



# Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions

## Summary of Findings

- ▶ Across California, people seeking treatment for behavioral health conditions — a term encompassing both mental health conditions and substance use disorders (SUDs) — often face limited access to care. Multiple surveys have found significantly increased levels of adverse mental health conditions, substance use, and suicidal ideation because of the COVID-19 pandemic.
- ▶ Medi-Cal enrollees needing behavioral health services must navigate a complex array of benefits and providers, often seeking services from multiple, very different systems.
- ▶ Several important factors contribute to access constraints — chronic workforce shortages, a complex care delivery system, and inadequate services within an interconnected system of care from inpatient to intermediary and outpatient services. Inadequate capacity in one part of a system often creates bottlenecks that affect other areas.
- ▶ California lacks the behavioral health workforce necessary to meet the state's growing need, and local experts in all regions reported an insufficient number of psychiatrists, psychologists, licensed clinical social workers, and other professionals to address residents' needs.
- ▶ Despite the access challenges, initiatives and investments by the state, counties, and public and private sector providers have modestly improved access to behavioral health services across the study regions. In several regions, efforts are underway to increase the number of psychiatric inpatient beds. In addition, there are initiatives to better serve people experiencing homelessness, many of whom suffer from mental illness and SUDs.
- ▶ Primary care clinic leaders reported that the pandemic more than doubled behavioral health services delivered by telehealth, an innovation that has reduced patient no-show and cancellation rates.
- ▶ Across the state, delivery of behavioral health services remains largely isolated from primary care. Efforts to better integrate behavioral health services include coordination initiatives between Medi-Cal managed care plans and county departments of behavioral health, Federally Qualified Health Centers (FQHCs) providing integrated care to patients, and the exchange of data for improved care coordination.
- ▶ The use of data exchanges to better integrate behavioral and physical health care, as well as some social services, has progressed in fits and starts, with some regions achieving key milestones.

## Introduction

Across California, people seeking treatment for mental health conditions and substance use disorders often face limited access to care. While access is a problem statewide, behavioral health care needs are more intense in lower-income regions, such as Humboldt/Del Norte and the San Joaquin Valley, where people are much more likely to experience drug-related hospitalizations, suicide, and self-reported mental distress than statewide averages. Moreover, many regions, particularly in rural California, also suffer from significant shortages of behavioral health professionals.

The California Health Care Foundation's longitudinal Regional Markets Study of seven California health care markets — Humboldt/Del Norte, Inland Empire, Los Angeles, Sacramento Area, San Diego, San Francisco Bay Area, and San Joaquin Valley — provided a unique opportunity to examine behavioral health care across California, including variation across regions in behavioral health needs, access to care and workforce shortages.<sup>1</sup> (For definitions of the regions and study methodology, see "Background on Regional Markets Study" box on page 20.)

This paper examines behavioral health needs in California broadly and assesses access challenges to behavioral services for Medi-Cal enrollees. The paper explores factors contributing to these access issues, including workforce shortages, the complexity of the Medi-Cal system for behavioral health services, and capacity gaps within different levels of care. Finally, this paper highlights some efforts underway to improve and integrate behavioral health services for Medi-Cal enrollees.

## The Behavioral Health Care Delivery System for Medi-Cal Enrollees

Behavioral health services for Medi-Cal enrollees across the state are provided through a complex system of organizations and provider networks. Medi-Cal managed care plans are responsible for delivering services to adults with less severe mental health conditions, referred to as "mild-to-moderate"

conditions. These "mild-to-moderate" benefits were added as part of the 2014 Medi-Cal expansion through the Affordable Care Act. Plans must also cover "nonspecialty" mental health services for those under 21. Some plans delegate administration of these services to managed behavioral health organizations such as Beacon Health Options and Magellan Health.

For Medi-Cal enrollees experiencing mental health conditions that require a higher level of care — generally, serious mental illness (SMI) for adults and serious emotional disturbances (SEDs) for children and youth — and for most care related to SUDs, county behavioral health departments are responsible for providing services.<sup>2</sup> This arrangement is commonly referred to as the "carve-out" of specialty mental health and SUD services from the larger Medi-Cal system for physical health care. Within the county behavioral health departments, specialty mental health services are organized and delivered via mental health plans. SUD services are managed through other divisions within the same county behavioral health departments or as part of a separate county department or agency. While county behavioral health providers have developed significant expertise in addressing the mental health and SUD needs of their clients, Medi-Cal enrollees needing behavioral health services often must navigate a complex array of benefits and providers and seek services from multiple, very different systems.

From January to September 2020, there was a monthly average of about 4,300 health visits for mild-to-moderate and nonspecialty conditions per 100,000 Medi-Cal enrollees of all ages.<sup>3</sup> This monthly average number of visits remained largely unchanged from the same period in 2019. During the same 2020 period, county mental health plans provided some 6,200 specialty mental health visits per 100,000 enrollees of all ages per month. This average number of monthly visits declined 11% from 2019 to 2020. Specifically, during the first six months of the COVID-19 pandemic, the number of monthly specialty mental health visits dropped from 8,300

in April 2020 to 2,100 in September 2020 — a decline of 75% as the transition to telehealth took time to develop, with only 10% of all visits delivered via telehealth during this period.

In FY 2018–19, some 343,000 Medi-Cal adult enrollees received specialty mental health services, with six in 10 of these enrollees receiving five or more visits in a year.<sup>4</sup> For SUD services delivered in the Drug Medi-Cal Organized Delivery System counties (which comprise 95% of California’s population), more than 42,000 enrollees per quarter received services for substance use during FY 2018–19.<sup>5</sup>

## Widespread Behavioral Health Needs

Behavioral health needs are prevalent across the state, and in some regions the needs are especially pronounced. According to research using 2015 data, about one in 13 children and youth experienced an SED. Prevalence of behavioral health conditions was also pronounced among adults, with about one in six experiencing mental illness, and one in 25 experiencing a serious mental illness.<sup>6</sup> According to the California Health Interview Survey, the prevalence of behavioral health needs has been increasing. Specifically, during the five-year period ending in 2019, the number of adults and teens enrolled in Medi-Cal experiencing serious psychological distress in the past year increased by 14%.<sup>7</sup> Substance use disorders are also quite common; according to a federal survey, 9.2% of Californian adults 27 and older reported an SUD in the past year, compared with 7.7% nationwide.<sup>8</sup>

Across the study regions, the strength of the local economy and access to urban job centers appear to correlate strongly with measures of mental health and substance use (see Table 1). Serious mental illness in adults and serious emotional disturbances in children are more common among those experiencing poverty and among people of color.<sup>9</sup> Moreover, many of those with mental illness and SUDs face housing and food insecurity. In the Sacramento region, for example, a 2019 study found that 26% of those experiencing homelessness have a debilitating cognitive or physical impairment, and 21% have a severe psychiatric condition, such as depression or schizophrenia.<sup>10</sup> The study also found that people experiencing homelessness are likely to have co-occurring SUDs as well.<sup>11</sup>

With the highest share of people living below the federal poverty line (21.5% of residents in 2018), the San Joaquin Valley region has the second-highest share of residents experiencing frequent mental distress. Only Humboldt/Del Norte residents, with the second-highest poverty rate and the lowest median income among the study regions, reported a higher share. Of the regions studied, both San Joaquin Valley and Humboldt/Del Norte also have higher-than-average suicide rates; Humboldt’s rate is more than twice the state-wide average. Amphetamine use is more prevalent in both regions as well, though Humboldt/Del Norte has suffered more from the opioid epidemic: on a population-adjusted basis, Humboldt County reports more than twice as many

**TABLE 1. Measures of Behavioral Health, by California Region**

	Humboldt/ Del Norte	Inland Empire	Los Angeles	Sacramento Area	San Diego	San Francisco Bay Area	San Joaquin Valley	STATEWIDE
Share of population reporting frequent mental distress (2018)	14.0%	12.5%	11.0%	11.8%	11.0%	9.8%	13.6%	<b>11.0%</b>
Per 100,000 people:								
▶ Suicides (2015–17 average)	21.5	11.2	8.0	13.3	12.4	9.9	12.3	<b>10.4</b>
▶ Opioid deaths (2018)	9.4	5.3	4.6	3.9	7.4	5.6	3.0	<b>5.8</b>
▶ Opioid emergency department visits (2018)	44.6	22.1	15.3	23.5	21.7	19.8	18.0	<b>21.4</b>
▶ Amphetamine-related hospitalization (2018)	21.5	6.2	3.8	7.8	4.0	3.2	15.1	<b>5.6</b>

Sources: “Frequent Mental Distress,” based on data from 2018, County Health Rankings and Roadmaps, 2021; California Department of Public Health, “County Health Status Profiles” 2015–17, California Department of Public Health; “California Opioid Overdose Surveillance Dashboard,” 2018, California Department of Public Health.

opioid-related emergency department (ED) visits and more than 50% more opioid-related deaths than the statewide average (though deaths have been decreasing in recent years).

By contrast, Bay Area residents in 2018 reported the lowest levels of mental distress, and drug-related hospitalizations and deaths have been relatively infrequent in recent years. (Among Bay Area counties in 2018, however, San Francisco stood out, with 15 opioid-related overdose deaths per 100,000 residents, more than 2.5 times the statewide average.)

### The COVID-19 Pandemic Has Exacerbated Behavioral Health Problems

Multiple surveys of patients and providers in California and a large study from the federal Centers for Disease Control and Prevention (CDC) found significantly increased levels of adverse mental conditions, substance use, and suicidal ideation because of the COVID-19 pandemic.<sup>12</sup> Another survey of low-income Californians found that the pandemic caused their mental and emotional health to deteriorate.<sup>13</sup> The same study revealed that more than two-thirds of survey respondents (68%) said they wanted to see a provider for a mental health problem during the pandemic.

According to the CDC, the number of drug overdose deaths nationwide increased during the pandemic by nearly 30%. In California, this increase in drug deaths was more than 45% from December 2019 to December 2020.<sup>14</sup>

## Behavioral Health Care Access Problems Widespread and Acute in Some Regions

Across the seven regions, data and interviews showed access challenges for residents needing behavioral health services. According to the California Health Interview Survey, among those respondents across the regions likely to have serious psychological distress, 51% reported they had not seen a behavioral health provider.<sup>15</sup>

### Use of Medi-Cal Specialty Mental Health Services Varies by Region

Adult Medi-Cal enrollees with a serious mental illness or children with a severe emotional disturbance can receive specialty mental health services through county mental health plans as described earlier. In FY 2018–19, more than 343,000 adult Medi-Cal enrollees received at least one specialty mental health service. The state Department of Health Care Services (DHCS) measures overall specialty mental health service use by “penetration rate,” or the percentage of all Medi-Cal enrollees in a county receiving any inpatient or outpatient specialty mental health service (Table 2).

**TABLE 2. Specialty Mental Health Penetration Rates, All Ages, by California Region and County Size, 2016–18**

	2016	2017	2018
Humboldt/Del Norte	5.6%	5.8%	6.0%
Inland Empire	3.9%	3.9%	4.0%
Los Angeles	4.9%	5.1%	5.3%
Sacramento Area	4.1%	3.9%	4.1%
San Diego	4.6%	4.4%	4.3%
San Francisco Bay Area	5.0%	5.0%	5.1%
San Joaquin Valley	4.3%	4.0%	4.4%
<b>Statewide</b>	<b>4.5%</b>	<b>4.5%</b>	<b>4.7%</b>
▶ Large counties	4.3%	4.2%	4.3%
▶ Medium counties	4.1%	4.1%	4.2%
▶ Small counties	4.9%	4.9%	5.0%
▶ Small rural counties	7.7%	7.6%	7.7%

Notes: The penetration rate is calculated by dividing the number of unduplicated enrollees served by the monthly average Medi-Cal enrollee count. County size designations: *small rural* — Del Norte, Madera, Mariposa; *small* — El Dorado, Humboldt, Kings; *medium* — Placer, San Mateo, Tulare, Yolo; *large* — Alameda, Contra Costa, Fresno, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco.

Source: “Mental Health Penetration Rates,” Behavioral Health Concepts, accessed April 1, 2020.

## Factors Contributing to Access Challenges

Access challenges reported in the seven regions spanned the continuum of behavioral health services — inpatient to outpatient, mild-to-moderate to specialty mental health services, and across the range of SUD services. Several important factors contribute to these access constraints, including chronic workforce shortages and a complex, often uncoordinated care delivery system. Additionally, inadequate capacity in one part of the system of care can create bottlenecks that affect other areas; for example, bottlenecks may be created by filling inpatient psychiatric beds as patients wait for available capacity in a facility providing a lower level of care.

### All Regions Report Behavioral Health Workforce Shortages

California lacks the behavioral health workforce necessary to meet the state’s growing need. Respondents in all regions reported an insufficient supply of psychiatrists and other behavioral health providers. Some respondents reported that behavioral health care providers may be reluctant to serve Medi-Cal patients because of administrative burdens and relatively low payment rates. While Medicare and commercially insured patients also face problems accessing psychiatrists, Medi-Cal managed care plans and counties face the greatest problems adding psychiatrists to their provider networks.

As shown in Table 3, there are wide disparities across regions in the number of psychiatrists per capita, one important indicator of a region’s capacity to meet the behavioral health needs of its residents. Unfortunately, the regions with the greatest need also tend to have the fewest providers, as psychiatrists are disproportionately located in large cities. The ratio of psychiatrists per 100,000 residents in the San Joaquin Valley is barely half the ratio statewide, and Humboldt/Del Norte does only slightly better on this metric. The Inland Empire, with 8.2 psychiatrists per 100,000 residents, is more than 30% below the statewide rate.

Respondents in all three of these regions repeatedly noted the difficulties of attracting specialists away from the state’s larger metropolitan areas. For example, the Humboldt County Behavioral Health Board 2019 report described difficulties recruiting and retaining behavioral health staff “in most job classes,” resulting “in impacts to quality of care, case-loads, coverage for essential services and job satisfaction” for the remaining professionals.<sup>16</sup> An Inland Empire respondent, lamenting the lack of specialists (including psychiatrists), cited the region’s lack of cultural and other amenities found in urban coastal areas as a significant recruitment challenge.

**TABLE 3. Psychiatrists per 100,000 Population, by California Region, 2020**

	Psychiatrists per 100,000 People
Humboldt/Del Norte	7.3
Inland Empire	8.2
Los Angeles	12.0
Sacramento Area	12.3
San Diego	13.6
San Francisco Bay Area	18.7
San Joaquin Valley	6.5
<b>Statewide</b>	<b>11.8</b>

Sources: Healthforce Center at UCSF analysis of Survey of Licensees (private tabulation), Medical Board of California, January 2020; Health Professional Shortage Area (HPSA) data from *Shortchanged: Health Workforce Gaps in California*, California Health Care Foundation, July 15, 2020.

Researchers at the University of California, San Francisco (UCSF) have noted other facets of the workforce challenge that are consistent with respondent interviews. The number of psychologists, licensed marriage and family therapists (LMFTs), licensed professional clinical counselors (LPCCs), and licensed clinical social workers (LCSWs) per 100,000 residents is lower than the statewide average in several regions, including the Inland Empire, the Northern and Sierra region (including Humboldt/Del Norte), and the Sacramento region and San Joaquin Valley.<sup>17</sup> Surveying behavioral health workforce demographics and employment opportunities, the UCSF study also found that more than one-third of the state’s psychologists who were active in 2018 are likely to retire or reduce hours by 2028. Assessing current utilization trends,

the report concluded that by the end of the decade, the state “will have 41% fewer psychiatrists than needed” and “11% fewer psychologists, LMFTs, LPCCs, and LCSWs than needed.”

Moreover, psychiatrist-to-resident and other workforce ratios may understate the challenges faced by providers and patients in some regions. The state’s inland and northern rural counties are typically lower density, with relatively poor public transit service and more sprawling communities. As a result, psychiatry and other behavioral health visits can prove particularly challenging, with long travel times. The emergence of telehealth (discussed later), however, may somewhat mitigate this access barrier.

Even in regions with more psychiatrists available, respondents nevertheless highlighted significant unmet needs. In the Sacramento region, there are more psychiatrists per 100,000 residents than the statewide average. One respondent in El Dorado County, however, said that hiring psychiatrists can take up to 18 months; another referred to the situation as “desperate.” The Bay Area is home to nearly 19 psychiatrists per 100,000 residents — by far the highest ratio among regions and 50% higher than the statewide average. But respondents still noted unmet need for bilingual providers and challenges recruiting psychiatrists willing to treat Medi-Cal patients. Similarly, San Diego respondents cited a lack of culturally competent psychiatrists.

## Medi-Cal Enrollees Face a Behavioral Health Financing and Service Delivery Jumble

While the Medi-Cal program covers services for enrollees’ physical and behavioral health needs, the delivery of care and financing of services is divided across multiple systems. Services for nonspecialty mental health needs are provided by Medi-Cal managed care plans (some of which subcontract for management of this service) while services for those with more severe mental health needs are provided by county mental health departments; SUD services are provided by yet another county entity. Because the funding streams for these services are separate, as are their care delivery and data

management systems, coordination of care is limited, and incentives faced by different providers and systems can be misaligned. Ultimately, this legal, organizational, and financing jumble creates obstacles for enrollees who must use multiple different delivery systems to access comprehensive care.

Many Medi-Cal enrollees who need specialty mental health or SUD services access them by initiating contact and undergoing a medical necessity assessment with county mental health and SUD providers. Others may be referred to these county-based services by providers in their managed care plan networks. These referrals may be as simple as handing an enrollee a phone number to call or can involve a “warm hand-off,” in which a care coordinator facilitates making an appointment and assuring an enrollee makes it to that appointment. While DHCS requires Medi-Cal managed care plans and county behavioral health departments to have memoranda of understanding to coordinate services for enrollees, these agreements vary widely, and many fail to meet minimum legal requirements.<sup>18</sup> As an added complication, when a patient’s condition improves so that he or she no longer meets the requirements for county-provided specialty mental health services, patients are supposed to “step down” to managed care plan services, necessitating another referral and transfer between systems.

Across the seven study regions, the behavioral health services delivery systems reflect these overarching policy and organizational complexities. Within individual regions, depending on the Medi-Cal managed care model and organization of county departments, navigational challenges for enrollees may be more difficult. For example, in Los Angeles County, the two Medi-Cal managed care plans, L.A. Care Health Plan and Health Net, each have plan partners that in turn have their own “mild-to-moderate” mental health provider networks.<sup>19</sup> The county Department of Mental Health organizes and provides specialty mental health services to Medi-Cal enrollees and uninsured people. SUD services in Los Angeles County are provided through the Department of Public Health, which operates the county’s Drug Medi-Cal

Organized Delivery System (DMC-ODS) pilot. With all of these organizations and providers involved in delivering care, Medi-Cal patients with complex needs often face significant care coordination challenges.

The Geographic Managed Care (GMC) Model in the Sacramento and San Diego regions can present an even greater level of complexity for Medi-Cal patients and providers to navigate.<sup>20</sup> Each of the five Medi-Cal managed care plans in Sacramento and seven plans in San Diego has to coordinate with the respective county department of behavioral health for enrollees accessing services in each of the systems. An advocate in the Sacramento region observed that despite efforts to coordinate between plans and counties, there is “no fluidity” in the system, and Medi-Cal enrollees do not know where and how to get services. In the forthcoming recontracting for managed care plans in GMC counties, DHCS will reduce the number of plans in both Sacramento and San Diego to two.<sup>21</sup>

### Capacity Constraints in Patchwork Systems of Care

Behavioral health services are delivered across multiple facilities and providers spanning different levels of care (see sidebar). County behavioral health departments, other county agencies, hospitals, managed care plans, and community-based providers are responsible for creating an interconnected “system of care.” Ideally, these systems of care facilitate the movement of patients to appropriate services when entering care and as their care needs evolve. However, the result is often a weakly stitched patchwork system with inpatient and outpatient capacity gaps and missing connections between levels.

#### Levels of Psychiatric Care

**Inpatient.** 24-hour care provided in psychiatric hospitals or general hospital psychiatric units.

**Intermediary.** Care that provides more support than routine outpatient care, but that is less intensive than inpatient hospitalization. Includes *residential care*, which provides long-term care in settings that are typically more comfortable than hospitals; *partial hospitalization and day programs*, in which individuals regularly receive partial-day mental health services for several hours per day; and *assertive community treatment programs*, through which community-based multidisciplinary teams provide treatment, rehabilitation, recovery, and support services to individuals with serious mental illness.

**Routine outpatient.** Less than 24-hour care provided in a wide range of care settings, such as community mental health centers, private therapy offices, and primary care clinics. Care is generally provided for less than three hours at a single visit.

**Emergency.** Care provided in emergency departments and crisis intervention and stabilization centers.

Source: Mathematica Policy Research, *Bed Check: Inpatient Psychiatric Care in Three California Counties*, California Health Care Foundation, April 2020.

People with behavioral health needs may engage with multiple providers across this system. For example, patients may initially be hospitalized before “stepping down” from a hospital inpatient setting to a less intensive level such as partial hospitalization or assertive community treatment programs. These facilities and programs function as an intermediary level between inpatient and routine outpatient care. Other patients may move from an emergency care setting directly to routine outpatient environments such as primary care and mental health clinics, avoiding ongoing inpatient services. The emergency level of service includes hospitals and community-based crisis intervention and stabilization facilities and often mobile crisis units.

Importantly, when patient throughput — flow across the behavioral health system of care — is obstructed by a

lack of capacity at one or more of these different levels of care, the effects may be felt throughout the system. For example, if beds, rooms, or services are unavailable in residential and community settings, bottlenecks form that can maroon patients in acute inpatient settings and emergency departments even after they are ready for discharge. Such a bottleneck can exacerbate inpatient bed shortages by forcing these facilities to keep patients longer than necessary at the expense of would-be new arrivals who instead receive care in a community setting which may not be appropriate for their needs. Inadequate residential placements and outpatient services can, in turn, precipitate a crisis, with people ending up at hospital EDs because appropriate non-hospital-based services are unavailable.

In the Bay Area, a hospital executive observed, “our experience is not that we need acute psychiatric beds, but all types of lower-level inpatient beds, especially locked subacute beds and psychiatric skilled nursing beds.” The Alameda Health System is investing in the system of care across facilities to expand outpatient care options, prevent admissions, and relieve pressure on the county-operated John George Psychiatric Pavilion, which serves adult patients with psychiatric needs.

In the Inland Empire, as in other study regions, the number of board-and-care homes (also known as adult residential facilities) has been declining, creating challenges for appropriately placing patients according to their need.<sup>22</sup> Such homes, which typically are privately operated, provide residential care for adults with mental illness who need less-intensive services than inpatient hospital care. Some residents may also need co-occurring services, such as SUD treatment. A respondent observed that board-and-care homes have faced increasing costs and trouble hiring and retaining adequately skilled staff to deal with a more acutely ill patient mix. In San Bernardino, the county brings outpatient specialty mental health and SUD services into some of these homes.

Respondents across other regions shared similar descriptions of interconnected capacity challenges within their respective systems of care. In Los Angeles County, a lack of subacute beds leaves patients stranded in inpatient facilities or experiencing long waits in psychiatric emergency service units. In the San Joaquin Valley, insufficient step-down capacity also leaves patients stuck in inpatient beds, which in turn creates waiting lists and forces counties to find beds elsewhere, sometimes hundreds of miles away. San Diego respondents observed that hospitals struggle with discharging psychiatric patients given so few options for specialty mental health patients, particularly the lack of residential board-and-care facilities.

In Placer County in the Sacramento region, respondents noted that the mental health system of care has gaps, because there are no inpatient crisis stabilization beds. Universal Health Services, an investor-owned company that specializes in psychiatric care, attempted to build an inpatient psychiatric facility in Rocklin, but community resistance scuttled the project. El Dorado County respondents also noted the lack of inpatient crisis stabilization capacity, adding that this shortage sometimes “strands patients in the ED for days or weeks.” Counties use Full Service Partnership resources from state Mental Health Services Act funds to deliver supplemental wraparound care and fill in gaps for patients with the most complex needs, including intensive day treatment and rehabilitation.

### Declining Inpatient Bed Capacity

Inpatient psychiatric services represent one modality in these complex, interconnected systems of care. Respondents in multiple study regions noted these capacity challenges throughout the system, with particularly acute bottlenecks in inpatient psychiatric facilities. One reason may be the number of inpatient beds each region has to begin with. Over the past 25 years, the supply of inpatient psychiatric beds across the state has declined significantly, to 17.2 beds per 100,000 residents in 2017 from 29.5 beds per 100,000 residents in



1995.<sup>23</sup> This decline has resulted from the decrease in inpatient psychiatric facilities, from 181 in 1995 to 139 in 2017. The statewide average masks significant variation by study region, with the Humboldt/Del Norte, Inland Empire, and San Joaquin Valley regions having one-half or less the per capita rate of inpatient psychiatric beds of the Los Angeles and Sacramento areas.

**TABLE 4. Inpatient Psychiatric Bed Supply, by California Region, 2017**

	Total Psychiatric Beds	Total Beds per 100,000 People
Humboldt/Del Norte	16	9.7
Inland Empire	558	12.2
Los Angeles	2,328	22.9
Sacramento Area	514	22.1
San Diego	694	20.8
San Francisco Bay Area	1,120	17.5
San Joaquin Valley	156	8.8
<b>Statewide</b>	<b>6,777</b>	<b>17.1</b>

Source: *California's Acute Psychiatric Bed Loss* (PDF), California Hospital Association, February 2019.

Humboldt County, for example, operates the 16-bed Sempervirens Psychiatric Health Facility, the only such facility in a 300-mile radius. The facility is staffed through a large contracted private provider able to recruit clinical staff. There is often a waiting list for admission, with one respondent observing that “psychiatric services are overwhelmed” in the region.

In the San Joaquin Valley, respondents noted that access to inpatient behavioral health services is a challenge, irrespective of the type of insurance coverage.<sup>24</sup> Again, one issue may be a lack of inpatient psychiatric beds to begin with. One study found that from 2010 to 2016, inpatient psychiatric beds per capita increased modestly in Fresno County but remained far below the statewide average.<sup>25</sup>

While overall acute care hospital bed supply in the Inland Empire has increased modestly, inpatient psychiatric beds remain in short supply.<sup>26</sup> To meet inpatient capacity need, San Bernardino, and other counties, frequently need to contract for beds outside county borders.

Despite a decline in the number of inpatient psychiatric beds in San Diego from 2010 to 2016, the county still had more beds per capita than the average statewide.<sup>27</sup> Nonetheless, San Diego respondents said that the lack of inpatient psychiatric beds was a pressing concern for behavioral health. Two acute care hospitals with inpatient psychiatric units — Scripps Mercy campus and the University of California, San Diego (UCSD) Hillcrest campus — do not intend to rebuild these psychiatric units when new (physical health) facilities are erected to meet seismic standards.

### Federal Payment Prohibition Adds to System of Care Challenges

According to respondents, access to psychiatric and SUD care within the system of care is also constrained, in part, by Medicaid’s exclusion of payment for “institutions for mental diseases” (IMDs), which directs that no federal funds be used for psychiatric or SUD services in settings with more than 16 beds for enrollees under 65 years old. The exclusion defines such facilities as any freestanding “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 diseases, including medical attention, nursing care, and related services.”<sup>28</sup> The exclusion does not apply to psychiatric units within a medical acute care hospital campus or short-term SUD inpatient stays in the Drug Medi-Cal Organized Delivery System pilots.<sup>29</sup>

The state DHCS IMD list includes acute psychiatric hospitals, mental health rehabilitation centers, psychiatric health facilities, and special treatment program/skilled nursing facilities.<sup>30</sup> Of the 38 acute inpatient psychiatric health facilities in the seven study regions, nearly two-thirds (25) are large enough to fall into the IMD exclusion (see Table 5 on page 10). While federal funds are not available to pay for stays in IMDs, counties use their own resources to finance these stays for county residents.

**TABLE 5. Acute Inpatient Psychiatric Hospitals, by California Region, 2019**

	NUMBER OF FACILITIES			Total Number of Beds
	Total	>16 Beds	≤16 Beds	
Humboldt/Del Norte	1	0	1	16
Inland Empire	4	3	1	279
Los Angeles	12	9	3	1,120
Sacramento Area	7	3	4	312
San Diego	4	4	0	645
San Francisco Bay Area	8	6	2	649
San Joaquin Valley	2	0	2	32
<b>Total all regions</b>	<b>38</b>	<b>25</b>	<b>13</b>	<b>3,053</b>
<b>Statewide</b>	<b>58</b>	<b>32</b>	<b>26</b>	<b>3,787</b>

Source: "Hospital Annual Financial Data – Selected Data & Pivot Tables," California Office of Statewide Health Planning and Development, accessed April 1, 2021.

Note: Data are for licensed inpatient psychiatric hospitals and do not include other "institutions for mental diseases": mental health rehabilitation centers, psychiatric health facilities (PHFs), and special treatment program/skilled nursing facilities.

The rationale behind the federal Medicaid prohibition on IMDs, in place since the program's establishment in 1965, was to discourage prolonged institutionalization of people with behavioral health conditions and to encourage better community-based outpatient services. However, many in the field believe the IMD exclusion creates significant barriers to care. The California Advancing and Innovating Medi-Cal (CalAIM) initiative included a proposal to test new approaches to caring for adults with serious mental illness and children with severe emotional disturbance,<sup>31</sup> and this proposal would have allowed counties to use federal funds for services provided in IMDs under a federal demonstration waiver. States pursuing these demonstrations must meet requirements about the length of stay in IMDs, improving community-based services, using technology, and assuring sufficient staffing.

Although counties must currently pay 100% of the cost for patients admitted to IMDs and so stand to benefit financially from the change in financing rules, some counties are nevertheless wary of this waiver opportunity given limitations on inpatient lengths of stay (and associated penalties when average lengths of stay exceed allowable limits) and the lack of sufficient intermediary care capacity. Some consumer advocates oppose the proposed demonstration,

citing a history of poor state regulatory oversight and the fact that the state has not established strict patient care standards for counties to follow or requirements for developing sufficient intermediate care capacity.<sup>32</sup> As of June 2021, this "IMD waiver" was not included in the state's Section 1115 waiver request to the Centers for Medicare & Medicaid Services, though DHCS has stated its intention to return to this discussion in the future.<sup>33</sup>

## Efforts to Improve Behavioral Health Services

In the face of access challenges faced by many Californians, the state, counties, and public and private sector providers have developed a series of initiatives and investments aimed at improving access to behavioral health services across the study regions. Many of these initiatives have modestly improved access to care, though more work remains.

### Expanding Psychiatric Inpatient Capacity

Across several regions, efforts are underway to increase the number of psychiatric inpatient beds in the next few years. In the San Joaquin Valley, Universal Health Services, an investor-owned firm, will build and operate a 128-bed inpatient psychiatric facility on the campus of Valley Children's Hospital in Madera, with a planned 2023 opening date. This new facility will serve the entire region and have 24 beds for pediatric patients, representing a 50% increase in regional pediatric beds.

In San Diego, Scripps is partnering with Acadia Healthcare to build a new 120-bed inpatient behavioral health facility in Chula Vista set to open in 2023. The new facility will reserve 20% of capacity for Medi-Cal and other low-income patients. San Diego County will partly finance a new 16-bed psychiatric health facility and partner with Tri-City Medical Center to build and operate it on Tri-City's Oceanside campus. As part of the county's "hub-and-network" approach (discussed in the next section), the new facility is expected to open in late 2022. The county is assessing a similar partnership with Palomar Health to increase inpatient psychiatric bed capacity.

In the Bay Area, Santa Clara Valley Medical Center is constructing a \$350 million psychiatric unit to provide adult and pediatric inpatient, emergency, and urgent care services. When the facility opens in 2023, Santa Clara Valley Medical Center will partner with Stanford, Kaiser, and El Camino Health hospitals to receive referrals from those facilities.

## Improving Systems of Care

San Diego has launched an initiative to reorganize and improve the delivery of behavioral health services through a regional “hub-and-network” model. The aim is to connect patients to community-based care along the continuum of step-down facilities (e.g., board-and-care) and care coordinators to manage patients’ post-discharge care, with a goal of reducing readmissions. These hubs will include several components: colocation with general acute care hospitals that treat psychiatric patients in their EDs; access to inpatient psychiatric services; and access to services along the step-down outpatient continuum, including crisis stabilization. San Diego’s efforts also include expanding the capacity and number of locations for crisis stabilization units for both mental health and SUD services.

The county envisions developing up to five hubs across the region with several anchored on hospital campuses. As part of the partnership, UC San Diego Health will operate the county’s inpatient facility, San Diego County Psychiatric Hospital (also known as Rosecrans), allowing the university to secure Medi-Cal reimbursement for patients, which the county currently cannot do because of the IMD exclusion. UCSD Health, as an acute care hospital with a psychiatric inpatient unit, is not subject to the exclusion. For another hub, the county would lease land adjacent to Rady Children’s Hospital, and in turn, Rady would build and lead operations to provide pediatric behavioral health services. Yet another hub in Escondido would partner with Palomar Health. The development of several regional hubs, however, has been

delayed as a result of funding limitations stemming from the pandemic.

In the Sacramento region, Yolo County in 2019 doubled the size of its program providing mental health and SUD services to those involved with the criminal justice system; the program was cited as a “model of collaboration” by an independent review. Sacramento County has been focused on improving its system of care — from prevention and early intervention, to outpatient services, crisis intervention and stabilization, and inpatient psychiatric services — and also coordinates with law enforcement. In addition, Sacramento added six mobile crisis units working throughout the county in recent years.

In the San Joaquin Valley, the Fresno County Department of Behavioral Health has leased the former campus of Valley Children’s Hospital with plans to relocate several psychiatric health facilities and crisis stabilization units into existing buildings there. The plan will create four 16-bed units, including one for pediatric mental health services. The county hopes to finance some of the development from the \$750 million Behavioral Health Continuum Infrastructure Funding proposed in the state FY 2021–22 budget.<sup>34</sup> These funds, if approved, will support infrastructure development to address capacity where most vital across systems of care in other regions as well.

In the Inland Empire, the San Bernardino County Department of Behavioral Health has addressed limited inpatient capacity, not with more construction of large inpatient facilities, but rather by developing more capacity at other levels in the system of care that can more appropriately serve the needs of patients. This capacity comprises mobile crisis response units as well as crisis stabilization units and crisis walk-in clinics, which offer outpatient crisis stabilization services. These services and facilities offer evaluation, assessment, stabilization, and referral to the appropriate level of service — including inpatient admissions if needed.

**TABLE 6. Visits to Behavioral Health Professionals as Share of All Federally Qualified Health Center Encounters, by California Region, 2019**

	Psychologists	Psychiatrists	Licensed Clinical Social Workers	Behavioral Health as a Share of Total Encounters	Change in Behavioral Health Visits, 2014–19
Humboldt/Del Norte	0.6%	0.6%	1.3%	2.5%	-12.4%
Inland Empire	1.8%	1.7%	2.0%	5.5%	330.8%
Los Angeles	0.7%	0.9%	3.7%	5.4%	138.6%
Sacramento Area	0.3%	1.3%	4.3%	5.8%	167.9%
San Diego	3.0%	2.3%	2.7%	8.0%	149.3%
San Francisco Bay Area	0.9%	0.7%	3.1%	4.7%	9.0%
San Joaquin Valley	0.7%	0.3%	1.7%	2.7%	113.8%
<b>Statewide</b>	<b>1.2%</b>	<b>1.2%</b>	<b>2.9%</b>	<b>5.3%</b>	<b>89.0%</b>

Source: "Primary Care Clinic Annual Utilization Data," California Office of Statewide Health Planning and Development, accessed April 1, 2020.

### FQHCs Expand Services

Since the Affordable Care Act Medicaid expansion, California FQHCs, which predominantly serve Medi-Cal enrollees and the uninsured, have added behavioral health staff and significantly increased behavioral health visits as a share of total encounters (see Table 6). In 2019, visits with psychologists, psychiatrists, and LCSWs accounted for 5.3% of all FQHC encounters statewide, an increase of 89% since 2015. All regions except for the Bay Area and Humboldt/Del Norte experienced triple-digit growth in the share of visits that were for behavioral health, with the Inland Empire's behavioral health encounters increasing more than threefold.

### Telehealth Visits Surge

According to DHCS, the use of telehealth for mild-to-moderate visits during the pandemic increased dramatically. In April 2019, only 1% of Medi-Cal mild-to-moderate visits were via telehealth; one year later, in April 2020, as the pandemic engulfed California, nonspecialty mental health telehealth visits surged to 51% of all visits by enrollees over 21 years old.<sup>35</sup> FQHC leadership reported that, during the pandemic, California clinics more than doubled the number of behavioral health services delivered by telehealth, and in the process reduced patient no-show and cancellation rates for

scheduled visits. In addition, FQHCs reported that care coordination for these patients has improved as telehealth offers faster referrals and more patient contact.

### Focusing on People Experiencing Homelessness

Many Californians with behavioral health needs also confront other challenges that can make treatment of their mental health conditions more difficult; one notable example of such a comorbidity is homelessness. Across the study regions, there are initiatives underway to better serve people experiencing homelessness, both to provide needed shelter and as a mechanism for facilitating treatment of chronic mental health issues.

In the San Joaquin Valley, several counties, including Kings and Mariposa, participated in the Medi-Cal Whole Person Care pilot program, which began in 2016 under the Section 1115 Medicaid Medi-Cal 2020 waiver and will transition to the CalAIM initiative in the beginning of 2022. Most of these pilots include a focus on people experiencing homelessness, with the goal of coordinating health, behavioral health, and social services to improve enrollee health and well-being through a more effective use of resources.<sup>36</sup> As Whole Person Care pilot counties, Kings and Mariposa together received more than \$2 million from the state to address housing.

Other programs in the San Joaquin Valley have also provided resources to tackle the intersection of homelessness and behavioral health. Fresno, Madera, Mariposa, and Tulare Counties all were awarded grants through the state No Place Like Home initiative, which supports permanent housing for people with mental illness who are homeless or at risk of homelessness. Together, these counties were awarded more than \$50 million in 2018 and 2019, with Fresno County receiving \$31 million.

In Humboldt County, the Board of Supervisors has adopted a “Housing First” model to increase housing, especially for Medi-Cal enrollees with serious mental illness. In addition, Partnership HealthPlan of California has worked with the county and contributed millions of dollars to support housing access.

Similarly, in the Bay Area, Alameda, San Francisco, and Santa Clara Counties have prioritized people experiencing homelessness in their Medi-Cal Whole Person Care pilots. The pilots coordinate physical and behavioral health care as well as social services for high-risk populations. San Francisco has invested in several other initiatives to address the mental health and SUD needs of homeless adults: the Mental Health SF initiative, launched in late 2019, seeks to reform the behavioral health delivery system and guarantee behavioral health care to all uninsured county residents or people who are homeless.

During the COVID-19 pandemic, Los Angeles repurposed empty hotel rooms to shelter at-risk persons experiencing homelessness. Through the state’s Project Roomkey program and funding, sites offer residents support services, meals, and on-site supervision. The five Bay Area counties housed some 4,800 people in hotels using Project Roomkey resources.

In the Inland Empire, San Bernardino County launched “Project InnROADS” in 2019, a \$17 million program to bring mental health services to the homeless living in rural areas.<sup>37</sup> Also in 2019, Riverside County received \$24 million from the state’s No Place Like Home program. The resources will provide more than 160 permanent supportive housing units

for people with severe and persistent mental illness who are homeless or at risk of homelessness.<sup>38</sup>

### Improved Continuum of Care for SUD Treatment

Fifteen counties in the study regions participate voluntarily in the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program.<sup>39</sup> Established as part of the state’s 2015 Medicaid Section 1115 demonstration waiver, the program aims to improve enrollees’ recovery while decreasing system health care costs.<sup>40</sup> DMC-ODS requires participating counties to provide SUD benefits along a continuum of care based on criteria from the American Society of Addiction Medicine.<sup>41</sup> Benefits include evidence-based care such as medication management and the coordination of SUD services with physical and mental health services. The DMC-ODS program requires the use of providers designated as licensed practitioners of the healing arts to provide SUD services and allows counties to set payment rates for providers. The CalAIM initiative proposes to extend the program for another five years, to 2027.

All four counties in the Sacramento Area region participate in the DMC-ODS pilot program, with Yolo and Placer Counties launching in 2018 and Sacramento and El Dorado Counties launching in 2019. The Placer County DMC-ODS program provides case management with individualized case plans for high-need clients. The county contracts with providers in adjacent counties to increase capacity. Placer County has a network of 23 sober living recovery residences with a total of 125 beds. Despite capacity and staff improvements, an independent review found that Placer County still struggles to meet standards for timely access to care, particularly for urgent and postdischarge appointments.

Since implementation, Sacramento County’s DMC-ODS pilot has seen a 90% increase in patients served, according to a behavioral health leader. The county increased payment rates for providers, resulting in less provider turnover and more retention of high-quality staff. There has also been an increase in available treatment beds.

In other study regions, Los Angeles and Riverside Counties, along with four of the five Bay Area counties, launched DMC-ODS pilots in 2017. Alameda, San Bernardino, and San Diego Counties implemented pilots in 2018. In the San Joaquin Valley, Fresno and Tulare Counties launched pilots in 2019. In 2020, Partnership HealthPlan of California began a Wellness and Recovery Program, which manages the DMC-ODS programs for seven of the plan's participating counties, including Humboldt County.

## **Integration with Physical Health Services Improves, but System Remains Fragmented**

Beyond the challenges confronting Medi-Cal enrollees who must often navigate two and sometimes three different systems to receive behavioral health care, these patients must also navigate a separate system to receive physical health care, often with little coordination between providers. People with serious mental illness and SUDs can have multiple chronic physical illnesses and often do not receive routine primary care. In recent years, some efforts have aimed to ease this challenge by coordinating services for enrollees between their managed care plan and county behavioral health departments.

### **Integrating Levels of Care in the Complex Medi-Cal System**

Despite policy, financing, and organizational challenges, county behavioral health departments, Medi-Cal managed care plans, and providers have collaborated to integrate some services for patients, though these efforts have been limited. In the Sacramento region, for example, Sacramento County and the five Medi-Cal managed care plans operating in the region have developed a tool for providers to coordinate care, navigate networks, and clarify steps for filling prescriptions. In Los Angeles, the Martin Luther King Jr. Community Hospital is developing a dedicated site on its main campus for obtaining behavioral health services. This "one-stop operation" will offer mental health, substance use, medical, and social services. The same site will also include

probation, public health, workforce development services, and assistance with reentry from incarceration.

Elsewhere, Inland Empire Health Plan has launched several initiatives to improve behavioral health care integration, including complex care management teams to aid patients with physical, behavioral, social, and environmental needs. For example, the Behavioral Health Integration Complex Care Initiative, a partnership between the health plan and 30 local health centers and clinic sites, established a goal of improving Medi-Cal enrollees' health outcomes by providing care management and care coordination for physical and behavioral health needs across multiple providers and care systems. This initiative, launched in 2019, became the foundation for the implementation of the Health Homes Program in the region, facilitating a transition to a system with improved care coordination services. Inland Empire Health Plan and the San Bernardino County Department of Behavioral Health have also explored how to better integrate physical and behavioral health services, while Riverside County operates an integrated system consisting of its hospital, outpatient clinics, and behavioral health department (as well as the public health department). With all of these service providers reporting to the same leadership and sharing an electronic health records system to facilitate data sharing across providers, Riverside County seeks to improve integration across specialties and improve patient care.

In the Bay Area, the San Francisco county mental health plan and San Francisco Health Plan, one of two Medi-Cal managed care plans, both contract with the same mental health providers, easing coordination between specialty and mild-to-moderate services.

### **FQHCs Move to Integrate Behavioral Health Services**

Across regions, FQHCs have expanded their scope of services to include mental health and SUD services. In expanding behavioral health services, some FQHCs have contracted as providers with Medi-Cal managed care plans' provider networks for mild-to-moderate conditions, and a small number

of FQHCs have contracted with counties as specialty mental health providers. Of the 91 clinics statewide responding to a 2020 survey, nearly all offer mental health and SUD services, either colocated or integrated into primary care.<sup>42</sup> The same survey found that 89% offer telehealth behavioral health services. Many larger FQHCs focus on providing integrated physical and behavioral health care and have invested in care management staff, quality improvement, and information technology infrastructure to improve care coordination. Ten FQHCs in California, six of which are in the study regions, are Certified Community Behavioral Health Clinics, part of a federal demonstration project to provide community-based mental health and SUD services and advance integration of behavioral health with physical health care.<sup>43</sup> One FQHC leader in the Sacramento region said that of the more than 40,000 patients the FQHC serves, 70% need some type of behavioral health service.

While numerous FQHCs have stepped in to provide some behavioral health services, statewide administrative constraints can make such service delivery challenging. First, FQHCs cannot bill for a physical health and a behavioral health visit on the same day. Second, only certain types of clinicians can bill the clinic's cost-based prospective payment system (PPS) rate (e.g., physicians, psychiatrists, LCSWs, clinical psychologists, and marriage and family therapists). These administrative challenges can be even more daunting for FQHCs seeking to contract with counties as specialty mental health and SUD service providers, although contracts have been permitted since 2017 under State Senate Bill 323 (Chapter 540 of 2017).<sup>44</sup> FQHCs contracting with county mental health plans or drug and alcohol programs to provide specialty mental health and/or SUD services must maintain a billing infrastructure separate from their physical health PPS billing infrastructure. While a clinic may use its own electronic health record (EHR) system for clinical documentation and share some data with the county EHR system, some counties require billing to be done on paper. An independent review

of Yolo County described this approach as an "inefficient and error-prone process which would benefit from automation."<sup>45</sup>

Despite the arduous requirements, a few FQHCs do contract with counties to provide specialty mental health and SUD services. In the Sacramento region, several FQHCs have contracts with county mental health plans to provide specialty mental health and/or SUD services. For example, WellSpace Health is one of the largest SUD and medication-assisted treatment contractors (for opioid use disorders) for Sacramento County, while CommuniCare contracts with Yolo County to provide both specialty mental health and SUD services. In Placer County, Chapa-De Indian Health contracts with the county to provide specialty mental health services.

In San Diego, some FQHCs have integrated behavioral health by colocating therapists and SUD counselors in clinic sites and facilitating referrals to psychiatrists and county services. Family Health Centers of San Diego and San Ysidro Health contract with the county to provide specialty mental health services. For the emerging "hub-and-network" system in San Diego, respondents cited FQHCs as important providers for success.

In the San Francisco Bay Area, clinics have integrated behavioral services into primary care, and a few, including HealthRIGHT 360 in several Bay Area counties, contract with the county to provide specialty mental health or SUD services. In Santa Clara County, county-operated FQHCs have on-site psychiatrists and LCSWs. Primary care clinics at Zuckerberg San Francisco General Hospital have also integrated behavioral health into care. In Alameda County, La Clinica de la Raza contracts with the county to deliver specialty mental health services. In addition, Alameda County Behavioral Health provides psychiatric consultation services to primary care and behavioral health providers at private FQHCs.

In other regions, FQHCs are also contracting with counties. In Humboldt/Del Norte, Open Door, a large FQHC network, provides most of the SUD treatment, including using medication-assisted treatment for opioid use disorder

in primary care settings. In Los Angeles, at least 10 FQHCs contract with the county to provide specialty mental health and/or SUD services.

## **Behavioral Health Data Exchange Slowly Emerges**

The use of data exchanges to better integrate behavioral and physical health care, as well as some social services, has progressed in fits and starts, with some regions achieving key milestones. In the Sacramento Area, respondents complained that data exchange capabilities were limited. According to a state DHCS quality review, providers have complained about the unreliability of the county data systems' connectivity and how this hampers consistent data sharing. Moreover, the use of multiple exchanges across providers and plans has continued to mean that some patient information remains siloed, as integration across platforms remains a work in progress. On top of these technical challenges, data sharing between behavioral health providers and physical health systems is typically fragmented. These and other factors have prevented county mental health plans from optimizing EHR systems to adequately address patient access and quality of care.

Still, respondents in some regions pointed to recent successes. In the Humboldt/Del Norte region, the North Coast Health Improvement and Information Network (NCHIIN) plays a central role in health information exchange between providers. The Humboldt County Department of Health and Human Services, along with local providers and using the NCHIIN, implemented data sharing for outpatient mental health to use on a care coordination platform. Clinicians at Open Door FQHC and hospitals receive a "mental health summary" with diagnoses and medications and are notified when patients receive county specialty mental health services.

All four hospitals in the Humboldt/Del Norte region send alerts to community-based care coordinators upon the admission of one of the county's 1,400 high-risk patients with complex needs to an ED. Coordinators also receive alerts when one of these patients is admitted to a psychiatric hospital, a crisis stabilization unit, or jail. For the remaining patients, regional leaders hope to establish a "community information exchange" that would allow community-based organizations across the county to share data, helping to connect physical health providers and the social services sector.

In Sacramento County, the UC Davis Medical Center (UCDMC) is collaborating with county mental health plans and social services providers to implement a health information exchange protocol that would notify participants when UCDMC physicians prescribe new medications and would smooth patient transitions from mild-to-moderate to specialty mental health services. Similarly, in El Dorado County, the mental health plan's implementation of the CareConnect Inbox, a secure health care communications platform, should facilitate the exchange of patient information between the plan and community-based providers. And Placer County recently launched an HIE similar to the one in Humboldt, enabling behavioral health clinicians to receive alerts when assigned patients go to hospital EDs.



## Issues to Track

- ▶ How will Californians' mental health fare as the COVID-19 pandemic recedes and the economy improves? Will increasing income inequities and unaffordable housing contribute to deteriorating mental health?
- ▶ Will the modest addition of inpatient beds in some regions address the need for such care? Will providers within the behavioral health systems of care add sufficient capacity to relieve the bottlenecks that occur when facilities are full?
- ▶ Will the state continue to struggle with behavioral health workforce shortages? How will California cope with an aging and retiring behavioral health workforce?
- ▶ Will telehealth modalities offer long-term solutions? Will the use of telehealth remain part of care routines after the pandemic?
- ▶ Will FQHCs continue integrating behavioral health services into their scopes? How many more will contract with counties to provide specialty mental health and SUD services?
- ▶ Will DHCS initiatives such as behavioral health payment reform and CalAIM drive improvements in behavioral health service delivery? Will the current labyrinth of policies, systems, and providers become disentangled?
- ▶ Does the future of health information exchange include behavioral health data? Can the modest innovations at the local level be scaled to more organizations?

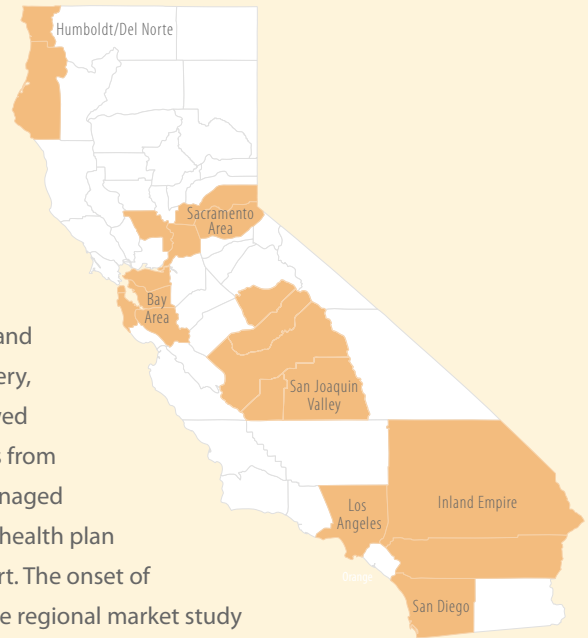
## ENDNOTES

1. Several study regions include multiple counties: San Joaquin — Fresno, Kings, Madera, Mariposa, Tulare; Sacramento — El Dorado, Placer, Sacramento, Yolo; San Francisco Bay Area — San Francisco, Alameda, Contra Costa, San Mateo, and Santa Clara; Inland Empire — San Bernardino, Riverside.
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## Background on Regional Markets Study

During 2020 and the spring of 2021, researchers from Blue Sky Consulting Group conducted interviews with health care leaders in seven regional health care markets across the state to study each market's local health care system. The purpose of the studies is to gain key insights into the organization, financing, and delivery of care in communities across California and over time. This is the fourth round of these studies; the first set of regional reports was released in 2009. The seven markets included in the 2020 project — Humboldt/Del Norte, Inland Empire, Los Angeles, Sacramento Area, San Diego, San Francisco Bay Area, and San Joaquin Valley — reflect a range of economic, demographic, care delivery, and financing conditions in California. Blue Sky Consulting Group interviewed nearly 200 respondents for these studies. Respondents included executives from hospitals, physician organizations, community health centers, Medi-Cal managed care plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report. The onset of the COVID-19 pandemic occurred as the research and data collection for the regional market study reports were already underway. While the authors sought to incorporate information about the early stages of the pandemic into the findings, the focus of the reports remains the structure and characteristics of the health care landscape in each of the studied regions.



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## ABOUT THE FOUNDATION

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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