Modoc ▪ St. Joseph's Health ▪ Sutter Health System ▪ UCSF Health System ▪ Watsonville ▪ Zuckerberg San Francisco General Hospital and Trauma Center
Health Information Exchanges in California https://www.worldprivacyforum.org/2013/08/hie/	Map of HIEs in California.
SACVALLEY MEDSHARE ✉ https://sacvalleyms.org/about-us	Mission: To improve the quality and safety of healthcare across the North Central Valley, by sharing health information in a secure and efficient fashion between all providers, facilities and patients. Participating members: Individual Acute-Care Hospitals, Hospital Systems, Critical Access Hospitals, Tribal Healthcare, Federally-Qualified Healthcare Clinics, Private Medical Clinics, Imaging Centers and Laboratories. Counties covered: Siskiyou, Modoc, Trinity, Butte, Plumas, Shasta, Lassen, Tehama, Plumas, Butte, Yuba, Sutter, Colusa, Glenn

ConnectHealthcare Lyman Dennis, Executive Director Ldennis@connecthealthcare.org https://sacvalleyms.org/about-us (707) 863-0130	Mission: To provide seamless health information among providers, facilities and patients to enhance the safety and effectiveness of healthcare across our service area. Participating members: Adventist Health, St. Joseph Health System, NorthBay Healthcare, Partnership Healthplan of California, Redwood Community Health Network, Counties covered: Napa, Solano, Yolo, Sonoma.
PROFESSIONAL DEVELOPMENT	
Center for Integrated Health Solutions (CIHS) integration@thenationalcouncil.org (202) 684-7457	A SAMHSA program that promotes the development of Integrated primary and behavioral health services by providing training and technical assistance to community behavioral health organizations, community health centers, and primary care centers.[40]
Kognito At-Risk in Primary Care info@kognito.com	Online training simulation that teaches primary care providers to: 1) Screen patients using evidence-based tools to assess substance use and mental health 2) Engage in collaborative treatment planning with patients and build treatment plans that integrate mental health services; 3) Apply motivational interviewing techniques to build trust and increase patient adherence to treatment plans; and 4) apply best practices in follow-up care.[41]
Project ECHO: University of New Mexico echo@salud.unm.edu (505)750-3246 (ECHO)	ECHO provides training in opioid addiction treatment at no cost, delivered to clinics. The ECHO program serves federally-qualified health centers, with a special focus on those that received the Substance Abuse Service Expansion awards.[42]
EMERGENCY PSYCHIATRIC SERVICES	
Unity Center for Behavioral Health contact@unityhealthcenter.org (503) 944-8000	Provides 24-hour mental and behavioral health emergency services for adults and longer-term inpatient mental health care for both adults and adolescents. A care navigation team creates and coordinates an ongoing treatment plan to be utilized after discharge. Funded through private donation.[43]
Rideout Regional Medical Center Theresa Hyer, RN *Director of Emergency Services* Thyer@frhg.org	Rideout Medical Center, the sole provider for Yuba/Sutter counties, provides rapid medical evaluation/determination of stability, 24/7 access to Emergency trained tele psychiatrist, and onsite Crisis Worker team 24/7 to coordinate dispositions.[44] County mental health professionals work out of hospital ED for greater coordination resulting in improved patient and hospital outcomes.

Appendix B: Behavioral Health Task Force Members & Support 2017

BEHAVIORAL HEALTH TASK FORCE		
Contact	**Title**	**Organization**
Beckie Shauinger	Interim, Chief Executive Officer	Bakersfield Behavioral Healthcare Hospital
Rosemary Younts	Senior Director, Behavioral Health	Dignity Health - Sac Regional Office
Michael Fitzgerald, MS, RN, CS	Executive Director, Behavioral Health Services	El Camino Hospital
Mike Wiltermood	President/CEO	Enloe Medical Center - Esplanade Campus
Karyn Tribble, PsyD, LCSW	Chief Administrative Officer, Behavioral Health Services	Alameda Health System
Cindy Bolter, RN, MSN, MP-C	Chief Nursing/ Operations Officer	John Muir Medical Center - Walnut Creek Campus
Stuart Buttlaire	Regional Director of Inpatient Psychiatry and Continuing Care	Kaiser Permanente Northern California Region
Gary Gray, D.O.	Chief Executive Officer	Natividad Medical Center
Robert J. Wentz	President/CEO	Oroville Hospital
Michael Tou	Regional Director, Government Relations	Providence Health & Services - Southern California
Paul Rains, RN, MSN	President	St. Joseph's Behavioral Health Center
John W. Boyd, PsyD, MHA	CEO, System Mental Health	Sutter Center for Psychiatry
Gwen Matthews, RN, MSN, MBA	CEO/Senior VP, Adventist Health/ Northern CA Network	Ukiah Valley Medical Center/Adventist Health
Lynne Ashbeck	Senior VP, Community Engagement	Valley Children's Hospital
Alexander Hazel, DO	Medical Director, Behavioral Health	NorthBay
TASK FORCE SUPPORT	**PROVIDED BY:**	
Contact	**Title**	**Organization**
Scott Zeller, MD	Consultant	CEP America
Tami Longo	Consultant	CEP America
Felicia Sze	Partner	Rotenberg & Sze, LLC
Sheree Lowe	VP Behavioral Health	California Hospital Association
Art Sponseller	President/CEO	Hospital Council

Appendix C: Background on Funding Delivery System

The primary payers of mental health services in the State of California are commercial payers, Medicare and Medi-Cal.[45] This Appendix provides general background around coverage for mental health services from each of these payer types. In addition, this Appendix discusses the source of state funding for Medi-Cal coverage of mental health services, including funding for the Medi-Cal Managed Care Plan ("MCP") coverage of mild to moderate mental health conditions and funding for County Mental Health Plan ("MHP") coverage of serious mental health conditions.[46]

This Appendix also includes a description of other grant programs funding local mental health services, including the Mental Health Services Act, which comprises approximately one quarter of county mental health funding.

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1. Commercial Insurance

Commercial insurers are required to cover mental health services pursuant to several laws, most notably the California Mental Health Parity Act and the federal Mental Health Parity and Addiction Equity Act ("MHPAEA").

California enacted the California Mental Health Parity Act in 1999.[47] The California Mental Health Parity Act applies to health care service plans regulated by the Department of Managed Health Care, as well as health insurers regulated by the Department of Insurance. However, the California Mental Health Parity Act does not apply to certain categories of insurers operating pursuant to federal laws, which may preempt these state laws, e.g., health insurance products operating under the Employee Retirement Income Security Act of 1974 ("ERISA") or the Federal Employees Health Benefits Act of 1959.[48]

The California Mental Health Parity Act requires health care service plans and health insurers to "provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child… under the same terms and conditions applied to other medical conditions[.]"[49] The four categories of benefits required to be covered are: outpatient services, inpatient hospital services, partial hospital services and prescription drugs.[50] The terms and conditions required to be the same are maximum lifetime benefits, copayments, and individual and family deductibles.

In addition, Congress enacted the Mental Health Parity and Addiction Equity Act of 2008, which currently applies to group health plans, group health insurance coverage, and individual health insurance coverage.[51] Small group health plans are subject to the MHPAEA indirectly through the federal government's implementation of the essential health benefits requirement enacted in the Affordable Care Act. Through this, all ERISA plans that may not be subject to state laws become subject to the federal mental health parity requirement. Medicaid plans, discussed in detail below, are subject to some of the federal mental health parity requirements.[52]

Among other things, the MHPAEA requires a "group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits to ensure that: (1) the financial requirements, such as deductibles and copayments, applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan; (2) there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; (3) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan; and (4) there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."[53]

2. Medicare

a. Part A Inpatient Services

Medicare Part A covers inpatient mental health services. Inpatient services are restricted under Medicare to a lifetime cap of 190 days on services provided in a psychiatric hospital.[54] For services provided in a hospital or portion of a hospital not designated as a psychiatric hospital, service limitations are calculated based upon a maximum payable amount of 150-day per spell of illness.[55] The designation of all or a distinct part of a hospital as a psychiatric facility determines whether days spent there count toward these limits.[56]

b. Part B Outpatient Services

Medicare Part B pays for mental health-related professional services, including treatment from psychiatrists, clinical psychologists, clinical social workers, clinical nurse specialists, occupational therapists, nurse practitioners and physician assistants. Covered mental health services must be part of a physician-directed course of care, and "reasonable and necessary for the diagnosis or treatment of the patient's condition." [57] There are no strict limitations on duration of outpatient care, as long as a patient shows improvement in the course of care, and the treatment is provided in conformity with generally-accepted medical standards of care.[58]

In addition, Medicare Part B covers other outpatient mental health services, such as partial hospitalization services. Partial hospitalization is a structured form of outpatient services for patients requiring a minimum of 20 hours a week of therapy, but not requiring an inpatient admission.[59] Partial

hospitalization services are services that are "reasonable and necessary" for diagnosis or treatment; are "reasonably expected to improve or maintain the individual's condition"; are part of a physician's plan of care; and may include individual and group therapy, occupational therapy, social worker services, therapeutic medications, activity therapies, family counseling, patient training and education, and diagnostic services.[60] Prior to 2014, partial hospitalization for mental health services was subject to a limitation on payment that limited reimbursement to between approximately sixty-two and eighty-one percent. Beginning in calendar year 2014, Medicare Part B pays for 100% of partial hospitalization, subject to patient cost-sharing.[61] "Partial hospitalization services not directly provided by a physician" are not subject to treatment limitation.[62]

c. Medicare Advantage Plans

Medicare Advantage, or Part C plans, are offered by private insurance companies, and are subject to various sources of potential regulation. As an initial matter, Medicare Advantage plans must cover the same services as Medicare Parts A and B discussed above as part of their agreements with the Centers for Medicare and Medicaid Services. In addition, Medicare Advantage plans offered through an ERISA group (non-senior) are subject to Mental Health Parity and Addiction Equity Act of 2008.[63]

3. Medi-Cal Coverage for Mental Health Services

a. Enrollment of Beneficiaries in Medi-Cal Managed Care

The State of California implements the Medi-Cal program through its traditional fee-for-service program, as well as through contracting with other entities to provide or arrange for Medi-Cal benefits. Pursuant to the MHPAEA and its implementing regulations, the State of California is required to ensure parity for mental health services across the Medi-Cal program, i.e., regardless of whether a specific service is delegated to MCP or a MHP.[64]

The California Department of Health Care Services ("DHCS") contracts with both MCPs and MHPs to serve Medi-Cal patients. Specifically, DHCS contracts with MCPs to provide or arrange for care for the patients' physical conditions as well as for "mild to moderate" mental health conditions.[65] DHCS delegates payment for serious mental health services to MHPs.[66]

However, not all patients have been assigned to a health plan to receive healthcare services. For those patients excluded from these health plan contracts, DHCS continues to be responsible to pay providers for services through the fee-for-service program.

b. MCP Funding

California operates its MCP program pursuant to a waiver granted by the Centers for Medicare and Medicaid Services ("CMS") under section 1115(b) of the Social Security Act. CMS approved the current waiver, the Medi-Cal 2020 Demonstration, in 2015. The waiver is effective through December 31, 2020.

For the most part, MCPs are classified as managed care organizations ("MCOs") under federal law.[67] As MCOs, MCPs execute comprehensive risk contracts with the State of California whereby the MCPs agree to take on responsibility for specified categories of services, in exchange for the payment of a per member per month capitation rate. MCPs generally fund their payments to providers out of this capitation rate.

c. MHP Funding

California operates its Specialty Mental Health Services ("SMHS") program pursuant to the waiver granted by CMS under section 1915(b) of the Social Security Act. The current 1915(b) waiver program will be in effect from July 1, 2015, through June 30, 2020.

MHPs are classified as prepaid inpatient health plans ("PIHPs") under federal law, meaning that they provide services, including inpatient hospital or institutional services, to their enrollees without a comprehensive risk contract.[68] California's contract with the MHPs is on a non-risk basis. Pursuant to this arrangement, MHPs have not accepted risk for utilization fluctuations. Instead, the State reimburses the MHPs based on costs incurred by the MHP. The State does not contribute any of its own funds to the reimbursement to the MHPs; instead, it passes through the federal share of Medi-Cal certified public expenditures by the MHPs.

As the result of several realignments of funding and responsibility between the State and counties, counties rely on several sources to fund the state share of Medi-Cal spending for serious mental health conditions. One of the most convoluted sources of funding for counties are Mental Health Services Act (MHSA) funds, authorized by Proposition 63, discussed below.

4. Mental Health Services Act / Proposition 63.

In 2004, the California electorate passed Proposition 63, named the Mental Health Services Act. Beginning in 2005, the MHSA imposed a 1% tax on incomes above one million dollars annually to fund mental health services in the state. Between its inaugural year and present day, MHSA funds have grown from $254 million in the 2004-2005 fiscal year to nearly $1.8 billion in 2015-2016, accounting for nearly one quarter of the state's mental health services budget.[69]

MHSA funds are distributed from the Mental Health Services Fund directly to counties, based on a formula that compares population size, low-income households, need for mental health services, and other demographic data. Counties with population under 200,000 receive a flat rate. Counties must create a three-year plan for expenditure, and the county mental health director must certify compliance with all applicable laws through a letter to the Mental Health Services Oversight and Accountability Commission.[70]

a. Role of the Mental Health Services Oversight and Accountability Commission

The Mental Health Services Oversight and Accountability Commission ("the Commission") is responsible for administration of the MHSA, as well as the Adults and Older Adults Systems of Care Act; Human Resources; Innovative Programs; Prevention & Early Intervention Programs; and the Children's Mental Health Services Act.[71] The Commission works in collaboration with agencies and groups including the DHCS, the California Mental Health Planning Council, and the California Mental Health Directors Association, under the direction of the California Health and Human Services Agency.[72] The Commission not only administers MHSA funds, but also analyzes all aspects of mental health care delivery systems in the state, in an effort to improve and integrate services.

b. General MHSA Funds

The MHSA funds projects under five categories outlined in the Act: 1) community services and supports,[73] 2) prevention and early intervention, 3) innovative projects, 4) workforce education and training, and 5) capital facilities and technology needs.[74]

- Eighty percent of MHSA funding goes to community services and supports ("CSS"), to fund full service partnerships, general system development, outreach and engagement, and the MHSA Housing Program.[75]
- Twenty percent of MHSA funds are used for prevention and early intervention ("PEI"), with emphasis on recognizing early signs of mental illness, suicide prevention, stigma reduction, and access to care.[76]

- Innovative projects are funded through allocation of five percent of a county's CSS funds and five percent of PEI funds, to encourage development of new approaches to care.[77] Innovative projects must be approved by the Commission, and be completed within five years.[78]
- Funds for the final two categories, workforce education and training projects, and capital facilities and technologies projects, were disbursed between 2007 and 2009 and must be expended by the end of the 2017-2018 fiscal year.[79]

Funds may be used to "establish or expand mental health services and/or supports" in the county under each of the above categories. Each county's three-year County Plan proposing to fund such services must outline a community planning process that includes stakeholder input and diversity measures.[80] County-level program development and significant stakeholder involvement are critical components of MHSA projects, to ensure that services are tailored to the needs of particular communities.[81] Counties may also, at their discretion, use MHSA funds to provide Medi-Cal reimbursable services to eligible beneficiaries, though MHSA funds should not be considered a replacement for existing state or federal mental health funding streams.[82] Most funds received through MHSA must be used within three years, or returned to the state for reallocation.[83]

c. MHSA Administration and Special Project Grants

The state may reserve up to five percent of MHSA funds for administrative purposes.[84] These funds support the Commission, but are also distributed to projects throughout the state. In fiscal year 2016-2017, the state's administrative share funded staffing and research including Mental Health Court Projects in both juvenile and adult courts; special projects in the military department and Department of Veterans Affairs (DVA); and research through the University of California. It also funded staffing for integration of mental health services projects in several agencies including the Department of Public Health and the Department of Education.[85] MHSA administrative dollars also fund supplemental subgrants from agencies, created by subsequent legislation or as deemed necessary by the Commission. The primary grant programs are the Investment in Mental Health Wellness Program mobile crisis support team (MCST) and triage personnel grants,[86] and Department of Veteran's Affairs local county grants.[87]

5. Early Psychosis Intervention Plus (EPI PLUS) Program

Effective January 2018, the passage of Assembly Bill 1315 will create a new source of funding called the Early Psychosis Intervention Plus (EPI PLUS) Program. As of the publication of this report the parameters of EPI Plus funding were still being determined, and the potential funding levels remain quite low. It is included herein because its future development may be of interest to mental health providers. The EPI Plus Early Psychosis and Mood Disorder Detection and Intervention Fund is created through private funding, in addition to federal and state grants, under the oversight of an advisory committee to the Mental Health Services Oversight and Accountability Commission. With a beginning balance of $500,000 in private funds, the Fund will award competitive grants to counties and localities "to create, and to expand and improve the fidelity of existing, service capacity for early psychosis and mood disorder detection and intervention services in California," with a focus on youth and the use of innovative service models including school-based programs and social media campaigns. These grants will supplement rather than replace funding counties receive from other sources, such as the MHSA.[88]

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[46] Additional information about the history of the bifurcated delivery model for mental health services in California is available from various sources, including the 1915(b) Specialty Mental Health Services Waiver, available at http://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf. See also Sarah Arnquist & Peter Harbage, A Complex Case: Public Mental Health Delivery and Financing in California (July 2013) California HealthCare Foundation <http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ComplexCaseMentalHealth.pdf> (as of Dec. 4, 2017).

[47] Assem. Bill No. 88 (1998-1999 Reg. Sess.), codified at Health & Saf. Code § 1374.72 and Ins. Code § 10144.5.

[48] See *Brazil v. Office of Pers. Mgmt.* (N.D. Cal. 2014) 35 F.Supp.3d 1101.

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[50] Health & Saf. Code § 1374.72, subd. (b); Ins. Code § 10144.5, subd. (b).

[51] H.R. No. 6983, 110th Congress, 2d. Sess. (2008), codified at 42 U.S.C. § 300gg-26. The MHPAEA expands the protections previously enacted in the Mental Health Parity Act of 1996, which required annual or lifetime dollar limits on mental health benefits to be no lower than such limits on medical and surgical benefits.

[52] *See* 42 C.F.R. §§ 438.900, et seq.

[53] H.R. No. 6983, 110th Congress, 2d. Sess. (2008), Bill Summary, <https://www.congress.gov/bill/110th-congress/house-bill/6983> (as of Dec. 4, 2017).

[54] 42 U.S.C. §1395d(b)(3); 42 C.F.R. § 409.62 ("once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual").

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[58] 42 C.F.R. § 410.155; Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, Pub. 100-02, Ch. 6, §70.1.

[59] 42 C.F.R. § 410.43.

[60] 42 U.S.C. §1395x(ff); 42 C.F.R. §410.43.

[61] 42 C.F.R. § 410.155(a).

[62] 42 C.F.R. § 410.155(b)(2)(iii).

[63] See 81 Fed. Reg. 18390 (Mar. 30, 2016) ("Final Rule: Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans"); 42 U.S.C. § 300gg-26(a)(1).

[64] 42 C.F.R. § 438.920(b).

[65] See Department of Health Services, Medi-Cal Managed Care Division Policy Letter Number 00-01 (Mar. 16, 2000) <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2000/MMCDPL00001REV.pdf> (as of Dec. 4, 2017).

[66] *Id.*

[67] 42 C.F.R. § 438.2. While County Operated Health Systems are considered health insuring organizations under federal law, for the purposes of mental health service coordination, they are treated much like MCOs.

[68] 42 C.F.R. § 438.2.

[69] Mental Health Services Oversight & Accountability Commission, *Prop 63 / MHSA: History* (2017) <http://www.mhsoac.ca.gov/history> (as of Dec. 4, 2017).

[70] Welf. & Inst. Code § 5847; Cal. Code Regs., tit. 9, § 3310; *see also* Arnquist & Harbage, *supra*, at p. 19.

[71] Welf. & Inst. Code § 5845.

[72] Welf. & Inst. Code § 5845, subd. (d)(12).

[73] Contrary to some suggestions, under the community services and supports category, MHSA funds may be used to pay for inpatient services. Cal. Code Regs., tit. 9, § 3620, subd. (k) ("the County may pay for short-term acute inpatient treatment, for clients in Full Service Partnerships when the client is uninsured for this service or there are no other funds available for this purpose."). However, MHSA funds only may be used for voluntary care. Cal. Code Regs., tit. 9, § 3400, subd. (b)(2).

[74] Cal. Code Regs., tit. 9, § 3310, subd. (b).

[75] Department of Health Care Services, Mental Health Services Act Expenditure Report, Fiscal Year 2016-2017 (January 2016) p. 10, <http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSAExpend_Report_Jan2016.pdf> (as of Dec. 4, 2017).

[76] Mental Health Services Act Expenditure Report, Fiscal Year 2016-2017, *supra*, at p. 15; Cal. Code Regs., tit. 9, § 3705.

[77] Mental Health Services Act Expenditure Report, Fiscal Year 2016-2017, *supra*, at pp. 15-16; Cal. Code Regs., tit. 9, § 3930, subd. (d)(7).

[78] Cal. Code Regs., tit. 9, §§ 3905, 3910.010.

[79] Mental Health Services Act Expenditure Report, Fiscal Year 2016-2017, *supra*, at pp. 11-15. Funds allocated for capital facilities, technological needs, or education and training must be used within ten years. Welf. & Inst. Code § 5892, subd. (h)(1).

[80] Cal. Code Regs., tit. 9, § 3300.

[81] Cal. Code Regs., tit. 9, §§ 3300, 3310, subd. (b), 3400, subd. (a).

[82] California Department of Health Care Services, Section 1915(b) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs and FFS Selective Contracting Programs 2015-2020 (June 10, 2015) p. 29, <http://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf> (as of Dec. 4, 2017).

[83] Welf. & Inst. Code § 5892, subd. (h)(1). Under California Welfare and Institutions Code section 5892.1, all unspent funds as of July 1, 2017 that had not yet been returned were automatically determined to have reverted

and been re-granted to the same county – that is, counties may now keep such funds. If they do, by July 1, 2018, each county must submit to the state a plan to expend these funds before July 1, 2020.

[84] Welf. & Inst. Code § 5892, subd. (d).

[85] Mental Health Services Act Expenditure Report, Fiscal Year 2016-2017, *supra*, at pp. 17-35.

[86] The Investment in Mental Health Wellness Act of 2013 ("SB 82") directed a portion of the state's administrative MHSA funds to be used to expand facility and personnel capacity for state and local health departments. Competitive grants allocated under this Act focus on crisis intervention, stabilization, and treatment. Welf. & Inst. Code § 5848.5. These mobile crisis unit and triage personnel grant funds are administered by the California Health Facilities Financing Authority (CHFFA) Investment in Mental Health Wellness Grant Program, and are used to supplement rather than replace existing funding. Welf. & Inst. Code § 5848.5, subd. (d)(I)(4).

[87] County Veterans Services Offices (CVSO) may apply for funding to enhance or promote mental health services for veterans. Mental Health Services Act Expenditure Report, Fiscal Year 2016-2017, *supra*, at pp. 34, 39-41.

[88] Assem. Bill No. 1315 (2016-2017 Reg. Sess.) §§ 5835.3, subd. (a), 5835.3, subd. (g).