California Mental Health and Substance Use Needs Assessment

Draft 1/30/12

Submitted to:
The California Department of Health Care Services

Completed by:

Technical Assistance Collaborative

31 St James Ave, Suite 710

Boston, MA 02116

Human Services Research Institute

2336 Massachusetts Ave

Cambridge, MA 02140

Contact person: Suzanne Fields: sfields@tacinc.org

I.   EXECUTIVE SUMMARY

The California Department of Health Care Services (DHCS) contracted with the Technical Assistance Collaborative (TAC) and Human Services Research Institute (HSRI) (referenced throughout the report as TAC/HSRI), to conduct a Mental Health and Substance Use Needs Assessment (referenced throughout the report as the Needs Assessment) and to develop a Mental Health and Substance Use Service System Plan. The Needs Assessment was carried out to satisfy the Special Terms and Conditions required by the Centers for Medicare and Medicaid Services (CMS) as part of California's Section 1115 Bridge to Reform waiver approval.

The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medicaid recipients and identify opportunities to ready Medi-Cal, California's Medicaid program, for the expansion of enrollees and the increased demand for services resulting from health reform. While the report is focused primarily on the Medi-Cal mental health and substance use systems, our review also included analysis of data from the State's Department of Alcohol and Drug Programs' California Outcomes Measurement System Treatment (CalOMS Tx) database, and the Department of Mental Health's Client and Services Information (CSI) data set. This was done to provide a full picture of the behavioral health system in California.

In addition to analysis of the three major datasets listed above; site visits, focus groups and interviews with over 140 key informants were an important element of the information collection process. TAC/HSRI also collected and reviewed over 100 documents related to California's mental health and substance use service systems. These activities resulted in a comprehensive report focusing on the following areas:

- Estimation of the prevalence of mental illness and substance use disorders among the population of California; (Chapter III)
- Analysis of service utilization, expenditures, and service penetration rates for the Medi-Cal, Department of Alcohol and Drug Programs, and Department of Mental Health programs; (Chapters IV, V, VI)
- Projection of numbers for and characteristics of the 2014 Medi-Cal expansion population; (Chapter VII)
- Identification of issues related to certain special populations enrolled in the Medi-Cal program; (Chapter VIII)

- Analysis of provider capacity and mental health and substance use workforce issues; (Chapter IX)
- Analysis of the state of health integration in California; (Chapter X) and
- Review of issues related to health information technology for mental health and substance use providers; (Chapter XI)

The following is an overview of the focus and major findings from the report.

A.   PREVALENCE OF MENTAL HEALTH AND SUBSTANCE USE SERVICE NEEDS IN CALIFORNIA

The chapter on prevalence of mental illness and substance use disorders addresses several important questions:

1. What is the estimated prevalence of mental illness among the population of California at both the state and county levels?
    a. What is the prevalence of serious emotional disturbance among youth?
    b. What is the prevalence of serious mental illness among adults?
2. What is the estimated prevalence of substance use among the population of California at both the state and county levels?
3. How does the prevalence of mental illness and substance use disorders among Californians compare to that of other states?

Results of the analyses show statewide estimated prevalence as follows:

Category	Statewide Prevalence Estimates
Youth (0 – 17) with serious emotional disturbance	7.56%
Adults with serious mental illness	4.28%
Adults: broad definition of mental health need	15.85%
Youth (0 – 17) with substance use needs	2.7%
Adults (18+) with substance use needs	8.76%

Prevalence of mental illness and substance use disorders vary by gender, age, race, ethnicity, and county of residence. Results of these analyses included:

- Hispanic youth were found to have a slightly higher estimated prevalence rate of 8.03% as compared with 6.85% for white youth (non-Hispanic). African American and Native American youth also have a slightly higher prevalence rate of 7.99% and 7.91%, respectively.

- Prevalence of serious emotional disturbance varies with income level with higher levels among youth from the lower income categories.

- Prevalence among adults with severe mental illness increases with age between the ages of 18-20 and 35-44, ranging from 1.98% of the population for individuals ages 18-20 to 6.23% of the population among individuals ages 35-44.

- Rates are higher among females (4.94% for females vs. 3.62% for males), Native Americans (7.02%), and individuals who are separated, widowed or divorced (6.93%). Prevalence tends to decrease as education level increases and as income increases.

State prevalence rates for youth with SED range from a low of 6.91% in New Hampshire to a high of 7.93% in Mississippi. California, with a prevalence rate of 7.44% for children with SED ages 0-17, falls approximately in the middle of the distribution with a rank of 28. State prevalence rates for adults with SMI range from a low of 3.26% in Hawaii to a high of 5.79% in Mississippi. Unlike with the children's estimate, California (4.28%) falls close to the lower end of the distribution for adults with SMI, coming in with the ninth lowest rate in the country. Similar state by state comparison data is not available for the substance use population.

The prevalence estimates of both mental health and substance use disorders at the county level provide officials with useful information about the potential service demand in their locality to assist them in their own planning efforts. These data can also help clarify particular subsets of their populations where need is greatest and can be used to help determine how best to tailor strategies and interventions to meet the needs of individuals with mental health and substance use disorders.

B. ANALYSIS OF MEDI-CAL DATA FOR MENTAL HEALTH AND SUBSTANCE USE SERVICES

Chapter IV includes a comprehensive analysis of Medi-Cal mental health and substance use claims and encounter data for the years 2007--2009. These data were analyzed to answer the following questions:

1. What are the enrollment and penetration rates in behavioral health services for Medi-Cal participants?
2. What behavioral health services do Medi-Cal participants access and utilize?
3. What are the overall expenditures for behavioral health services in Medi-Cal?
4. Who are the high utilizers of Medi-Cal behavioral health services and what are the associated expenditures?

5. To what degree do Medi-Cal beneficiaries access behavioral health interventions in hospital emergency departments?

6. What is the current performance of the system as measured by HEDIS indicators (time from hospital discharge to follow-up outpatient appointment, and hospital and emergency department readmission rates)?

7. In what ways do the above variables vary by age, ethnicity, eligibility category, diagnostic category and participation in specialty versus non-specialty plan services?

Major findings of these analyses included:

1. Penetration rates

TAC/HSRI used the prevalence estimates described in Chapter III as the basis for calculating penetration rates for Medi-Cal and also for the DADP and DMH datasets. The prevalence estimates are based on the total population of individuals needing mental health or substance use services, not just individuals who are or will be eligible for Medi-Cal. Also, the estimates do not reflect the number of people will ask or present for services, but rather estimate the number of people in each category who theoretically need services. Finally, there are some people in the prevalence estimates already receiving mental health or substance use services through commercial insurance, private pay, or safety net service provision under county DADP and DMH programs. Thus, the prevalence estimates do not reflect un-met need or demand for services in an absolute sense. Nonetheless, use of the prevalence estimates support an accurate assessment of the degree to which the Medi-Cal, DADP and DMH systems are meeting the need for mental health and substance use services in California.

For example, the target populations of Medi-Cal specialty mental health programs under the 1915(b) waiver are adults with serious mental illness and youth with serious emotional disturbance. Thus, the most relevant calculation of penetration rates is to compare the number of individuals within these population groups actually served versus the estimated number of these types of individuals in California. At the same time, the broader definition of mental health need is used to calculate penetration rates for people accessing Medi-Cal services through fee for service or physical health plans, since these individuals would be referred to the specialty mental health plans if they met the clinical definition of the narrow prevalence estimates.

1. Penetration rates[1] for SMI and SED in the Medi-Cal program were 22% and 14% respectively.[2]

2. Penetration rates for substance use were 3% for the Medi-Cal program.

3. Penetration rates for adult other behavior health in the Medi-Cal program is 2%.

4. Asian and Hispanic populations have the lowest penetration rates.

2.   Utilization, expenditures and performance - DHCS

1. Total dollars spent on behavioral health care services grew from just under $3.2 billion to a little over $3.8 billion during the years 2007 to 2009.

2. Substance use service expenditures averaged 11% of total behavioral health expenditures across the three years.

3. The number of individuals receiving Medi-Cal funded services grew over the three year period – 3% from 07 to 08 and 4% from 08 to 09. The number of unique users of the system increased from 523,072 to 564,480 in 2009.

4. Expenditures increased 17% over the three year period, but overall average costs per service participant increased by just over 10%. This occurred despite a positive shift of resources away from inpatient services and towards outpatient services between 2007 and 2009.

5. The largest eligibility category is SSI/SSP under age 65 at 42% in 2009.

6. The data showed a large number of people receiving a small number of service encounters (three or fewer).

7. High cost users of services represent a large percentage of total expenditures – the top 20% used 82% of total expenditures in 2009 and the top 5% used 55% of total expenditures.

8. The data indicates improving performance – e.g. increasing proportion of participants receiving an outpatient follow-up visit after an inpatient stay.

C.   ANALYSIS OF THE DADP CALIFORNIA OUTCOMES MEASUREMENT SYSTEM TREATMENT (CALOMS TX) DATA

The questions addressed in Chapter V include:

1. What are the characteristics of people accessing DADP services in California?

2. Are there differences in substance use service utilization based on these characteristics?

---

[1] Defined as number who receive a service within a demographic category divided by the number that need the service in the state according to prevalence estimates.
[2] Note that the penetration rate is based on the prevalence of SMI, SED, and SUD among the population of California and is not limited to current Medi-Cal beneficiaries.

3. What patterns can be described relative to single episodes of care versus multiple (continuous and recurring) episodes of care in substance use services?
4. What are the average lengths of stay in services for different service modalities?
5. What proportion of service participants complete treatment?
6. What are the average wait times for accessing substance use services?
7. What patterns can be discerned related to resource utilization within the ADP system?
8. How do California's DADP service access and utilization patterns compare with national averages?

TAC/HSRI received CalOMS-Tx data for the time period 2007 through 2010. Data was analyzed according to: (a) time (fiscal year); (b) demographic characteristics (gender, age, race and ethnicity, etc.); (c) treatment service type or modality (outpatient, detox, long-term residential, etc.); and (d) proxy best practice indicators (days waited to enter treatment, length of stay, discharge status, and recurrent and continuous users of the treatment system). The project team examined these dimensions in relation to the following types of variables: Medi-Cal beneficiary status, referral source (individual, criminal justice, etc.); substance use conditions (primary substance use, poly drug use, needle use); other health-related services conditions (physical health, mental health, etc.); and social conditions (living with someone who uses substances, serious conflict with family members).

The following are some key findings from the DADP data analysis:

- The overall penetration rate within DADP is 6%.[3]
- The DADP system currently accomplishes over 180,000 service admissions per year, and the non-Medi-Cal budget for county-level substance use services is over $550 million.
- Access and utilization of DADP services is similar to national patterns.
- Compared to national estimates the system is producing better than average treatment completion rates for detox and residential services and slightly lower treatment completion rates for outpatient and narcotic treatment services.
- Unlike national trends DADP short-term residential (1%) is much lower than long-term residential (16%).
- Positive measures include short time to treatment (e.g. 72% of all admissions within one day and 89% within a week) and a good balance of outpatient, residential and detoxification services relative to national norms.

---

[3] As previously described, this is calculated by dividing the current DADP service population (unique individuals served within a year) by the estimated prevalence for that group.

D. ANALYSIS OF THE DMH'S CLIENT AND SERVICES INFORMATION (CSI) DATA

CSI data supplied by DMH permitted analysis of a number of key questions related to non Medi-Cal funded mental health services in California. Questions addressed in Chapter VI include:

1. What are the characteristics of people accessing DMH services in California?
2. What are the types and amounts of services delivered?
3. To what extent are evidence-based practices and best practice service strategies being utilized across the state?
4. What is the functional level of people served by the system?
5. Are there differences in the type and amount of services received by functional status level?
6. Are there differences in how people transition into and out of the system by functional level and service utilized?

The CSI dataset includes some variables not included in the Medi-Cal claims data, such as level of functioning (GAF score) and use of evidence base practice service models. This allowed analysis of the relationship between levels of functioning and the receipt of certain service modalities. However, this dataset does not include specific claims-based information on service encounters or costs. Nor does it identify which providers delivered services to DMH participants. It should be noted that there is likely to be considerable cross-over between participants in the CSI data and the Medi-Cal data. Given limitations in identifying information, it was not possible to compare unique individuals between the datasets.

Key results of the CSI data analysis include:

1. DMH penetration rates were 35% for SMI and 32% for SED.[4]
2. There is low utilization of evidence-based practices (approx. 1-2% across the years).
3. EBPs seemed to be on the rise until 2010. This is a valuable data set to keep tracking as most states are not maintaining data systems on EBPs and service strategies.
4. Adults who received an EBP seemed to be more likely to be retained and engaged by the system.
5. Lower functioning youths who received an EBP were more likely to improve and higher functioning youth were more likely to exit the system (potentially an indicator they no longer needed services).

---

[4] As with Medi-Cal and DADP, these penetration rates are calculated by dividing the total unduplicated number of individuals in each group served by the estimated prevalence for these groups. As noted previously, some people do not request services, and some people receive services from other systems with other payment sources. Thus, the difference between the penetration rates and 100% is not an indicator of unmet need.

6. Functional level data appears to show DMH is effective at persons maintaining their current level of functioning.

E. MEDI-CAL EXPANSION POPULATION

The specific questions addressed in the expansion population chapter include:

1. What is the estimated size of the overall Medi-Cal expansion population that will begin enrollment in 2014?
2. What is the predicted composition of the Medi-Cal expansion population?
3. What is the health/behavioral health status of the expansion population?
4. What will be the county-by-county distribution of the expansion population?
5. What proportion of the overall expansion population can be expected to want and need mental health and substance use treatment services?
6. Will there be differential effects in behavioral health needs across the counties?

TAC/HSRI used a combination of national and California based literature and data analysis to prepare estimates of the expansion population. Key findings include:

1. Expansion population size and demographics

1. The total Medi-Cal expansion population beyond 2014 is estimated to be in the range of 1.5 to 2 million additional enrollees.
2. The following demographic characteristics are projected: 26% age 18-26 years (this could be significant given this coincides with typical onset of behavioral health issues and seeking of treatment); 40% age 27-44 years; 18% age 45-54 years.
3. 70% of the overall expansion population is expected to be non-Caucasian, with 23% non-English speaking.

2. Health status and behavioral health need

1. Between 279,000 and 373,200 individuals within the expansion population are estimated to need (but not necessarily ask for) mental health services.
2. Between 113,250 and 151,000 of the overall expansion population are expected to need substance use services.[5]

---

[5] There is likely to be duplication between the substance use and mental health expansion populations, so the estimates cannot be added together.

3. Individuals with the most serious health and behavioral health disabilities are likely to have already enrolled in Medicaid and are not likely to be heavily represented in the expansion population.

4. The rates of mental health and substance use disorder among the total estimated mental health and substance use expansion populations are not likely to be substantially different from expected prevalence in the general population, but early enrollment of people with higher mental health and substance use needs is expected based on the experiences of other states.

5. Ten counties (Los Angeles, San Bernardino, Orange, San Diego, Riverside, Sacramento, Fresno, Santa Clara, Alameda, Kern) are expected to account for 50% of the increase in Medi-Cal enrollments after 2014.

3.   Preparing for adverse selection

1. Many childless adults have been categorically ineligible for Medicaid. Medicaid expansion presents a first opportunity for these individuals to obtain health coverage.

2. Public health and behavioral health systems have been using extremely limited non-Medicaid public resources to serve people currently ineligible for Medicaid. When these individuals become eligible, there will be a powerful incentive for public systems and providers to assure these individuals are enrolled in Medicaid.

3. Although it is likely the expansion population will be enrolled in managed care plans, there is likely to be a need for facilitated access to both Drug Medi-Cal and the specialty mental health plans for some portion of the expansion population. Not all members of the expansion population will have mental health and substance use service needs that can be met solely through the benchmark plan benefit design.

4. Due to predicted higher co-morbidity of physical health and mental health and substance use issues for the early enrollees in the expansion population, the degree of need for multi-system approaches and integrated care coordination models is likely to be higher among the expansion population than for the current non-disabled Medi-Cal population.

F.   MEDICAID STRATEGIES FOR SPECIAL POPULATIONS

The special populations discussed in Chapter VIII are:

- People experiencing homelessness;
- People with substance use disorders;
- Adults exiting the criminal justice system;

- Youth involved with the child welfare or juvenile justice systems; and
- Racial, ethnic, and cultural minorities.

Key questions of interest include:

1. What are the current barriers to Medicaid enrollment for these populations, and what opportunities are available for targeting outreach and enrollment strategies?
2. What mental health and substance use benefit design and service array are effective in addressing the special mental health and substance use needs of these populations and what gaps exist in the current benefit design?
3. What range and type of providers (including special skills and competencies) are required to address the unique needs of these populations?
4. What can penetration rate data tell us about how well the current Medi-Cal mental health and service system is performing related to access and quality for particular special populations?

TAC/HSRI accessed a variety of qualitative and quantitative information for the analysis of special population issues. These include:

5. Review of published reports related to best practices occurring nationwide and in California related to enrollment, outreach, services, provider qualification and network, and quality monitoring for these special populations.
6. Interviews with key informants about the needs and gaps related to services, enrollment mechanisms, providers, and other issues impacting the effectiveness of the system to adequately address the mental health and substance use needs.
7. Analysis of penetration rates, service utilization, and prevalence of mental health and substance use disorders for certain special populations.

Key findings of the analysis of special population issues include:

- California already has in place several provisions that support treatment access for special populations (e.g., 12 months continuous Medi-Cal enrollment for children; coverage of foster care involved children until age 21 (in place prior to new health reform requirements.)
- Asian and Hispanic people have the lowest overall mental health and substance use service participation rates within the Medi-Cal, DMH and DADP datasets. These population groups are also estimated to be highly represented in the currently uninsured Medi-Cal expansion population. Special outreach and engagement efforts directed at these population subgroups are

recommended within the system plan. It should be noted that all population groups, not just special populations, experience low participation rates, particularly in Medi-Cal.

- Given the vulnerability of special populations, continued efforts to monitor gaps, engage a diverse provider network, and include services in the benefit package that impacts these populations is critical.

- Many of the special populations discussed in this chapter, such as persons experiencing homelessness, persons with substance use disorders, and persons exiting the corrections systems will comprise a significant portion of the expansion population. Without specific attention to these needs of these populations in the design of outreach and enrollment strategies, services, provider qualifications and networks, as well as quality monitoring and improvement activities, these populations could continue to experience barriers to service access, poor treatment outcomes, and high utilization of costly services such as emergency departments and inpatient care.

G. PROVIDER CAPACITY AND WORKFORCE ANALYSIS

Chapter IX highlights some of the critical workforce issues facing California, details provider and workforce capacity information and key trends, and discusses results of the various key informant interviews. Several key questions drove both the quantitative and qualitative aspects of this provider capacity and workforce analysis. These questions included:

1. Who are the enrolled providers of Drug Medi-Cal (DMC), Medi-Cal Specialty Mental Health (SMH), and other Medi-Cal reimbursable mental health and substance services; and what is their geographic distribution?

2. Given that Medi-Cal enrolled providers may also deliver services to persons covered by other insurers, an important question is: what is the functional capacity of the current Medi-Cal behavioral health provider system for Medi-Cal beneficiaries? What is the number of unique Medi-Cal participants served by Medi-Cal enrolled providers?

3. What is the inpatient capacity designated for acute psychiatric inpatient and/or substance use detoxification and treatment and what is the geographic distribution?

4. What are the types of providers and mental health and substance use workers that are in demand?

5. To what extent are persons with lived experience being utilized in the provision of mental health and substance use services?

6. What are the characteristics of the mental health and substance use workforce including racial/ethnic composition, and linguistic capacity?

7. What are the skills and competencies considered necessary to meet the needs of Medi-Cal beneficiaries?

Several quantitative and qualitative data sources were used for this analysis. These include:

- Published reports related to national and California specific workforce issues and trends;
- State and County-level reports about provider and workforce, including selected Workforce Education and Training (WET) plans and needs assessments and county specialty mental health plan External Quality Review Organization reports;
- Interviews with key informants about issues facing the mental health and substance use workforce and the perceived needs and gaps in the provider workforce;
- Data about human resource capacity and labor statistics both nationwide and in California;
- Data from licensing and certification boards for various behavioral health practitioners; and
- Medi-Cal claims and provider identification data.

In combination, these sources of information illuminate a number of key findings, as summarized below:

- California has invested significant effort in expanding and supporting the behavioral workforce.
- Determining provider capacity is incredibly challenging. Much of the data that is available to assess capacity are proxy measures (e.g. bed capacity), are only "moment-in-time" snapshots, and do not capture capacity dedicated solely to Medi-Cal beneficiaries (given that providers serve multiple payers).
- Analysis of inpatient psychiatric and detoxification beds suggests there is an inadequate supply as well as mal-distribution of these beds in the state.
- Specific issues include: (a) shortages of psychiatrists/nurse prescribers (b) rural access issues; (c) need to further leverage FQHC capacity; and (d) untapped workforce of consumers/persons with lived experience that could serve as Medi-Cal providers.
- There is a need to address SUD certification variation and alignment with best practice in SUD treatment; improve ability to treat co-occurring mental health and addiction issues; and challenges with readiness for broader implementation of EBP's.

- There is variability among the counties in the use and training of staff in state-of-the art and evidence-based and recovery-oriented treatments such as integrated treatment for co-occurring disorders, ACT, SBIRT, MST, or medication assisted therapies;
- There is a need for more culturally responsive and competent provider practices to engage underserved populations;
- There is a need for more collaboration and stronger partnerships between FQHCs and county mental health and substance use departments.

H. HEALTH INTEGRATION

Chapter X on health integration focuses on the following issues:

1. What structural, financing, practice, and/or regulatory issues promote care integration or conversely make integration of care challenging?
2. What best practice models exist for integration of care across physical health, mental health and substance use and what lessons learned can be applied as California considers various options available under health reform to promote better integration of care?

The following activities were conducted as part of this health integration analysis:

- Published reports related to national and California specific health integration activities were reviewed and analyzed for key themes including selected county specialty mental health plan External Quality Review Organization reports.
- Interviews were conducted with key informants about the lessons learned from various health integration projects in California. Key informant interviews also focused on understanding the various structural, financial, and regulatory issues that impede or promote integration.

Key findings of the analysis of health integration strategies include:

- There are examples of exemplary practices occurring within several counties. Most Medi-Cal participants in California still do not have access to state of the art integrated treatment.
- As with other states, there is a need to turn pilots into scalable approaches.
- The unique configuration and diversity of county level physical and specialty health plans and related funding streams necessitates creative planning and problem-solving within each county as well as at the state level.

- There is a need to address a variety of different but interrelated integration strategies and for the mental health and substance use service populations. These include customized approaches for children and youth, and coordination and access strategies for non-behavioral health services such as housing, employment and education.
- Current consideration of implementing Health Homes for certain Medi-Cal populations may lead to effective multi-system physical health/behavioral health integration models.
- The state level reorganization of the Departments of Mental Health and Alcohol and Drug Programs, including integration of these agencies' Medi-Cal functions into DHCS, promises to increase the uniformity and integration of policy and financing across these programs.

I. BEHAVIORAL HEALTH INFORMATION TECHNOLOGY

TAC/HSRI addressed the following questions in the chapter on Health Information Technology:

1. What is the current status of California's mental health and substance use health information technology and exchange infrastructure?
2. What has occurred in the development and use of health electronic health records and the interoperability of different systems, the use of telemedicine and e-prescribing to support care delivery?
3. What are the implications for the health care delivery system including integration of care and delivery of high quality and cost effective care; and implications specific to the mental health and substance use system including workforce, privacy/confidentiality laws, vulnerable populations, and support of recovery-oriented care?

The analyses of Health Information Technology included:

- Review of published reports related to best practices occurring nationwide and in California related to Health Information Technology, Health Information Exchange, electronic health records, and use of technology to support care delivery (i.e., tele-health)
- Interviews with key informants about the current status of implementation of HIT in the physical health field and the mental health and substance use field; as well as the implications of confidentiality rules and laws for mental health and substance use that impact implementation of HIT.

Key findings of this analysis include:

- California has several specific efforts to address HIT (e.g. ARRA, MHSA).
- There remains a dearth of fully integrated health/behavioral health systems and sites within which EHR and health information exchange would be most natural.
- A disparity exists between behavioral health providers and physical health providers in the use of and access to HIT. This gap will only grow wider given that ARRA funding is limited to physical health providers.
- The continued separation among the Medi-Cal physical health plans, specialty mental health plans, and Drug Medi-Cal at the state and county levels exacerbates the difficulties of forging effective health information exchange strategies and technologies.
- There are multiple statutory and regulatory barriers to exchanging personally identified health information among substance use, mental health and physical health providers.
- Proprietary health plans and systems may have disincentives or limitations in the amount they can exchange health information.
- Clinical information sharing remains difficult because health care organizations do not use data definitions and structures that can be easily cross-walked. This is true even when mental health and primary care services are located within the same organization and when both systems have electronic health records.
- EHRs are not sufficient by themselves to facilitate sharing and full use of critical information across providers and payers: a patient registry as a key building block to integration, and most local systems are not yet developing such integrated patient registries.
- The variation in vendor systems across California's counties and their health plans impedes cross-county operability and integration between primary care and behavioral health.
- There is a proliferation of local county-specific databases designed for programs such as Criminal Offenders with Mental Illness, Drug-Court, Computer Resource Allocation Inventories and others that are not compatible in many different and idiosyncratic ways.
- Each county has to engage in specific efforts to establish data sharing agreements and navigate different systems.
- In order to implement EHR systems, mental health and substance use service provider staff must be trained to function within an EHR environment and to adapt to HIT. This is a whole different dimension to workforce development and retention over and above training in best practices, cultural competence, etc.

It is recognized that neither the physical health system nor the behavioral health system will have sufficient resources to significantly increase HIT/EHR and health information exchange on the own over the next few years. However, some health integration and improvement opportunities under the ACA cannot be implemented without further progress with HIT/EHR, particularly in the mental health and substance use services realms. Improved use of technology and expanded exchange of health information must continue to be a priority for the field, even in the face of restricted resources.

J.   REPORT CONCLUSION

This report has described the California mental health and substance use service systems from a variety of perspectives. As noted in the introduction, the central focus of the report is Medi-Cal. However, Medi-Cal does not exist in a vacuum, and thus the report includes quantitative and qualitative information about behavioral health consumers, services, providers, workforce, integration strategies and information technology for the larger system. All of these factors affect the quality and performance of Medi-Cal mental health and substance use services going forward.

In the course of conducting this comprehensive review, TAC/HSRI identified a number of strengths and challenges inherent in the various public systems that now finance, oversee, and deliver services to people with mental health and substance use service needs. These are summarized in the conclusion chapter, and are accompanied by a number of global recommendations for the mental health and substance use services plan that will result from this analysis. Highlights of this discussion are presented below.

1.   Strengths

In the course of collecting qualitative information and analyzing quantitative data, TAC/HSRI identified a number of key strengths in the current system.   Major strengths in the system are summarized below.

a)   *Implementation of the Bridge to Reform Waiver*

- Enrollment of seniors and people with disabilities (SPDs) into managed care is likely to increase participation of these individuals in behavioral health as well as physical health primary care and preventive interventions.
- The enrollment of uninsured single adults in the Low Income Health Plans (LIHP) will increase access to mental health (not substance use in most cases) services. And, as with the SPD managed care initiatives, enrollment in LIHP is expected to increase both the potential and the

incentives for LIHP counties to coordinate care across the physical health and specialty health plans.

- The Delivery System Reform Incentive Pool (DSRIP) initiative includes numerous opportunities for public hospitals to improve quality of care for individuals with mental health and substance use disorders.

b)   *The Potential for Health Home implementation*

Section 2703 of the ACA, Health Homes for Individuals with Chronic Conditions, holds great promise for improving care for individuals with mental health and substance use disorders. It offers the opportunity to overcome barriers to information sharing and care coordination between the physical health and specialty health plans. It also has the potential to generate substantially increased integration of care at the point of service for people with multiple disabilities. Health Homes provide both a framework and incentives for behavioral health providers to forge partnerships related to both integrated care delivery models and health information technology. As California considers which opportunities to pursue as part of national health reform, Health Homes offer the chance to reduce the fragmentation in care received by people with chronic mental health and substance use disorders.

c)   *Medi-Cal benefit design*

California has most of the service category and definition tools it needs for adult mental health in the specialty mental health plans. With the implementation of the *Katie A*. settlement, California will have many of the tools it needs for youth with serious emotional disturbance within the specialty mental health plan. And, although California's Drug-Medical program and covered services is limited and incomplete, it is on par with Medicaid coverage for substance use services in many other states.

The fact that California has relatively good covered services (benefit design) in the specialty plans does not mean that (a) it has all the covered services, best practice service definitions, etc. that are desirable; or (b) that these services are being widely or correctly implemented. For example, Drug Medi-Cal (DMC) includes Naltrexone, an evidence-based medication assisted therapy for substance use disorders, as a covered benefit. To date, this benefit is rarely if ever accessed by DMC providers on behalf of DMC participants.

d)   *Proposition 63: The Mental Health Services Act (MHSA)*

California has been able to add substantial resources to the mental health system for adults and youth through MHSA. MHSA funds have also supported beneficial planning and infrastructure development within county based mental health systems. Investments have been made in the implementation of evidence-based services, and in the development of partnerships to coordinate care at the point of service for consumers with complex, multi-system needs. MHSA funds now also constitute a portion of the certified public expenditures that comprise the match for Medicaid FFP for the specialty mental health program. This has expanded the utility of MHSA funds, but has also limited the flexibility with which the funds can be used.

In addition, MHSA funds have supported initiatives to improve and expand the mental health workforce, particularly with regard to addressing health access disparities based on cultural and linguistic barriers. Finally, MHSA funds have been used to foster improved health information technology (HIT) and the implementation of electronic health records (EHRs). These initiatives are limited at this point, but they could provide useful implementation experience to other counties and providers as they seek to implement HIT and EHR capacities.

e)   *Philanthropic and educational commitment*

California's Medi-Cal and related behavioral health systems have benefitted from long term and continuous support from both philanthropic organizations and educational institutions. Both the California Endowment and the California HealthCare Foundation (CHCF) have invested substantial funds in research and demonstration projects of benefit to Medi-Cal and the public behavioral health system. The California Institute for Mental Health (CiMH) has spent many years fostering best practices within the public mental health system. For substance use services, the Integrated Substance Use Center at UCLA has provided similar expertise and technical assistance. Additionally, the Center for Health Policy research at UCLA has supported numerous initiatives.

f)   *Evidence-based practices*

California has demonstrated some progress in the implementation of evidence-based practices as defined by SAMHSA. It is notable that DMH's CSI database has the capability to track and report the numbers of individuals in that system receiving evidence based practices. Increasing participation in evidence-based services, particularly if these services maintain fidelity to their models, should assist to reduce inpatient and emergency department utilization in the specialty mental health plans over time.

2.   Needs and gaps in the current system

As has been described throughout this report, there are a number of gaps and issues with regard to the system that need addressing. These include:

a)   *Disparate administration and financing of major components of the system*

Until recently there has been trifurcated administration of behavioral health administration, policy, financing and operations in California. This administrative separation (a) has exacerbated the inherent differences and boundaries between the physical health and specialty health plans; (b) has diffused accountability for the overall performance of these various systems and funding streams; and (c) has perhaps created unintended incentives for cost or care-shifting between the various plans and fund sources.

The administrative separation of these functions and program areas is further complicated by the devolution of the programs to the county level. There are 58 counties, each of which administers or contracts for physical health plans, mental health specialty plans, and with the exception of 18 non-participating counties, the DMC program. The new phase of realignment, which places most sources of mental health and substance use funding at the county level, could potentially increase the already wide discretion at the county level with regard to managing these programs.

The consolidation of mental health and substance use service Medi-Cal functions and other community service funding streams within DHCS presents an opportunity to integrate management and policy across these systems. However, at the county and provider level the DADP, DMH and DHCS systems are still quite separate, and a variety of strategies will have to be used to forge greater coordination and integration within those local systems.

b)   *Gaps in benefit design and coverage*

Consistent with the administrative separation of substance use, mental health and physical health services, differences in benefit design and coverage have also emerged.   Perhaps the biggest gap is between the physical health benefit (both fee for service and health plans) and the two types of specialty plans. People have to meet high diagnostic, clinical and functional guidelines to access services from either DMC or the specialty mental health plans. At the same time, there is sparse coverage for behavioral health services in the fee for services program and among most of the physical health plans. This leaves a wide gap in

coverage for people with serious needs for substance use or mental health services who do not meet the clinical eligibility criteria for the specialty health plans.

Another major gap in coverage is the lack of specific benefits for people with co-occurring mental illness and substance use disorder. Neither DMC nor the specialty mental health plans have specific benefits for integrated dual diagnosis treatment. Nor could we identify any formal mechanisms or financial provisions for effectuating referrals and coordinated treatment between the two types of specialty plans. The overall Medi-Cal claims data show very few participants receiving both mental health and substance use service encounters. Plus, only 10% of providers in the Medi-Cal claims data deliver both substance use and mental health service encounters.

c)   *Care is not integrated or coordinated*

As noted above, there are no mechanisms for measuring performance or providing incentives to physical health and specialty plans for integrating and coordinating care. Nor are there specific reimbursement mechanisms within Medi-Cal that would support team service delivery, joint plan of care development, psychiatric consultation to primary care, or many other mechanisms of care coordination and integration. If DHCS implements a Health Home program it is likely much of this issue will be addressed. Nonetheless, there are many Medi-Cal participants, including potentially the expansion population, who are not eligible to participate in Health Homes. In addition, there are additional barriers to information sharing and accessing HIT/EHR technology that will not automatically be corrected in a Health Home initiative.

Cross system and cross-plan integration and coordination is an area that could be improved through performance measurement and financial incentives as well as through traditional collaborative and co-location approaches. Enhanced performance measurement and incentives could be incorporated into a uniform purchasing plan that would integrate DHCS's prudent purchasing objectives across the multiple plans and jurisdictions.

d)   *There are cultural/linguistic and regional variations in access to services*

California is similar to many other states in that: (a) it does a good job of tracking and reporting access to Medi-Cal services for each ethnic group; (b) the proportion of people within each ethnic group service by Medi-Cal, at least in the specialty plans, is not very far off from the proportion of each group in the general population; and (c) despite these efforts and successes, there are is still disproportionate access to behavioral health services on the part of certain ethnic populations. When compared to overall estimated

mental health and substance use service needs (prevalence), White and African American groups are served in higher proportions (17% and 31% respectively) than are Asian, Native American, or Hispanic populations (6%, 13% and 8% respectively). This issue is compounded by the relative lack of cultural/linguistic capacity among providers and practitioners in California.[6]

County level variations in access to Medi-Cal behavioral health have also been identified in the data. When analyzing penetration rates for the expanded definition of mental health prevalence (the definition most likely to reflect the Medi-Cal expansion population), there is a range in penetration rates of 18% (Yuba County) to 3% (Sutter, Alpine and Sierra Counties). Within the large county category, there is a range of 10% (San Francisco) to 4% (Orange, Riverside and San Mateo Counties).

For substance use prevalence, the ethnic and geographic variations are similar. For example, penetration rates as a function of estimated prevalence of SUD for Hispanic people is 12%, whereas the rates are for African Americans (33%), Asians (34%), Native Americans (40%) and Whites (24%). At the county level, the range of penetration rates is from 14% (Lake County) to 1% (Orange, San Mateo, San Luis Obispo, Sutter, Colusa and Mono Counties). For the large counties, the range is from 7% (San Francisco) to 1% (San Mateo).

e) *Gaps in evidence based practices and integrated care*

Between the years 2006—2010, only 1% of individuals received an EBP or identified service strategy consistent with best practice, as categorized by SAMHSA. The fact that the reported employment rate for consumers in the DMH database is only 2% (compared to a national average of over 20%) is evidence that recovery-focused EBPs are not having a widespread effect on adults with serious mental illness.

The new EBP services being implemented under the *Katie A*. settlement will significantly improve access of multi-system SED youth to best practice modalities. This is a relatively new development, and there is no data yet about the degree to which these EBPs are reaching high risk youth in the system.

With regard to substance use services, the system does use ASAM criteria and levels of care in some counties to determine level of care and to triage for needed services, which are considered to be good practice. However, evidence based practices such as medication assisted treatment, are sparsely implemented in the current SUD system, and there is opportunity to expand the use of EBP's for addiction services.

---

[6] As noted earlier in this summary, the prevalence calculation is based on comparisons of the estimated prevalence for each sub-group with the actual number of individuals within these sub-groups being served.

K.   TARGET AREAS FOR PLANNING

1.   Prudent purchasing plan

TAC/HSRI recommends development of a comprehensive and uniform purchasing plan for DHCS, DMH and DADP. This purchasing plan would addresses critical system functions:

- intended results and outcomes for beneficiaries
- equity of access to services
- best practice array of services and clinical modalities for people at each level of care
- protocols and mechanisms for integrated treatment
- responsibilities of the counties, the plans, and their provider networks
- sufficient cultural/linguistic competency, use of health information technology, staff certified in evidence based practices
- leveraging financial risk for over spending or under spending
- incentives for performance

2.   Strengthened local oversight

TAC/HSRI recommends that DHCS and its state partners assert a strong and coordinated role with regard to how money is spent for behavioral health services, who is served, what services they receive, and how performance of the system is assessed and rewarded. We have recommended that this approach extend to the physical health plans as well, since care must be coordinated across the boundaries of the physical and specialty health plans. We believe this centralized role as the prudent purchaser of services is both necessary and appropriate for the state level managing agencies.

We also recommend that the county role in managing the mental health and substance use systems in the context of the purchasing plan be strengthened and clarified.   A comprehensive purchasing plan with uniform standards and measures of performance, and an equivalent benefit design across physical health and specialty plans will support counties to innovate with local customized approaches to attain statewide programmatic goals.

3. Integration of mental health and substance use service systems

DHCS and the counties need to address effective integration of mental health and substance use services. This needs to occur before integration of behavioral health and physical health can be fully implemented.

4. Benefit design for the expansion population

TAC/HSRI recommend that the essential benefit behavioral health services benefit design and service definitions be consistent between the Medi-Cal benchmark plan and the benchmark benefit for the exchange plans. We also recommend that DHCS assure that there is not a substantive gap between the benefit design for the benchmark plans and that for the specialty plans.

L. NEXT STEPS

1. Public release of the needs assessment for review and comment: January 30, 2012
2. Completion of the public review and comment period: February 15, 2012
3. Submission of the needs assessment report to CMS: March 1, 2012

This full report can be found at the link below:

http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx