



INFORMATIONAL HEARING

Assembly and Senate Health Committees

The Medi-Cal Mental Health Delivery System

Tuesday, February 26, 2019 ♦ 1:30 p.m.

State Capitol ♦ Room 4202

BACKGROUND

INTRODUCTION

The Assembly and Senate Health Committee’s February 26, 2019, hearing entitled “The Medi-Cal Mental Health Delivery System” is the first of two scheduled hearings. This hearing will provide an overview of the current Medi-Cal mental health delivery system and set the stage for subsequent hearings. The discussion will include an overview of the prevalence of mental health conditions in California with a focus on the Medi-Cal population, and what the Medi-Cal mental health benefit consists of, how mental health services are delivered, administered, and financed, and how quality is measured and ensured.

MENTAL HEALTH DISORDERS IN CALIFORNIA

Mental health disorders are among the most common chronic illnesses that people face, both in the United States and in California. According to the California HealthCare Foundation’s March 28, 2018, publication, “Many Californians Have Coverage, but Not Care, for Mental Health Conditions,” nearly one in six adults statewide experiences a mental illness of some kind in any given year. One in 24 has a serious mental illness resulting in functional impairment that limits activities of daily life. Children and teenagers also experience mental health disorders at high rates: one in 13 has an emotional disturbance that limits participation in regular activities. California has a statewide suicide rate slightly below the national average, but the suicide rate in the Northern and Sierra region is nearly triple that of Los Angeles County. While mental illnesses generally can be managed successfully, many people miss out on treatment, with significant differences by race and ethnicity, region, age, and income, with lower income adult Californians disproportionately suffering from serious mental illnesses and lower income children suffering from serious emotional disturbances. Nearly two-thirds (63%) of adults with a mental illness do not receive treatment. Of the one in eight teenagers with depression, only about one-third (30.5%) receive treatment. As the primary payer of mental health services, and the program entity responsible for the coverage of nearly one-third of Californians, the mental health coverage under Medi-Cal provides is a fundamental component of the state’s mental health delivery system.

LEGAL FRAMEWORK

Medicaid is a joint-state and federal program that operates under both federal and state laws and regulations. Federal Medicaid law sets broad requirements for the program and mandates coverage of some populations and benefits, while other populations and benefits are optional. States make the operational and policy decisions to determine who is eligible for enrollment, which services are covered, and how payments are set. Each state specifies the nature and scope of its Medicaid program through its Medicaid State Plan, a comprehensive document which must be approved by the Centers for Medicare & Medicaid Services (CMS) for a state to access federal Medicaid funds. The state plans can be amended as needed to reflect changes in state policy and federal law and regulation (State Plan Amendments are commonly referred to as SPAs). States can also seek federal approval for waivers of federal Medicaid requirements. California operates its Medi-Cal managed care (MCMC) and county specialty mental health plans (MHP) programs under two separate waivers (described further below).

MCMC AND MHPs

Medi-Cal mental health benefits are delivered through two separate systems. MHPs provide a broad range of specialty mental health services (SMHS) to individuals with more severe mental illnesses, while MCMC plans provide non-SMHS (described further below). The delivery of SMHS through MHPs is commonly referred to as a “carve out,” as is the coverage of anti-psychotic prescription medication through FFS Medi-Cal. A “carve out” is when services covered by the Medi-Cal program are delivered outside of a MCMC plan.

ADMINISTRATION OF MEDI-CAL MENTAL HEALTH SERVICES

The Department of Health Care Services (DHCS) is one of nine departments within the California Health and Human Services Agency.¹ DHCS is the single state agency that administers California’s Medicaid (Medi-Cal) program under federal Medicaid law,² including developing and implementing mental health plans for Medi-Cal beneficiaries.³

The scope and responsibility for Medi-Cal mental health services is contained in state and federal law, federal Section 1115 and 1915(b) waivers, DHCS-issued All Plan Letters (APLs are issued by DHCS and detail MCMC plan obligations), DHCS issued-Mental Health and Substance Use Disorder Services (MHSUDS) Information Notices (MHSUDS are issued by DHCS and detail MHP obligations), contracts between the DHCS and counties and MCMC plans, and Memorandum of Understanding between MCMC plans and counties.

There are multiple provisions of existing state law requiring DHCS (or granting DHCS the authority) to deliver Medi-Cal-covered services through MCMC plans using various delivery models, and authorizing or requiring most Medi-Cal beneficiaries to enroll in those plans.⁴ State law requires DHCS to contract with a county or counties acting jointly for the delivery of SMHS to each county’s eligible Medi-Cal beneficiary population. If a county decides not to contract with DHCS, does not renew its contract, or is unable to meet the standards set by the DHCS, the county is required to inform DHCS of this decision in writing. If a county is unwilling to contract for the delivery of SMHS, DHCS is required to ensure that SMHS are provided to Medi-Cal beneficiaries. The Medi-Cal SMHS Consolidation waiver program provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single MHP operating in the county of the beneficiary.⁵

MEDICAID WAIVERS

The two Medi-Cal mental health delivery systems are established through two separate Medicaid waivers, which enable the state to waive federal Medicaid requirements (such as freedom of choice) to require beneficiaries to enroll in different types of managed care plans and receive non-emergency services from managed care plan providers.

California delivers services (including non-SMHS) for most Medi-Cal beneficiaries through MCMC plans under a federal Section 1115 Medicaid demonstration waiver known as “Medi-Cal 2020.” This waiver expires in December 31, 2020. The MHP is also a form of managed care delivered under a separate Section 1915(b) waiver. MHPs are considered a prepaid inpatient health plan (PIHP) under federal Medicaid managed care regulations. PIHPs provide services to Medi-Cal enrollees under contract with the State, and meet specified criteria but do not have a comprehensive risk contract.⁶

The current MCMC plan delivery system began in the 1990s in urban counties with mandatory enrollment of women and children enrolled in Medi-Cal. The program has since been expanded to cover nearly the entire state, with most Medi-Cal beneficiaries required to enroll in a MCMC plan. MHPs are operated under a Section 1915(b) waiver since 1995.⁷ The current 1915(b) waiver is the ninth renewal of the SMHS waiver and is effective from July 1, 2015 to June 30, 2020. Appendix A has a description of the specific federal provisions “waived” through these two waivers.

MEDI-CAL MENTAL HEALTH DELIVERY SYSTEMS

MHPs are responsible for providing SMHS to Medi-Cal beneficiaries who meet SMHS medical necessity criteria. SMHS are delivered through 56 county mental health plans (Placer and Sierra and Yuba and Sutter operate two separate dual-county combined MHPs). Medi-Cal beneficiaries that meet medical necessity criteria for SMHS are entitled to receive medically necessary SMHS from their county MHP, regardless of whether or not they are enrolled in a MCMC plan.⁸

MCMC plans are responsible for providing non-SMHS, and are responsible for prescription drug coverage for mental health conditions, except for approximately 40 anti-psychotic medications. These medications are contractually carved out of nearly all MCMC plan contracts and instead reimbursed through Medi-Cal fee-for-service (FFS).⁹ Over 24 contracting MCMC plans and their subcontracting providers and plans deliver services. MCMC plans cover 82% or 10.2 million of the state’s Medi-Cal 13.2 million beneficiaries projected to enroll in the program each month in 2019-20. Medi-Cal beneficiaries who are not enrolled in MCMC plans receive non-SMHS through Medi-Cal FFS.

MCMC plans deliver their scope of mental health coverage in different ways. For example, some MCMC plans use a specialized healthcare service plan to administer their mental health benefit (major specialized mental health plans include Beacon and MHN), while other plans manage the benefit directly, and one plan contracts with its county behavioral health department. Appendix B shows the different MCMC delivery system models, enrollment as of December 2018, participating plans and counties served, and how each plan administers the non-SMHS.

ELIGIBILITY FOR MEDI-CAL MENTAL HEALTH SERVICES

A Medi-Cal beneficiary meets SMHS medical necessity criteria when the beneficiary has a covered mental health diagnosis, and meets specific impairment and intervention criteria related to that diagnosis, as defined in state regulations, depending on whether the determination is for adults or children,¹⁰ or for children under the federal Early and Periodic Diagnosis, Screening and Treatment (EPSDT) benefit.¹¹ The determination of medical necessity for SMHS is based on an assessment of the beneficiary by the MHP or its contracted provider. Both children and adults have to be diagnosed with one of 19 mental health conditions (such as schizophrenia, mood disorders, anxiety disorders and other conditions listed below).^A However, the medical necessity definition, level of impairment and intervention criteria for eligibility for Medi-Cal SMHS differ between children and adults. A broader federal definition of medical necessity applies to children as compared to adults. For children and youth under the federal EPSDT benefit, EPSDT services include necessary health care, diagnostic services, treatment, and other measures to “correct or ameliorate” defects and physical and mental illnesses and conditions discovered by an EPSDT screening services, whether or not such services are covered under the state’s Medicaid program.¹² For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.¹³

In addition to the “correct and ameliorate” medical necessity standard, the “impairment” criteria component of SMHS medical necessity is also broader for children than for adults. For example, a child with a mental health diagnosis that results in “a reasonable probability a child will not progress developmentally as individually appropriate” meets the impairment criteria, whereas adults must (as

^A Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:

- (A) Pervasive Developmental Disorders, except Autistic Disorders
- (B) Disruptive Behavior and Attention Deficit Disorders
- (C) Feeding and Eating Disorders of Infancy and Early Childhood
- (D) Elimination Disorders
- (E) Other Disorders of Infancy, Childhood, or Adolescence
- (F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
- (G) Mood Disorders, except Mood Disorders due to a General Medical Condition
- (H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- (I) Somatoform Disorders
- (J) Factitious Disorders
- (K) Dissociative Disorders
- (L) Paraphilias
- (M) Gender Identity Disorder
- (N) Eating Disorders
- (O) Impulse Control Disorders Not Elsewhere Classified
- (P) Adjustment Disorders
- (Q) Personality Disorders, excluding Antisocial Personality Disorder
- (R) Medication-Induced Movement Disorders related to other included diagnoses

described below) have a higher level of impairment.¹⁴ By contrast, an adult Medi-Cal beneficiary must meet all of the following criteria to receive outpatient SMHS:

- 1) The beneficiary has one or more of 19 mental health diagnoses whether or not additional diagnoses are also present.¹⁵
- 2) The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis:
 - a) A significant impairment in an important area of life functioning; or,
 - b) A reasonable probability of significant deterioration in an important area of life functioning.
- 3) The proposed intervention is to address the impairment resulting from the covered diagnosis, with the expectation that the proposed intervention will either:
 - a) Significantly diminish the impairment; or,
 - b) Prevent significant deterioration in an important area of life functioning.
- 4) The beneficiary's condition is not responsive to physical health care-based treatment.

MHPs may not use alternate criteria as a basis for determining SMHS medical necessity or making referrals to the MCMC plan or a FFS Medi-Cal provider. When an MHP's assessment identifies that a beneficiary meets SMHS medical necessity criteria, the MHP must provide SMHS to that beneficiary consistent with the beneficiary's mental health needs and treatment goals, as documented in the beneficiary's client plan.

MCMC plans must provide mental health benefits covered in California's Medicaid State Plan for those beneficiaries that do not meet medical necessity criteria for SMHS.¹⁶ Disputes between MHPs and MCMC plans about which entity is responsible for providing services to a beneficiary are handled according to a dispute resolution process described in the memorandum of understanding (MOU) between the two entities.¹⁷ Disputes that cannot be resolved between the two entities can be submitted to DHCS for resolution in accordance with plan and county information notices.¹⁸

MEDI-CAL MENTAL HEALTH BENEFITS

Existing regulation defines "specialty mental health services"¹⁹ to mean rehabilitative mental health services^B, psychiatric inpatient hospital services; targeted case management; psychiatrist services; psychologist services; EPSDT supplemental specialty mental health services; and psychiatric nursing facility services. Medi-Cal covered SMHS are required to be provided in the beneficiary's home community, or as close as possible to the beneficiary's home community. In addition, under the objectives of the rehabilitation option,²⁰ mental health services may be provided in a facility, a home, or other community-based site.²¹ The scope of services and providers authorized to provide services

^B Rehabilitative services include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services and psychiatric health facility services. Appendix D has DHCS' description of the SMHS services from the Medi-Cal Specialty Mental Health: November Estimate Policy Change Supplement for Fiscal Years 2018-19 and 2019-20.

under MHPs is much broader than a traditional insurance model benefit. For example, the “rehabilitation option” benefit enables rehabilitative mental health services to be provided by additional providers^C in non-traditional settings, such as via telephone, in the field or an office setting.

“Rehabilitation” is defined as a recovery or resiliency focused service activity identified to address a mental health need in the client plan, with the service activity providing assistance in restoring, improving and/or preserving a beneficiary’s functional, social, communication or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary.²² While the scope of SMHS is broader, MHPs are not responsible for providing, arranging, or, pay for several types of Medi-Cal covered services, including outpatient prescribed drugs, laboratory, radiological, and radioisotope services, medical transportation (other than between hospital settings).²³

Existing law requires MCMC plans to provide mental health benefits covered in the California’s Medicaid State Plan, excluding those benefits provided by MHPs under the Section 1915(b) waiver.²⁴ Existing law authorizes DHCS to require MCMC plans to cover mental health pharmacy benefits to the extent provided in the contracts between DHCS and the MCMC plans.²⁵ Prior to 2014, Medi-Cal beneficiaries with mental health conditions that did not meet the criteria for SMHS only had access to limited outpatient mental health services, delivered by primary care providers or a limited network of FFS mental health providers. SB X1 1 (Hernandez and Steinberg) was one of two bills implementing the Patient Protection and Affordable Care Act (ACA) Medicaid changes and expanded the benefit package for MHSUDS. AB X1 1 (John A. Perez) implemented the Medicaid expansion established under the ACA, and SB X1 1 included the expanded benefit package for mental health and substance use disorder services. As a result of SB X1 1, MCMC plans became responsible for delivering an expanded set of mental health services, including individual and group psychotherapy, psychological testing, psychiatric consultation, and medication management.²⁶ While the ACA only required these essential health benefit services to be made available to the ACA expansion population²⁷ (primarily non-disabled adults without minor children), SB X1 1 required these same services be made available to all Medi-Cal beneficiaries, including expanding the types of providers and removing previous per visit limits.

Under the SB X1 1 benefit expansion, MCMC plans must provide specified services to adults diagnosed with a mental health disorder (as defined by the current Diagnostic and Statistical Manual of Mental Disorders or DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning.²⁸ This adult benefit is commonly referred to as the “mild to moderate” benefit. MCMC plans must also provide medically necessary non-specialty mental health services to children under the age of 21. MCMC plans must also deliver the outpatient mental health services specified in their MCMC contracts, whether they are provided by primary care providers

^C Mental health services may be provided within their scope of practice by a physician, psychologist, a waived psychologist, a licensed clinical social worker, a waived/registered clinical social worker, a licensed professional clinical counselor, a waived/registered professional clinical counselor, a marriage and family therapist, a waived/registered marriage and family therapist, a registered nurse, a certified nurse specialist, a licensed vocational nurse, a psychiatric technician, a mental health rehabilitation specialist, a pharmacist, an occupational therapist, and other qualified provider. (Supplement 2 to Attachment 3.1-B. 13. 3. 4. Rehabilitative Mental Health Services State Plan Amendment, December 18, 2012.

(PCPs) within their scope of practice or through the plan’s provider network. MCMC plans are also responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical healthcare services, not otherwise excluded by contract, for plan beneficiaries who require SMHS.

SERVICES	MCMC Plan	MHP - Outpatient	MHP– Inpatient
	<p>Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:</p> <ul style="list-style-type: none"> • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications,* supplies, and supplements • Psychiatric consultation 	<ul style="list-style-type: none"> • Mental Health Services <ul style="list-style-type: none"> ○ Assessment ○ Plan development ○ Therapy ○ Rehabilitation ○ Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential Treatment • Adult Residential Treatment • Crisis Intervention • Crisis Stabilization • Targeted Case Management • Intensive Care Coordination • Intensive Home-Based Services • Therapeutic Foster Care • Therapeutic Behavioral Services 	<ul style="list-style-type: none"> • Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in FFS hospital

Source: DHCS All Plan Letter (APL) 17-018.

*Approximately 40 psychiatric drugs are contractually excluded from coverage from MCMC plans and reimbursed through FFS Medi-Cal. The list of carved out drugs is in APL 17-08.

At any time, MCMC beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCMC’s provider network. Each MCMC is still obligated to ensure that a mental health screening of beneficiaries is conducted by network PCPs. Beneficiaries with positive screening results may be further assessed either by the PCP or referred to a network mental health provider. The beneficiary may then be treated by the PCP within the PCP’s scope of practice. When the condition is beyond the PCP’s scope of practice, the PCP must refer the beneficiary to a mental health provider within the MCMC network. For adults, the PCP or mental health provider must use a Medi-Cal-approved clinical tool or set of tools mutually agreed upon with the MHP to assess the beneficiary’s disorder, level of impairment, and appropriate care needed. The clinical assessment tool or set of tools must be identified in the MOU between the MCMC and MHP, as discussed in APL 13-018. DHCS is required to ensure that all contracts for MCMC include a process for screening, referral, and coordination with any MHP of medically necessary specialty mental healthcare services.²⁹

UTILIZATION OF MENTAL HEALTH SERVICES

DHCS Medi-Cal data for 2017 indicate between 14.8 and 19.4 for every 1,000 Medi-Cal beneficiaries had a visit for a mild to moderate mental health condition each month in 2017.³⁰

DHCS indicates in fiscal year (FY) 2014-15 (the first year of the mild to moderate expansion), 32,865 adult beneficiaries received psychosocial services through MCMC plans. The 2016-17 the number of adult beneficiaries receiving these services increased to 187,152. In 2014-15, 12,956 children/youth received mental health services from a MCMC plan and that number increased to 73,906 children/youth in FY 2016-17.

In FY 2014-15, 259,301 children and 341,797 adults received specialty mental health services from MHPs. In FY 2016-17, 259,870 children and 341,362 adults received SMHS from MHPs.³¹ In FY 2014-15, 191,249 children and 192,686 adults received five or more SMHS visits. In FY 2016-17, those numbers increased to 209,648 children and 212,021 adults who received five or more SMHS visits.³²

FINANCING FOR MHPS AND MCMC PLANS

Medi-Cal costs are generally shared between the federal government and either the state or local governments. The federal government typically reimburses (referred to as federal financial participation or FFP) between 50% and 93% of Medi-Cal costs, depending upon the population receiving coverage. The sources of funds used to fund MCMC plans and MHPs and the method of claiming federal Medicaid matching funds are different.

Under federal Medicaid regulations, MHPs are considered PIHPS, and they are not “at risk” for FFP for the cost of services.³³ CMS has indicated that capitation is the definition of “at risk” and MHPs are not paid on a capitated basis. Instead, MHPs are paid on a FFS basis by certifying their costs (known as certified public expenditures or CPEs). DHCS utilizes CPEs for the state share of funding each type of payment made to an MHP.³⁴ MHPs pay for the total cost of services using non-federal funding sources and then submit a claim to the State for FFP reimbursement using the CPE process. County MHPs receive interim CPE reimbursement of FFP on a FFS basis pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes; the state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state FY; and the final cost reconciliation of county MHP interim Medicaid payments occurs within 36 months after the certified reconciled state–developed cost report is submitted.³⁵

California’s mental health system underwent two major changes to its fiscal and governance structure in 1991 and again in 2011 under what is commonly referred to as “realignment.” Under the 2011 realignment,³⁶ counties bear the full financial responsibility for the non-federal share of Medi-Cal SMHS, including the EPSDT Program and mental health managed care, with the exception of newer mandated costs. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment applies to local agencies only to the extent that the state provides annual funding for the cost increase.³⁷ Realignment revenue is also used to fund the

community mental health system, to the extent resources are available. The fund sources used to draw down federal Medicaid funds for MHPs are 1991 and 2011 realignment funds (a portion of dedicated sales tax and Vehicle License Fees), Mental Health Services Act (MHSA) [generated by the surtax on incomes over \$1 million from voter approved Proposition 63 in 2004], some General Fund (GF), and local county funds (depending upon the county). The state budget does not identify the dollar amount of the varying sources of funds used by counties (e.g., 1991 and 2011 realignment, MHSA) to draw down the federal match.³⁸

MCMC plans are paid on a pre-paid risk (capitated) basis by DHCS. Rates paid to MCMC plans have to be actuarially sound³⁹ and are based on plan costs incurred two to three years previously, subject to various adjustments. Funding comes from the state GF, provider taxes levied on specific plans and providers (such as hospitals, skilled nursing facilities and managed care plans), intergovernmental transfers from public providers and local governments, and federal Medicaid matching funds.

Spending on Medi-Cal mental health services by MHPs, MCMC and Medi-Cal FFS is shown below:

Medi-Cal Managed Care and Fee-for-Service* (2017-18 in millions)	MCPs - Mild-to Mod Outpatient	FFS - Acute Psychiatric	Psychotropic Drugs
Medi-Cal Federal Funds	387	228	671
Medi-Cal General Fund	154	144	425
Total	542	372	1,096
Medi-Cal SMHS (2017-18 in millions)			
Medi-Cal Federal Funds	2,954		
Medi-Cal General Fund	167		
Medi-Cal County Funds**	1,719		
Total	4,840		

**Includes funding from Local Realignment Revenues, Prop 63 MHSA, County GF

Source: Legislative Analyst’s Office.

In addition to the differences in the way MHPs and MCMC claim and are reimbursed for Medi-Cal services, these entities also pay providers in different ways. MCMC reimburse contracting health care providers through a number of different ways, including FFS, FFS with incentive payments (for example, additional funds for meeting patient satisfaction and quality goals, extended hours of operation, or meeting reporting requirements), and capitation. The arrangements vary by MCMC plan and provider type and are spelled out in the provider contracts. By contrast, MHP regulations spell out claiming procedures for providers in which certain services are billed based on minutes of time⁴⁰ (e.g., Mental Health Services, Medication Support Services, Crisis Intervention, Targeted Case Management and plan development for Mental Health Services and Medication Support), other services are billed in half-day or full-day basis⁴¹ (Day Treatment Intensive and Day Rehabilitation) with a face-to-face visit required, while other services are reimbursed based on calendar days (e.g., Adult Residential Treatment Services, Crisis Residential Treatment Services, Psychiatric Health Facility Services.⁴² Existing regulations allow a MHP to request approval from DHCS to establish a contract with a provider for SMHS for alternative payment arrangements where a provider is held financially

responsible for SMHS provided to beneficiaries by one or more other providers or to establish a payment arrangement with contract or non-contract providers that would not be allowed under existing regulation (such as capitation or a case arrangement).⁴³

In claiming for SMHS, the provider must document actual time (not estimated time) involved in providing an eligible service. After a provider provides a service to a Medi-Cal beneficiary, the MHP pays the contractor for the service (using non-federal funds), and the MHP submits a claim to DHCS for interim reimbursement. Payments are made based on established interim rates based on the amount the MHP certifies to the state as a public expenditure. DHCS then reimburse the MHP for the federal share of the MHP’s cost.

An August 2018 federal Office of Inspector General (OIG) report found that California did not always comply with federal and state requirements when claiming federal reimbursement for SMHS expenditures. On the basis of 500 sample service lines, OIG estimated that California claimed at least \$180.6 million in unallowable federal reimbursement. DHCS repaid the federal government in December 2018. DHCS indicates that, because the responsibility for SMHS was realigned to counties as a part of 2011 Realignment, these disallowances will ultimately be repaid by the counties on a quarterly basis, over a period of four years, beginning in the last quarter of FY 2018-19.

Oversight of MCMC and MHPs

The Managed Care Quality and Monitoring Division of DHCS is responsible for the monitoring and oversight of all MCMC plans, and the MHSUDS of DHCS oversees MHPs. The deputy director of the MHSUDS is a DHCS or gubernatorial appointee subject to Senate confirmation.⁴⁴ The chart below from the National Health Law Program⁴⁵ outlines requirements imposed by federal law and regulation, state law and Medicaid waivers to monitor and oversee the quality of MHPs and MCMCs:

Measure and Governing Law	Applies to	Frequency	Process	Result
Managed Care Program Reports 42 Code of Regulations (CFR) §438.66	MCMCs MHPs	Annual	DHCS must submit to CMS	DHCS is to evaluate each managed care plan in 10 areas specified in the regulation and produce an annual report summarizing its findings.
Healthcare Effectiveness Data and Information Set Measures/External Accountability Set 42 CFR 438.330(c)(1)	MCMCs MHPs	Annual	Plans must provide to External Quality Review Organization (EQRO) for validation	EQRO validates plan measures and publishes results in External Quality Technical Report (MCMCs) / External Quality Statewide Report (MHPs)
Health Plan Grievance Reports 42 CFR §438.416; APL 17-006	MCMCs	Quarterly	Plans must submit to DHCS	DHCS aggregates data and publishes quarterly in its Medi-Cal Managed Care Performance Dashboard
Annual Beneficiary Grievance and Appeal Report (AGBAR) 42 CFR §438.416; 9 CCR §1810.375(a)	MHPs	Annual	Plans must submit to DHCS	DHCS reviews the AGBAR as part of the Triennial Review; plans must develop a POC to address any non-compliance determined by the review.

Measure and Governing Law	Applies to	Frequency	Process	Result
Implementation Plans 9 CCR §1810.310	MHPs	Before operations and updated when changed	DHCS must approve	DHCS reviews the Implementation Plan including any proposed changes and must approve (explicitly or tacitly by not disapproving in 30 days) before changes are effective.
Performance Improvement Plans (PIPs) 42 CFR §438.330(d); 42 CFR §438.350	MCMCs MHPs	Annual	Plans must provide to EQRO for validation	EQRO evaluates and validates PIPs annually and includes its analysis in External Quality Technical Report (MCMCs)/External Quality Statewide Report (MHPs).
QIWP 1915(b) Waiver Terms & Conditions 4; 9 CCR§1810.440	MHPs	Annual	Plans must review and update their plans annually	Plans must publicly post their plans
External Quality Technical Reports 42 CFR §438.350	MCMCs	Annual	EQRO creates for DHCS	The EQRO obtains data and evaluates it to determine plan compliance in three areas. Using a protocol developed by CMS, and also reviews additional areas as directed by the state, and publishes its findings in an annual report.
Consumer Assessment of Healthcare Providers and Systems (CAHPS) APL 17-014	MCMCs	Triennial	The EQRO performs consumer satisfaction surveys every three years and produces a report for DHCS	The EQRO includes its results in the External Quality Technical Report.
Consumer Perception Surveys 9 CCR §3530.40	MHPs	Semi-annual	Plans survey consumers using an instrument developed by DHCS and a private contractor.	The survey results and analysis are validated by the EQRO and its validation is published in the External Quality Statewide Report.

CONCLUSION

Mental health conditions affect a substantial number of people in the U.S. and are especially common among low-income individuals. As a major source of coverage for low-income Californians, Medi-Cal plays a key role in covering mental health care. This hearing is intended to provide an overview and framework for understating the Medi-Cal mental health delivery system. The second joint hearing entitled “Improving the Medi-Cal Mental Health Delivery System” will be held on Tuesday, March 5, 2019, and will focus on how well the Medi-Cal mental health benefit is delivered. The committees will hear the following related to the Medi-Cal mental health delivery system:

- What works well in the delivery of the Medi-Cal mental health benefit?
- What needs improvement in the delivery of the Medi-Cal mental health benefit, with a focus on how to improve the delivery of services?
- How to better integrate the delivery of physical and mental benefits in the overall Medi-Cal healthcare delivery system?

- What should the Medi-Cal mental health delivery system look like in five, 10 or 15 years?

The purpose of these hearings is to provide an overview of the current Medi-Cal mental health delivery system and to ensure it is working effectively for California’s Medi-Cal beneficiaries.

¹ Government Code Section 12803.

² Welfare and Institutions Code Section 14105.07.

³ Welfare and Institutions Code Section 14682.1.

⁴ Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.82 (commencing with Section 14087.98), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Chapter 8 (commencing with Section 14200), including dental managed care plans, Chapter 8.9 (commencing with Section 14700).

⁵ Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs 2015 -2020, Version June 10, 2015, p. 58. The name of the waiver is the Medi-Cal Specialty Mental Health Services (SMHS) Consolidation.

⁶ 42 CFR, Section 438.2.

⁷ Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs 2015 -2020, Version June 10, 2015, p. 7..

⁸ Mental Health and Substance Use Disorder Services Information Notice 16-061, issued December 9, 2016.

⁹ The list of nearly 40 carved out psychiatric medications is in APL 17-018. DHCS indicates Health Plan of San Mateo and Kaiser Permanente in Sacramento County have these drugs carved in.

¹⁰ California Code of Regulations, Title 9, Section 1810.205.

¹¹ California Code of Regulations, Title 9, Section 1810.210.

¹² Social Security Act, Section 1396d(r)(5) and Welfare and Institutions Section 14059.5.

¹³ Welfare and Institutions Code Section 14059.5.

¹⁴ California Code of Regulations, Title 9, Section 1810.305.

¹⁵ California Code of Regulations, Title 9, Section 1830.305.

¹⁶ Mental Health and Substance Use Disorder Services Information (MHSUDS) Notice 16-061, issued December 9, 2016.

¹⁷ California Code of Regulations, Title 9, Section 1810.370(a)(5).

¹⁸ APL 15-007 and MHSUDS Information Notice 15-015.

¹⁹ California Code of Regulations, Title 9, Section 1810.247.

²⁰ Welfare and Institutions Code Section 14021.4, 42 U.S.C. § 1396d(a)(13); 42 CFR, Section 440.130.

²¹ Welfare and Institutions Code Section 14684(a)(5).

²² California Medicaid State Plan, Supplement 2 to Attachment 3.1-B, 13.d.4 Rehabilitative Mental Health Services, Approval Date December 18, 2012.

²³ California Code of Regulations, Title 9, Section 1830.355.

²⁴ Welfare and Institutions Code Section 14189.

²⁵ Welfare and Institutions Code Section 14189, as added by SB X1 1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013.

²⁶ Welfare and Institutions Code Section 14132.03.

²⁷ Section 2001 of the Patient Protection and Affordable Care Act, Public Laws 111-148 & 111-152, which amended 42 U.S.C. 1396u–7(b))

²⁸ Department of Health Care Services All Plan Letter 17-081, issued October 27, 2017.

²⁹ Welfare and Institutions Code Section 14681.

³⁰ Department of Health Care Services “Managed Care Performance Monitoring Dashboard Report” Released December 19, 2018, page 12 of 24.

³¹ DHCS 2018 Statewide Aggregate Specialty Mental Health Services Performance Dashboard, p. 5 and 21.

³² DHCS 2018 Statewide Aggregate Specialty Mental Health Services Performance Dashboard, p. 12 and 27.

³³ Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs 2015 -2020 Version June 10, 2015, pages 27-28.

³⁴ DHCS 1915(b) Waiver Standard Funding Questions, March 24, 2015.

³⁵ Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs 2015 -2020 Version June 10, 2015, page 155.

³⁶ Section 30025 of the Government Code, as amended by SB 1020 (Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2012).

³⁷ California Constitution, Article 13, Section 36, subdivision (c), paragraph (4), and DHCS November 2018 Medi-Cal Estimate, Base Policy Change Number 61.

³⁸ Medi-Cal November 2018 Local Assistance Estimate for Fiscal Years 2018-19 and 2019-20, Base Policy Changes 61 and 62. Medi-Cal Specialty Mental Health Services, November Estimate, Policy Change Supplement For Fiscal Years 2018-19 and 2019-20.

³⁹ 42 CFR, Section 438.4.

⁴⁰ California Code of Regulations, Title 9, Section 1830.316.

⁴¹ California Code of Regulations, Title 9, Section 1830.318.

⁴² California Code of Regulations, Title 9, Section 1830.320.

⁴³ California Code of Regulations, Title 9, Section 1830.438.

⁴⁴ Welfare and Institutions Code Section 4024.7

⁴⁵ “Navigating The Challenges of Medi-Cal’s Mental Health Services in California: An Examination of Care Coordination and Dispute Resolution” by Kimberly Lewis, Abigail Courosolle, Hector Hernandez-Delgado, Hayley Penan, and Alexis Robles, 2018.