California Children's Trust

Difficult Bi-Design

The Promises and Possibilities of California's Bifurcated Mental Health System

Over the past few years, California has taken admirable steps towards more robust and fairer access to the mental health resources young people need in the midst of an enormous surge in demand. With innovations such as the California Youth Behavioral Health Initiative, the addition of new provider classes, and the Multi-Payer Fee Schedule, we are proud that our state is on the leading edge of youth mental health systems change and reform.

But as any patient, parent, caregiver, or medical professional knows, getting mental health care for young people in California remains hard. What many may not realize is that it is made more challenging by the existence of two independent, publicly funded systems that are not set up to work seamlessly with one another—the county-run mental health plans (Specialty Mental Health Services, SMHS) and the managed care plans (Non-Specialty Mental Health Services, NSMHS)

Two systems, operating independently, add up to less than the sum of their parts. At a time when our young people need seamless access to an expanding range of services, the diagnostic requirements, administrative burdens, disparate county practices and competencies, and lack of support from the state have led to a world where California talks the talk about expanding access, but is sadly failing to walk the walk.

However, we remain hopeful. In this paper we show how a set of relatively straightforward and common-sense reforms can increase the number of children served, improve cultural congruence (especially for non-specialty services,) and reduce the burden placed on young people, and those that love them, to receive the care they need.

GLOSSARY

NSMHS: Non-specialty mental health services are the mental health services provided through managed care plans

SMHS: Specialty mental health services is a broader continuum of services provided by County mental health plans often dealing with higher acuity patients

No Wrong Door: The California Advancing and Innovating Medi-Cal (CalAIM) policy enacted in 2022 was designed to ensure Medi-Cal beneficiaries get the right mental health services at the right time and place. DHCS created statewide screening and transition tools, removed the requirement for a diagnosis to start services (confirming what is legally mandated with Early and Periodic Screening, Diagnostic, and Treatment benefits), and made permissible language for an individual to be served simultaneously in both systems if coordinated and non-duplicative.

The Rise of Non-Specialty Mental Health Service Utilization

Responsibility for delivering California's Medi-Cal mental health services is split between the state's 56 county-operated Mental Health Plans (MHPs) and roughly 20 Medi-Cal Managed Care Plans (MCPs). This bifurcation dates back to 2014 to comply with the 10 essential health benefits required by the Affordable Care Act, when California added outpatient mental health services to the Medi-Cal managed care plan package. The new outpatient services were modeled on what was available in commercial health plans—largely office-based individual therapy and psychiatric medication management.

To deliver the new services, California's Medi-Cal MCPs created provider networks composed mostly of solo and small group practitioners and Federally Qualified Health Centers (FQHCs). There is minimal overlap in providers who are contracted for Specialty and Non-Specialty services. An analysis of a large Medi-Cal managed care plan's network, for example, found that only 15% of county-contracted specialty mental health providers were in-network with the managed care plan to deliver non-specialty services.

Data shared by the California Children's Trust shows that the utilization rates of MCP-funded non-specialty mental health services are nearly equal (in terms of unique beneficiaries served) to County MHP specialty services statewide , especially for children ages six and older. The utilization rate (percentage of those eligible who recieved a service) for non-specialty mental health services has increased annually since its creation in 2014, however, the utilization rate for specialty mental health services has stagnated or even fallen in some counties.

Managed Care Is Here to Stay

California's expansion of Medicaid managed care—both in terms of number of individuals and the programs and benefits they are being required to manage—is in line with national trends.

Today, more than 90% of Medi-Cal beneficiaries are enrolled in managed care,[1] including many individuals with complex health, social and behavioral needs. Medi-Cal policy changes over the last decade have expanded the Medi-Cal managed care plans' role in mental health service administration and addressing social drivers of health.

Examples of services added to California's Medi-Cal managed care plans' responsibility over the last decade include:

1. Non-specialty mental health services (2014)
2. Behavioral Health Treatment for Autism (2014)
3. Collaborative care (2021)
4. Expansion of non-specialty mental health services to include family therapy (2020) and dyadic care behavioral services (2023)
5. CalAIM Benefits: Enhanced Care Management and Community Supports (2022)
6. School-linked mental health services expansion/ All-Payer Fee Schedule (2024)
7. New Provider Classes including Community Health Workers (2022) Doulas (2022) and Wellness Coaches (2025).
8. Population Health Management and Quality Improvement Initiatives (2023)
9. MOU Requirements with Child Welfare (2024) and new screening and level of care tools in collaboration with MHPs (2022).

This expanded benefit design has shifted the scale and scope of the Medi-Cal behavioral health service delivery in California.

1 Medi-Cal Monthly Eligible Fast Facts October 2023. www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-July2023.pdf

The Labyrinth of No Wrong Doors

The California Department of Health Care Service (DHCS) oversees both the SMHS and NSMHS delivery systems. Through CalAIM, DHCS promotes a "no wrong door" approach to service delivery, supported by a set of standardized screening and transition tools. The roll-out of these tools created renewed confusion and disagreement between county MHPs and MCPs similar to the initial benefit roll out a decade earlier.

We hear stories across California of unmatched supply and demand for services, and providers spending more time trying to get claims paid based on the new screening tool. One integrated primary care-base provider reports that claims are routinely denied by MCPs if a youth was previously screened for needing specialty services. Provider confusion translates into delay in providing mental health care to children and youth.

The needs of children and youth are not static, nor do they conform to either the specialty or non-specialty benefit and network design. They should be able to continue working with a trusted provider as their needs fluctuate and change over time. A primary obstacle to fully realizing this vision of a seamless system for children, youth, and families is that only a small percentage of specialty providers are contracted with managed care plans.

Specialty mental health providers cite substantially lower non-specialty payment rates and high administrative burdens of contracting, credentialing and seeking payment from multiple managed care plans as reasons for not joining the MCP networks to deliver non-specialty services. On the other end, Medi-Cal managed care plans may not be familiar with the specialty mental health program certification requirements and place undue burdens on the providers.

Foundational Issues Impeding the Promise of Care

While we can celebrate the fact that the total number of Medi-Cal enrollees who have received mental health services is greater since the benefits were created a decade ago, below are examples of structural challenges with benefit delivery which means the full promise of the benefits is not yet being realized for California's most vulnerable children, youth and families.

Workforce

California's workforce of licensed mental health providers does not reflect the Medi-Cal population. Provider–patient alignment built from cultural competency is a key driver to better outcomes for young people, but the majority of California's counselors, psychologists and social workers are white women over age 40, while the majority of children and youth on Medi-Cal identify as BIPOC. This disparity is especially true in the managed care non-specialty networks predominantly composed of individual and small group practices.

Reimbursement rates

Compounding the workforce issues, non-specialty payment rates are frequently cited by specialty mental health providers as being too low. The majority of community mental health providers have built budgets and business practices that managed care plan rates cannot afford. Resolving this mismatch is essential to addressing the challenges of the bifurcated mental health delivery system.

Provider enrollment: California's long network timelines make it an outlier

Federal Medicaid program compliance requires that participating providers complete an initial screening and enrollment process, in addition to also being credentialed by each and every managed care payer whose network they wish to join. California law allows DHCS 180 days to enroll non-physician behavioral health providers. That is twice as long as any other state reviewed (see Table 1).

TABLE 1: Maximum allowable time frames for completing Medicaid provider enrollment

STATE	REQUIRED COMPLETION TIME
Colorado	State reports average processing times of 5 business days
Minnesota	30 days
Washington	30 days
New Jersey	35 calendar days
Florida	60 days for providers that require a site review and 14 days for all other providers
Texas	60 days
Arizona	60 days
Kentucky	90 days
California	90 days for physicians; 180 days for non-physicians

After enrolling in Medi-Cal (usually through the DHCS PAVE portal[2]), providers must complete a credentialing process separately for each managed care plan. California has more Medicaid enrollees and managed care plans than any other state (at least 20 Medi-Cal Managed Care Plans and 56 county-operated mental health plans—not counting separately operated Drug Medi-Cal plans). Today, California has no publicly available information to monitor performance of Medi-Cal enrollment or credentialing processing timelines.

COMMON MYTHS DEBUNKED

Prior authorization of NSMHS is required. ***FALSE***

Managed care plans cannot require prior authorization for outpatient non-specialty mental health services.

You have to refer everyone to your county access line to get NSMHS authorization. ***FALSE***

To get a NSMH appointment, Medi-Cal beneficiaries can work with their Primary Care Physician's office, call their MCP or find an available provider themselves with the online directory and schedule an appointment.

Children and youth must meet specific diagnostic criteria. ***FALSE***

With EPSDT children are not required to have a diagnosis before receiving services from either system. Further, children under 21 with experience of foster care, juvenile justice, and/or homelessness may meet access criteria. Similarly, youth may be eligible for specific NSMHS through the experience of various traumatic life experiences.

You can only be credentialed to one system—SMHS or NSMHS. ***FALSE***

It is encouraged for providers to cross-credential into both systems. The criteria for individual clinicians are the same but the processes may vary.

Medicaid beneficiaries can only access one system—SMHS or NSMHS—at a time. ***FALSE***

For example, it is possible to bill Enhanced Care Management (ECM) and Intensive Care Coordination (ICC) per DHCS guidelines.

2 Nonprofit public benefit corporations are not an allowable provider type to enroll in Medi-Cal via the PAVE portal. Instead, individually licensed clinicians must enroll via PAVE. Managed Care Plans are accustomed to contracting with groups, which are professional corporations, and thus do not always have credentialing policies that reflect the unique requirements of California's community mental health centers, creating confusion and delays.

What Can Be Done: Moving from Bifurcated to Aligned

While hundreds of thousands of additional Medi-Cal enrollees have accessed non-specialty mental health services over the last decade, the state's bifurcated system has not achieved its full potential. A number of reforms can be done to smooth rough edges and improve outcomes.

1. Center children and caregivers.

- Managed care plans and county Mental Health Plans can jointly capture real life experiences of children, youth and families trying to navigate the bifurcated system. Then jointly deploy a human-centered design approach to improving the experience.
- Work with children, caregivers, and mental health practitioners to co-create public awareness campaigns busting myths and alerting them to the programs available to them through their managed care plans.
- Directly invest in youth organizing, power building, and violence prevention strategies.

2. Continue expanding the workforce in a culturally concordant manner.

- California has become a national leader in expanding the types of providers who can receive Medi-Cal funding to include more school-based, community-based, and peer-to-peer programs. However, it is unclear how many of these new providers are actually delivering reimbursable services. California should ask managed care plans and mental health plans to set performance targets for adding these new provider types to their networks and have a dashboard that shows how much services they have delivered.
- California should identify key drivers of low adoption rates and develop specific strategies to address them. It may require increasing rates for community health workers and dedicating new non-federal dollars to MHPs and require they scale peer support specialists.

3. Acknowledge differences in reimbursement methodologies and provide technical assistance to help providers manage the complexity.

Starting in January 2024, California will increase Medi-Cal fee-for-service non-specialty mental health rates to at least 87.5% of Medicare. Many managed care plans already pay that much or higher. However, these rates are significantly lower (often by half or more) than the specialty mental health rates. Community mental health agencies state they cannot maintain their quality, accreditation status and compliance standards with the non-specialty rates.

4. Address the unintended consequences of payment reform in the specialty mental health system.

- Address rate disparities between licensed clinicians and extenders to remove the incentive to drive utilization to high cost clinical settings.
- Standardize pass through rate setting methodology and encourage the creation of case rate models for priority populations and settings (wraparound, Short-Term Residential Therapeutic Programs, Evidence Based Programs, etc).
- Require a modifier for field based services to encourage best practices of community mental health

5. Facilitate and incentivize providers to cross-credential in the specialty and non-specialty systems.

As a first step to this goal, policymakers and managed care leaders should acknowledge it is administratively burdensome and complex for providers to credential and contract across both systems. Delays in credentialing and contracting create major cash-flow disruptions for providers that they cannot easily absorb, making them reluctant to expand. Specific implementation recommendations include:

- Explore options to streamline credentialing across the systems in a manner compliant with the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS). For example, several states are moving toward centralized credentialing and require acceptance of that credentialing across systems. CalMHSA also recently engaged with a centralized entity on behalf of county MHPs.

- Set maximum credentialing processing times in managed care contracts. California is unique among states in not having performance benchmarks for credentialing turnaround times in managed care contracts. This should change.
- Invest in and support the growth of provider collaboratives and network intermediaries that can bridge systems and encourage more culturally concordant community-based organizations to join managed care networks.
- Create a quality improvement bonus program (like the CalAIM Behavioral Health Quality Improvement Program) to financially reward providers that work in both systems and create care and operational models that promote seamless access to care. At a minimum, this could help address the payment disparity while providers work to revamp business and operational processes.

6. Ensure the continuum of care works.

DHCS should set system performance goals that are specific, measurable, time-bound and associated with incentives and penalties, and then publish progress toward meeting these goals. Examples include:

- **Monitor implementation of new benefits.** MHPs nor MCPs should not be allowed to move at their own timelines when adding new benefit codes to provider contracts. More than a year after the addition of the dyadic behavioral health services, for example, many MCPs have not configured their claims systems to pay these codes or added them to provider contracts.
- **Provider alignment.** Measure the baseline of network crossover of specialty providers who are als in-network with MCPs for non-specialty services in 2025 and set targets to increase the overlap through a stakeholder process.
- **Inter-system coordination.** Generate contract templates to demonstrate how child welfare and juvenile justice stakeholders can work with specialty mental health and pool non federal dollars to increase access to care for system involved children in evidence based models of care. (Wrap services and Multisystemic Therapy, as examples)
- **Track conversion rates.** Require MHPs and MCPs to track how many individuals who called and were screened for services actually attended an appointment. Have them set quality improvement goals from their baseline.
- **Dyadic services.** Set a specific target for the number of programs to be operating and billing by 2026. Track and publish progress quarterly.
- **Wellness coaches.** Have more than 500 wellness coaches in place and billing for services rendered at school-linked sites by 2026.

7. Expand access for outpatient substance use disorder (SUD) services.

- MCPs can pay claims for covered outpatient services delivered to beneficiaries with a primary SUD diagnosis. DHCS should encourage MCPs to develop their prescribing and outpatient individual, group and family therapy networks with providers that have specialties in treating SUD.
- MCPs can continue building out primary-care based SUD services for medication-assisted treatment and screening, brief intervention and referral.
- DHCS should consider renaming the Non-Specialty Mental Health Services “Outpatient Behavioral Health” services to embrace the treatment of both mental health and addiction.

Moving Forward

Although hundreds of thousands of additional Medi-Cal enrollees have accessed non-specialty mental health services over the last decade, the state's bifurcated system has not achieved its full potential. Far too often this leaves youth with an inability to access needed supports at the peak of an unprecedented mental health crisis.

While the challenges of the state's bifurcated children's mental health systems may seem daunting, they are not insurmountable. California can improve behavioral health access and transform the experience of the children and families served in Specialty and non-Specialty systems of care through better coordination and leveraging resources across systems. A number of reforms can be done to smooth rough edges and improve outcomes, including adopting policies that shorten the Medi-Cal enrollment timelines, reduce administrative burden on providers trying to operate across the bifurcated delivery system in multiple counties, and enforce credentialing processing timelines in managed care contracts through financial incentives and reporting. The state can and should encourage case rate models for priority populations and specific practices the want to encourage and scale.

Managed care plans have a growing role in ensuring children, youth and families have access to necessary mental health services. We should advance policy goals focused on finding solutions that help managed care plans build networks integrated into existing systems and structures, rather than build parallel networks and systems of care. Only then will California live up to its ideals of providing high quality and compassionate care to all who need it.