Sutter Behavioral Health Learning Collaborative (SBHLC)

PROVIDER MEETING

October 8, 2024

SUTTER COUNTY
HEALTH AND HUMAN SERVICES

AGENDA

1. **Behavioral Health Knowledge Level Survey**
2. **Brief History of Public Behavioral Health Services in California**
3. **Brief Review of Benefit Structures**
4. **Sutter-Yuba Behavioral Health: Mental Health Plan (MHP) Benefits: Specialty Mental Health Services (SMHS)**
   - Overview
   - SMHS benefit group feature in this section: Inpatient/Residential

Behavioral Health Knowledge Level Survey

- We would like to assess your behavioral health knowledge level to better understand where to target our educational content and its effectiveness
  - Focus: knowledge and awareness of behavioral health benefits for Sutter County residents with Medi-Cal as their primary insurance coverage
  - Should only take 2-3 minutes of your time!

Scan the QR code here

Pre-Education Survey

A Step Back in Time

- It is important to know where we have come from to know where we are going
- Institutionalization through asylums and mental hospitals developed in the 1700s and peaked in the 1950s
  - California had close to 37,000 patients hospitalized in 14 mental hospitals in the late 1950s
  - Expensive and susceptible to underfunding
  - Facilities quickly became overcrowded
  - Isolation from employment, social support, civic life
  - Under development of patients' rights
  - Controlling patient's behavior often became the goal, not therapy, rehabilitation, recovery, and wellness

Development of Community Mental Health Services

- As early as the 1920s, more progressive funding and legislation at the state and federal levels begin to establish mental health resources and services in communities (such as treatment at local hospitals)
- 1957, Short-Doyle Act (California) provided state matching funding for cities and counties that established and provided community-based mental health services
  - 1963, Short-Doyle funding was enhanced and service scope expanded
  - Service scope = ADDITIONAL BENEFITS
- 1963, Community Mental Health Act (Federal, signed by John F. Kennedy) provided federal support for the development of community-based mental health care and treatment facilities

Development of Community Mental Health Services

- 1965, Medicare and Medicaid were created as amendments to the Social Security Act
- 1966-67, Congress, as part of the Child Health Component of Medicaid, introduces the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit
- 1966, California established Medi-Cal
- Specialty mental health services (or benefits) such as psychiatric inpatient hospitalization (in local hospitals, NOT state mental hospitals/asylums), nursing facility care, and treatment under psychiatrists and psychologists were eligible for reimbursement through Medi-Cal
- STATE PLAN AND WAIVER BACKGROUND
  - Assumed that medication and other medical treatments used to control patients in mental hospitals would translate to outpatient, community-based care
  - Budget Act 1966-68

Development of Community Mental Health Services and Accompanying Legislation

- 1967, California Mental Health Act
  - Increased State funding for community-based services
  - This was money presumably saved by having fewer patients in state mental hospitals

- 1968, Lanterman-Petris-Short (LPS) Act
  - Part of the California Mental Health Act of 1967
  - Significantly tightened standards for involuntary psychiatric hospitalization by limiting length of a hold to 72 hours
  - Prompt evaluation and treatment should be provided in the community
  - Increased demand for services, which is why state funding for local services was increased

Development of Community Behavioral Health Services

- Through the work of the State of California and the counties, coverage of specialty mental health services would continuously grow into the system that exists today.
  - 1969-1971, state mental hospitals began to close
  - 1971, CA counties receive matching funds for Short-Doyle services from Medi-Cal
  - 1974, CA counties are required to have mental health programs, which are later organized into Mental Health Plans (MHP)
    - Any County Behavioral Health is a MHP
  - DHCS begins **Drug Medi-Cal Services in 1978 and in 1980** enters into an Interagency agreement with the Department of Alcohol and Drug Programs (DADP)

California Examines Gaps in Mental Health Services

- 1985, Bronzan-Mojonnier Act
  - Identifies service shortages that have resulted in criminalization, homelessness, vocational challenges, and which leave severely emotionally disturbed children vulnerable
- 1988, McCorquodale-Bronzan Mental Health Act
  - Defines the mission of the State's mental health system to provide services "tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive settings available"
  - Tests community-based integrated service systems of care
- 1988, Children's Civil Commitment and Mental Health Treatment Act, 5585.52
- 1989, Federal Omnibus Budget Reconciliation Act of 1989, Adds EPSDT language for Medicaid to cover services that "correct or ameliorate defects, physical and mental illnesses, and conditions discovered by screening services, whether or not such services were covered under the Medicaid State Plan."

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  - 1991 (A.B. 1288-1989)

    Welfare and Institutions Code, Section 5671.5, Programs to serve children and adolescents; legislative intent; criteria

    1) The programs should, to the maximum extent feasible, be designed so as to reduce disruption and promote reintegration of the family unit of which the child is part

    2) The programs should have an educational focus and should demonstrate specific linkage with community education resources

    3) The programs should contain a specific follow-up component

    Welfare and Institutions Code, Section 5672, Programs to Serve children and adolescents; program types; criteria; licensure requirements

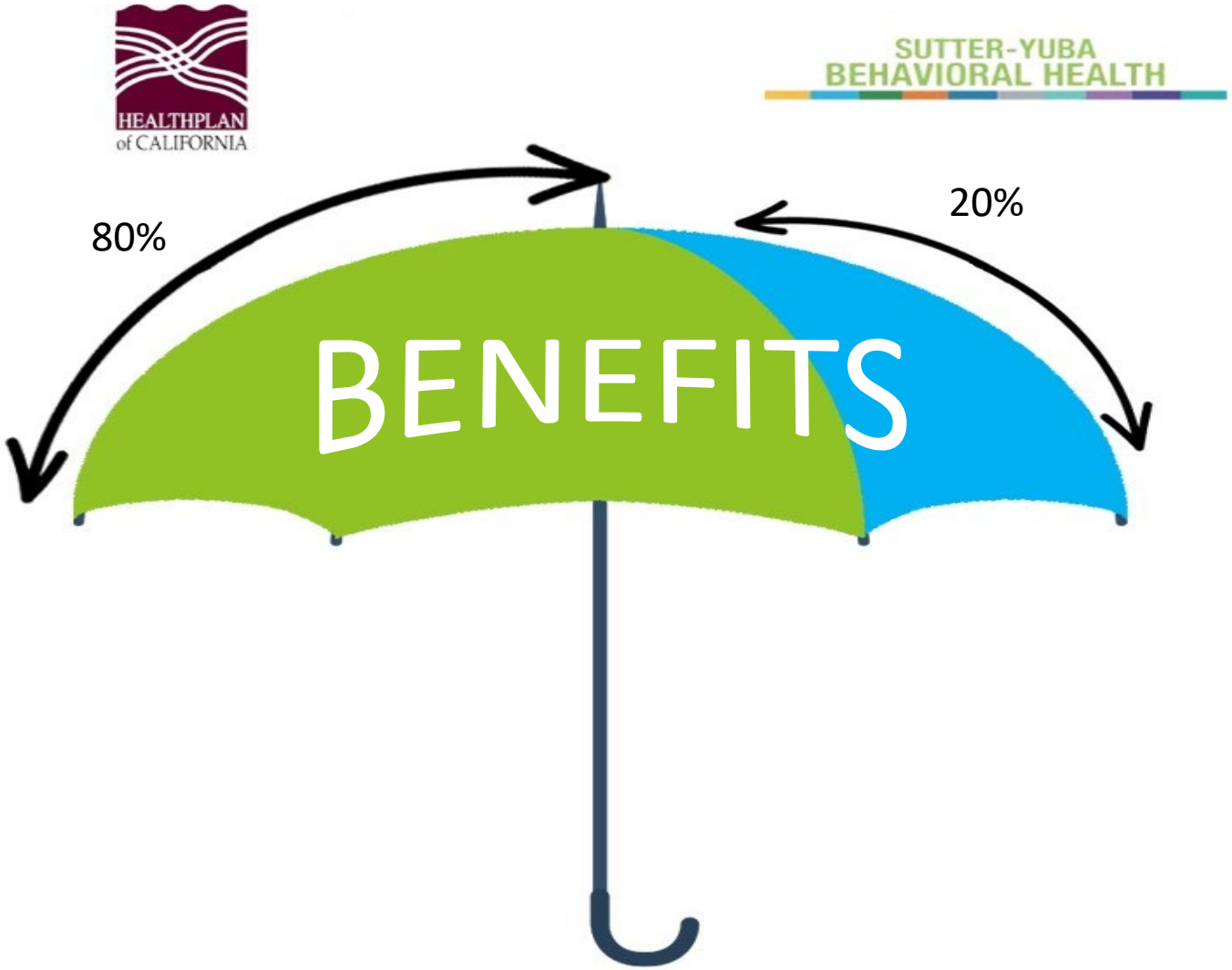
Care through County MHP's Is Powerful Evidence of ACA Reform Principles in Action for Chronic Illness

- Recovery and wellness is promoted through a health care service delivery approach that was ahead of its time and provided by MHPs:
  - **Field-based Services:** Services can be field-based based on the 1993 California State Plan Amendment (AB 218) to adopt the Medicaid Rehabilitation Option was added: "Community-based (non-clinic) services, expanded provider types, permitted additional services, included long-term community care model" and expanded beyond clinic-based Short-Doyle Medi-Cal Program
  - **Targeted Case Management**: Individual recovery plans and goals are developed and monitored in a partnership between the consumer, the service provider, and support persons (such as family members)
  - **Rehabilitative Services**: Programs that minimize disability through the restoration of functioning in daily life with a focus on recovery, resiliency, and enhanced self-sufficiency

California Reorganizes Behavioral Health Services

- 1995, Medi-Cal Psychiatric Inpatient Hospital Services Consolidation created the mental health managed care model that characterizes the county carve out today
- 1995, T.L. Vs Belshe (Kim Belshe), The state agreed to promulgate regulations to guide process for covering EPSDT treatment services not included in the state Medicaid
- 1997, Medi-Cal SMHS Consolidation made county MHPs the responsible agent for outpatient specialty mental health services
- 2004, Mental Health Services Act (Prop 63) provides income tax revenues to expand innovation, technology and training, and prevention/early intervention services
- 2011, dedicated sales tax revenues are distributed to counties for mental health, substance abuse, and criminal justice services (including children's residential)
- In 2012, the Drug Medi-Cal Treatment Program is transferred from DADP to DHCS
- In 2014, DHCS worked with Medical Managed Care Plans to add Mild to Moderate Behavioral Health Services
- In 2015, DHCS includes a plan for an Organized Delivery System for Drug Medi-Cal in the 1115 Bridge to Reform Waiver
- In 2022, CalAIM rolled out
- In 2024, BHSA approved

MEDI-CAL INSURANCE COVERAGE



MEDI-CAL BENEFITS

MEDI-CAL MANAGED CARE PLANS (MCP's) (PARTNERSHIP HEALTHPLAN)		COUNTY MENTAL HEALTH PLANS (MHP's) (SUTTER-YUBA BEHAVIORAL HEALTH)
Has the responsibility to arrange and/or pay/provide for coverage:		Has the responsibility to arrange and/or pay/provide for coverage:
Array of Health Services Plus Mild, Moderate Behavioral Health Services & Some Medicated Assisted Treatment		Specialty Mental Health Services (SMHS)
(CalAIM) Enhanced Care Management (ECM)	(CalAIM) Community Supports	Severe & Persistent or Chronic Behavioral Health Conditions
Some Long-Term Care and other Specialty Benefits www.partnershiphp.org/Providers/BehavioralHealth/Pages/Mental-Health-Services.aspx		Substance Use Disorder (SUD) Services Under Drug Medi-Cal

Medi-Cal benefits are one insurance coverage product even when sections of coverage are administered but different plan types (i.e. MCP & MHPS)

SUTTER-YUBA BEHAVIORAL HEALTH
MENTAL HEALTH PLAN (MHP)

MHP SPECIALTY MENTAL HEALTH SERVICES BENEFITS

INCLUDES THREE "BUCKETS" OR CATEGORIES OF SERVICES

INPATIENT / RESIDENTIAL

ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Acute Psychiatric Inpatient Hospital services are provided by a hospital to a client (beneficiary) for whom the facilities, services and equipment described in Title 9, Chapter 11, Section 1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with Section 1820.205.

ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Cal. Code Regs. Tit. 9, § 1820.205 For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in Subsections (a)(1)-(2) below:

(1) One of the following diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IVT (1994)*, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy or Early Childhood
(D) Tic Disorders
(E) Elimination Disorders
(F) Other Disorders of Infancy, Childhood, or Adolescence
(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
(I) Schizophrenia and Other Psychotic Disorders
(J) Mood Disorders
(K) Anxiety Disorders
(M) Somatoform Disorders
(N) Dissociative Disorders
(O) Eating Disorders
(P) Intermittent Explosive Disorder
(Q) Pyromania
(R) Adjustment Disorders
(S) Personality Disorders

Ref: https://www.law.cornell.edu/regulations/california/9-CCR-1820.205

INPATIENT ADMISSION REQUIREMENTS

(2) Both the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):
    a. Represent a current danger to self or others, or significant property destruction.
    b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
    c. Present a severe risk to the beneficiary's physical health.
    d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:
    a. Further psychiatric evaluation.
    b. Medication treatment.
    c. Other treatment that can reasonably be provided only if the patient is hospitalized.

Ref: https://www.law.cornell.edu/regulations/california/9-CCR-1820.205

INPATIENT CONTINUED STAY REQUIREMENTS

Continued stay services in a hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications that meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications that meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

Ref: *https://www.law.cornell.edu/regulations/california/9-CCR-1820.205*

AUGMENTED BOARD AND CARE SERVICES (NOT BILLABLE TO MEDI-CAL BUT PAID BY SYBH)

Augmented Board and Care services provide rehabilitation in a noninstitutional residential setting where clients are supported in their efforts to restore, maintain and apply interpersonal and independent living skills and community support systems.

Programs shall provide a therapeutic community, including a range of activities and services for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.

The services are offered in a structured setting and are available 24 hours a day, seven days a week.

Ref: *https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/05/QM6036.pdf*

LONG TERM RESIDENTIAL TREATMENT PROGRAM (16 beds or less)

Long Term Residential Treatment Programs are designed to serve chronically mentally ill individuals who have the potential for improving their emotional, social and vocational functioning.

Individuals must be able to benefit from the treatment program with the goal of moving to a less intensive level of care (e.g., community care facilities, semi-independent living and independent living).

Without this level of care, these individuals are likely to require long-term psychiatric hospitalization or skilled nursing care or may become frequent users of acute hospital services.

A full range of social rehabilitation services, including day programming for individuals who require intensive support, is provided in this 24-hour therapeutic residential setting.

The planned length of stay should be in accordance with the client's assessed needs, but not to exceed 18 months.

Ref: https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/05/QM6036.pdf

INSTITUTIONS OF MENTAL DISEASE (IMD) (EXCLUDED FROM BILLING MEDI-CAL BECAUSE OF BEING INSTITUTIONALIZED)

An IMD is a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental illnesses, including medical attention, nursing care and related services.

Ref: https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/05/QM6036.pdf

CRISIS STABILIZATION

Crisis Stabilization involves an immediate face-to-face response to or on behalf of a person exhibiting acute psychiatric symptoms.

It is provided at a 24-hour health care facility or hospital-based outpatient program or a provider site certified by DMH or a Mental Health Plan to provide this service.

The goal is to avoid the need for Inpatient Services by alleviating problems that, if not treated, might result in the need for a higher level of care.

This service is to be provided for less than 24 hours.

**Counties can offer crisis intervention services as well.*

Crisis intervention is offered in our county.

Ref: https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/05/QM6036.pdf

SUBSTANCE USE DISORDER RESIDENTIAL TREATMENT SERVICES

- Persons screened and assessed, at SYBH outpatient clinic, for a Substance Use Disorder and determined to need an inpatient level of care, are referred to area contracted residential treatment providers.
- The inpatient residential treatment programs are 30, 60 or 90 days in length, in an unlocked residential treatment setting.
- The programs are social models, supporting medication assisted treatment, designed to educate and treat persons with Substance use Disorders.
- Providing the necessary skills to live a recovery, drug & alcohol free, lifestyle.
- Curriculum includes groups, individual sessions, and social detox services.

QUESTIONS / COMMENTS

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Next Meeting: TBD

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