SAN BERNARDINO COUNTY

Behavioral Health
Administration

History of Behavioral Health

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Our History

- Institutionalization thru asylums and mental hospitals began 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 - highly discriminatory.
- Controlling patient's behavior often became the goal, not therapy, rehabilitation, recovery & wellness.

Birth of Community Mental

- 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.
  - 1971, many Short-Doyle services become eligible under Medi-Cal.
- 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.

Birth of Community Mental Health

- 1965, Medicare and Medicaid were created as amendments to the Social Security Act.
- 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.

Birth of Community Mental Health

- 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.

Birth of Community Mental Health

- 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.
- 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 (ADP).

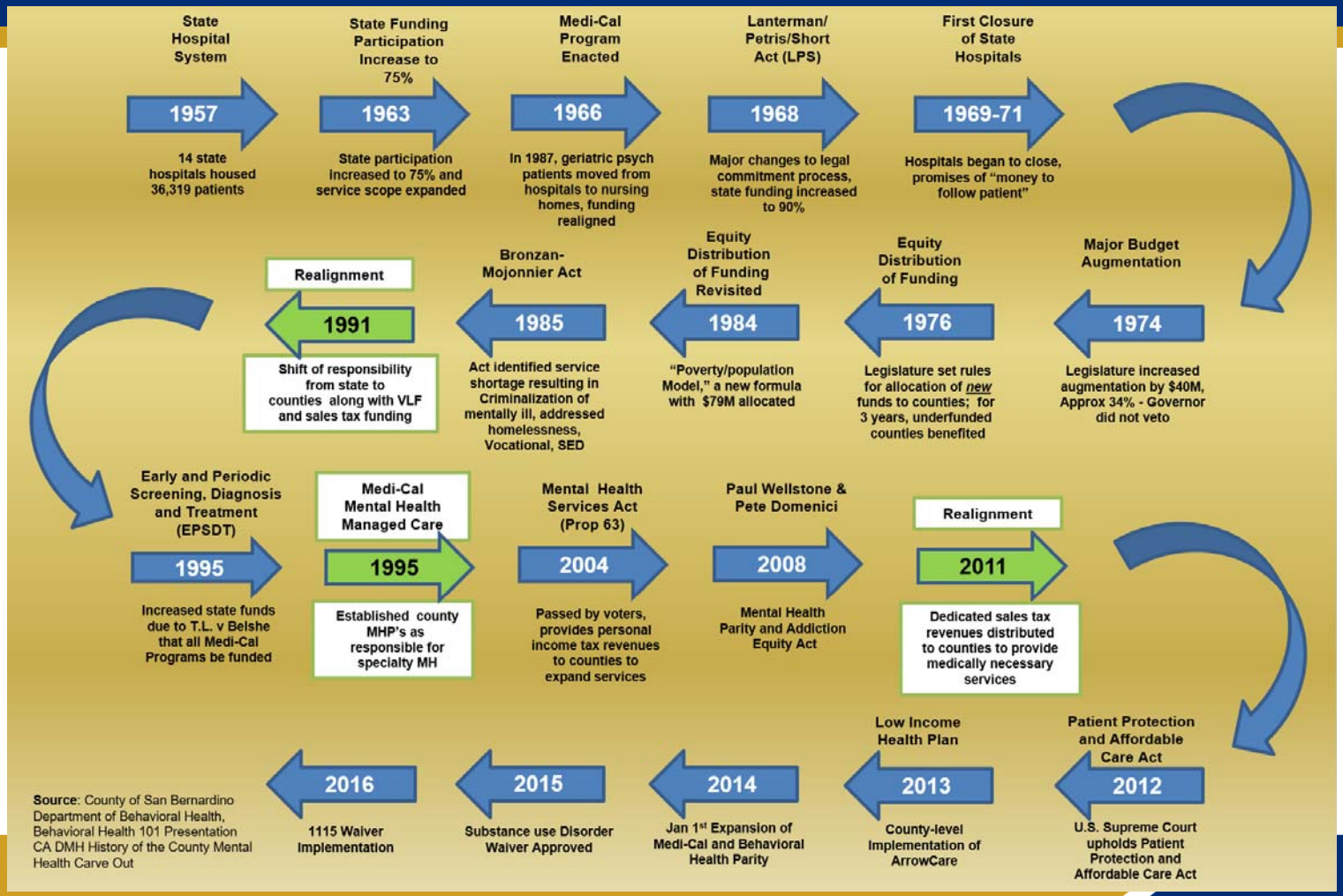
California focused on gaps in services

- 1985, Brozan-Mojonnier Act- identified service shortages that resulted in the criminalization of mental illness, homelessness, vocational deficits, and targeted severely emotionally disturbed (SED) kids.
- 1988- Bronzan- McCorquodtae Act- Defines mission of states mental health system, “tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living their most constructive and satisfying life in the least restrictive setting available.”

Counties gained more responsibilities

- 1991 and 2011 saw realignment of funding and responsibility to counties.
- 2004- MHSA.
- 2011- Department of Mental Health (DMH) removed- changed in administration to Department of Health Care Services (DHCS).
- 2012- ADP moved to DHCS.
- 2014- ACA - mild/moderate go to MCPs.
- 2015- Organized Delivery System (ODS).

Major Milestones in California's Mental Health System



What is the Carve Out?

- Refers to the Specialty Mental Health Services (SMHS) California counties' Mental Health Plans (MHP) provide for Medi-Cal, some Medicare and uninsured consumers and Substance Use Disorder Treatment.
- SMHS, services covered under Drug Medi-Cal and the ODS waiver are a benefit package.
- The County MHP is a Health Plan Type and is provided by counties via a contract with DHCS.
- The SUD Plan (formerly NNA) is same for SUD.
- Our official Managed Care Plan Name, "Prepaid Inpatient Health Plan," defined under Code of Federal Regulations, Title 42, Section 438
- County MHPs specialize in providing a continuum of social-service based care focused on recovery and rehabilitation, to include Early and Periodic Screening, Diagnostic and Treatment.
- There are 2 distinct SUD plans- State Plan- business as usual and ODS-1115 Waiver

MCPs vs. MHP/SUD

- Medi-Cal Managed Care Plans (IEHP, Molina in SBC)
- Array of health services plus, Tier I, II BH
- Complex Care Coordination

Dementia

Autism Spectrum

- County
- Specialty Services
- Tier III for SMI
- All for SUD

Other State Carve Out Programs

- Below is a list of examples of benefits or services carved-out of Medi-Cal Managed Care Plans but not intended to be an exhaustive list as carve outs vary by plan model and county:
  - Dental
  - Long Term Care
  - Home and Community Based Services
  - California Children's Services
  - Targeted Case Management
  - High cost pharmaceuticals
  - High cost procedures like transplants
  - Tuberculosis- related services
  - Developmental Disability services

Where are we going?

- DHCS looking to Innovate and Modernize Medi-Cal- via CalAIM
- Behavioral Health Stakeholder Advisory Committee
- Targeted Stakeholder Committee

Questions?

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