Mild-to-Moderate Mental Health Coverage in Medi-Cal: The Challenge and Promise of Coordination between Counties and Health Plans

December 15, 2016

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Made possible with support from Blue Shield of California Foundation and the California Health Care Foundation
Questions?

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Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Two Part Series

Dec 1st
Overview of Mild-to-Moderate Mental Health Coverage and System Organization

Dec 15th
The Challenge and Promise of Coordination between Counties and Health Plans
Agenda

- Welcome and Introductions
- Implementation Challenges and Promising Practices
- On the Ground Perspectives
- Q&A
Meet Today’s Presenters

- **Allison Hamblin, MSPH,** Vice President, Center for Health Care Strategies
- **Rachel Wick, MPH,** Senior Program Officer, Health Care and Coverage, Blue Shield of California Foundation
- **Lamar Smith, PsyD,** Director of Clinical Services, Behavioral Health Department, L.A. Care Health Plan
- **Caryn Sumek, MPH,** Health Planning and Program Specialist, Behavioral Health Services, San Diego County HHS
- **Michael S. Krelstein, MD,** Clinical Director, Behavioral Health Services, San Diego County HHS
About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans
Welcoming Remarks

Rachel Wick
Senior Program Officer, Health Care and Coverage
Blue Shield of California Foundation
Promising Practices for Plan/County Coordination
Why Do Plans and Counties Need to Coordinate?

Ensure seamless access to mental health services

- Mild-to-moderate benefit via managed care plans
- Specialty services through counties

Promote physical-behavioral health integration

- Managed care enrollees with SMI
- Medicare/Medi-Cal enrollees in Cal MediConnect
Opportunities to Improve Plan-County Coordination

- Supported by Blue Shield of CA Foundation
- Based on interviews with key stakeholders
- Available at: www.chcs.org/resource/promising-practices-integrate-physical-mental-health-care-medical-members/
Key Challenges to Coordination

- Defining moderate and severe
- Ensuring smooth transitions
- Exchanging information
- Bridging cultural divides
Substantial room for interpretation

Eligibility for County MHP Reimbursement of Specialty Mental Health Services

A beneficiary is eligible for services if he or she meets all of the following criteria:

- Has an included diagnosis;
- Has a significant impairment in an important area of life functioning, or a reasonable probability of significant deterioration in an important area of life functioning / a reasonable probability of not progressing as individually appropriate (for members under 21 who meet criteria for EPSDT);
- The focus of the proposed treatment is to address the impairments;
- The expectation that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function; and
- The condition would not be responsive to physical health care-based treatment.

Wide variation across counties
PROMISING PRACTICE 1: Establish Clear Definitions

- Standardize definitions at local or regional levels
- Collaborate to develop screening tools that clarify placement decisions
- Consider opportunities to standardize at state level
CHALLENGE 2: Mental Health Needs are Dynamic

- Individuals transition across systems
- Provider networks are non-overlapping

### Specialty Mental Health Network
- County directly operated clinics
- County-contracted agencies

### Mild-to-Moderate Network
- Federally Qualified Health Centers
- Private providers who take commercial AND some public insurance

Credit: Beacon Health Options
PROMISING PRACTICE 2: Establish Policies and Procedures to Facilitate Smooth Transitions

- Use a transition of care form
- Leverage community-based clinics
- Allow for member preference
- Ensure support services are maintained upon transition from county to plan
- Encourage transition from county to plan as a step toward recovery
CHALLENGE 3: Barriers to Data Exchange Inhibit Coordination

- Philosophical differences about data privacy
- Constraints imposed by federal and state privacy laws
- Varying levels of IT capability
- Lack of interoperability
PROMISING PRACTICE 3: Develop Tools and Infrastructure to Facilitate Data Exchange

- Standardized release of information forms
- Access to portal systems
- Electronic “crosswalks” between systems
- Dedicated staff
CHALLENGE 4:
Significant Cultural Divides Exist

- Lack of shared language and understanding
- Differing financing structures and incentives
- Difficulty “letting go of the reins”
- Varying levels of sensitivity to data and privacy concerns
PROMISING PRACTICE 4: Begin Building Those Bridges

- Engage leadership as champions
- Invest in outreach and education
- Explain the benefits of coordination
- Experiment with pilots
- Develop personal and trusting relationships
Implementation Perspectives
Coverage of Mild-to-Moderate Mental Health Conditions

Lamar Smith, PsyD, Clinical Director, Behavioral Health Services, L.A. Care
Lsmith2@lacare.org
Disclosure

Dr. Smith has no relevant financial relationships with commercial interests to disclose.
Learning Objective

- Discuss and identify strategies to address the implementation of the mild to moderate mental health benefit
Care coordination across agencies – successes and challenges
Team Members

• Health Plan
  • Coordinates the mild to moderate mental health benefit

• Beacon
  • Delegated responsibility for providing the mild to moderate benefit to members.

• Department of Mental Health
  • Manages the severely and persistently mentally ill population.
Care Coordination Problems

- Defining “Mild to Moderate”
- Communication
- Data Exchange
- Step ups and step downs
Care Coordination Strategies

• Clinical Judgement to define Mild to Moderate

  • Does the member have hospitalization history? Functional Impairment? Would member benefit from case management services, wraparound, or other DMH level care?
Care Coordination Strategies

• Communication
  • Co- Located Team
  • Member Information Form
  • Follow up for referrals and linkage
Care Coordination Strategies

• Data Exchange
  • Delivery of Care Plans
  • Tracking of Data through BH Steering Committee
Care Coordination Strategies

• Step ups and step downs

  • Fluidity in moving members from one level of care to the next.
    • Members may not wish to separate from their existing provider.
    • Provider might want to maintain member whose symptoms are increasing.
    • Beacon provider may not know how to initiate step up or be aware of services in DMH that could benefit member.
I thank you for your part in my journey.
3.2 million residents in San Diego County

Medi-Cal Managed Care Enrollment

- In 2014 - 450,000 (80% of Medi-Cal Enrollees)
- In 2016 – 720,000 (97% of Medi-Cal Enrollees)
State mandate to coordinate public health and managed care with community partners and consumers

San Diego – Geographic Managed Care (GMC) County:

- Community Health Group
- Molina
- Health Net
- Care 1st
- Kaiser
- United Healthcare and Aetna joining the market in July 2017
HEALTHY SAN DIEGO VISION

- Patient choice selecting health plan
- “Value added” local involvement in assuring access and quality
- Community defined local standards
  - Participation of traditional and safety net providers
  - Coordination of care with health plans and community partners
  - Integration of public health services
- Local oversight
  - Problem solving and continuous quality improvement of the delivery system
1) Basic Requirements

2) Covered Services and Populations

3) Oversight Responsibilities of the MCP and MHP
   - MCP organization approach to management
   - MCHP and MHP MH Medi-Cal oversight team
   - MCP and MHP multidisciplinary clinical team oversight process

4) Screening, Assessment, and Referral. Policies and Procedures must include:
   - MH assessment conducted by MCP with mutually agreed upon tool
   - Referrals from MCP to MHP
   - Referrals from MHP to MCP

5) Care Coordination. Policies and Procedures must include:
   - Identified point of contact from each party
   - Coordination of care for inpatient MH treatment provided by the MHP
   - Transition of care for members transitioning to or from MCP or MHP services
   - Regular meetings to review referral, information exchange, and other protocols.
6) **Information Exchange.** Policies and procedures to ensure timely sharing of PHI for purposes of medical and MH coordination.

7) **Reporting and Quality Improvement Requirements**
   - Regular meetings to review referral and care coordination process and to monitor member utilization and engagement.
   - Semi-annual calendar year review of referral and care coordination process to improve quality of care with semi-annual reports summarizing findings.
   - Reports that track cross-system referrals, beneficiary engagement, and service utilization (including disputes).
   - Performance measures and quality improvement initiatives

8) **Dispute Resolution.** Describe a mutually agreed upon review process to facilitate timely resolution of clinical and administrative disputes.

9) **After-Hours Policies and Procedures**
   - Access for members and providers after hours
   - 24/7 emergency access

10) **Member and Provider Education.** Mutually determine requirements for coordination of member/provider information about access to MH services (e.g. develop and post a mutually agreed upon FAQ)
INITIAL PROCESS

- Utilized existing Healthy San Diego structure

- Created a specific operational workgroup
  - Representatives from BHS and each Health Plan
INITIAL PROCESS

- Workgroup collaboratively amended existing MOU

- Realized a need to define mild, moderate and severe
  - Worked to establish a clinical framework
### CLINICAL DISCUSSIONS

- Developed tools for the community
  - Quick Guide and Screening Form
  - Frequently Asked Questions

### San Diego County

#### Medi-Cal Mental Health Severity Screening

*For new clients who are accessing services; not individuals already connected with a provider*

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty Mental Health Services Provided by the County Mental Health Plan</strong></td>
<td>If any of the following indicators of serious impairment/disturbance in mood, behavior, and/or psychosocial functioning are met, the member may be referred for Specialty Mental Health Services through the County.</td>
</tr>
<tr>
<td>- Contact the San Diego County Access &amp; Crisis Line at (888) 724-7240</td>
<td>- Acute risk of harm to self or others</td>
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<td>- A member may access a County Behavioral Health Program directly</td>
<td>- Psychotic symptoms (delusions, hallucinations, paranoia)</td>
</tr>
<tr>
<td>- For an emergency, call 911</td>
<td>- Marked cognitive impairment (confusion, disordered thinking, poor concentration)</td>
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</tbody>
</table>

**Behavioral Health Services Provided by the Medi-Cal Managed Care Health Plan**

| | If any of the following indicators of mild to moderate impairment/disturbance in mood, behavior, and/or psychosocial functioning are met, the member may be referred to their Medi-Cal Managed Care Health Plan |
| | - In need of behavioral health treatment due to a situational issue such as loss, break up, major life changes |
| | - Isolation or substantial disruption in relationships with family, friends, or other social supports, resulting in extreme distress |
| | - Excessive truancy or suddenly failing school |
| | - Symptoms are likely to be resolved in 6 months or less with psychotherapy |
| | - Member has been stable on psychotropic medications for 1 year or longer and requires medication management only |
Developed tools for clinicians
- Severity Analysis grid

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**San Diego County Adult Medi-Cal Mental Health Severity Analysis**

Mental Health Plan will follow Medical Necessity Criteria for Medi-Cal Specialty Mental Health Services described in Title 5, CCR

<table>
<thead>
<tr>
<th>Element</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Passive ideation or thoughts of suicide or self-harm</td>
<td>Passive ideation or low-level active danger to self/danger to others (DSM/DSO) history</td>
<td>Suicidal ideation or active intention, plan or intent</td>
</tr>
<tr>
<td></td>
<td>Minimal emotional background</td>
<td>Mid-level suicide risk, brief jail stays</td>
<td>Severe or current active ideation, plan or intent</td>
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<td></td>
<td>Severe or current active ideation, plan or intent</td>
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<td>Ego dystonic</td>
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<td>Severe or current active ideation, plan or intent</td>
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<td>Severe or current active ideation, plan or intent</td>
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<tr>
<td></td>
<td>Schizophrenia, major mood or anxiety disorder, recent instability or worsening function, precarious recovery, cognitive impairment</td>
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<td>Inpatient mental illness (SMH)</td>
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<td>Limited AOD use</td>
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<tr>
<td>Clinical Complexity</td>
<td>Adjustment reaction</td>
<td>Severe or current active ideation, plan or intent</td>
<td>Severe or current active ideation, plan or intent</td>
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<tr>
<td></td>
<td>Minor depression/adjustment disorder, initial NCH or CTC, treatment hospitalization, brief hospitalization for mental illness, Elopement, and/or engagement with one’s self</td>
<td>Severe or current active ideation, plan or intent</td>
<td>Severe or current active ideation, plan or intent</td>
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<td></td>
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<td>Limited AOD use</td>
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<td>Limited AOD use</td>
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<tr>
<td>Life Circumstances</td>
<td>Emotional distress arising to the course of normal life, life cycle or environmental stressors, family/social/both based support, resilience</td>
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<td>Adequately supported</td>
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<td>Relatively supported</td>
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<td>Benefit of Integrated Care</td>
<td>High (1)</td>
<td>Medium (2)</td>
<td>Low (3)</td>
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<td>High acuity in primary care setting for chronic mental illness or co-occurring serious mental health, emotional distress, or severe mental illness</td>
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<td>High behavioral, low medical care</td>
<td>High behavioral, low medical care</td>
<td>High behavioral, low medical care</td>
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<td>Total:</td>
<td>Tier 1 (0-4)</td>
<td>Tier 2 (5-8)</td>
<td>Tier 3 (9-12)</td>
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<tr>
<td>Referrals</td>
<td>Augmented Primary Care Provider (CPSP) Impact Health Plan Network</td>
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<td>Augmented Primary Care Provider (CPSP) Impact Health Plan Network</td>
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<td>Federally Qualified Health Center (FQHC)</td>
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<td>Health Plan Behavioral Health (BHW) Network</td>
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<td>County Mental Health Plan (CMHP):</td>
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<td>-Organizational Provider</td>
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<td>-System Fee-for-Service (FFS) Provider</td>
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**SAN DIEGO COUNTY MEDI-CAL MANAGED CARE HEALTH PLANS**

- Care1st Health Plan (858) 556-2311
- Community Health Group (858) 404-2332
- Health Net (858) 436-0030
- Kaiser Permanente (858) 404-0040
- Molina Healthcare (858) 560-0411
- San Diego County Homeless Network: (858) 726-5000

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Disseminated tools with a reference guide

- Intended to be a community shared conceptual framework and a useful guide regarding the various populations seeking mental health services

Is not:

- An all-inclusive list of assessment domains
- A concrete delineation of mild, moderate vs. severe status
- Required as part of a routine clinical assessment
ONGOING ACTIVITIES

- Development of a Case Consult forum
  - Medical Director level

- Regular meetings to ensure discussion of issues to address as they arise
BEST PRACTICES

- Designated representatives
- Ongoing dialogue
- Shared conceptual framework for patient centered care
- Collaborative approach = shared commitment
- Case Consult Forum
THANK YOU

CONTACT INFORMATION:

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Caryn Sumek, MPH
Health Planning & Program Specialist, Behavioral Health Services
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