



## **RECOMMENDATIONS ON MENTAL HEALTH**

### **CALIFORNIA WORKING FAMILIES POLICY SUMMIT JANUARY 13, 2009**

#### **INTRODUCTION**

Many, though not all, private health plans and other managed care plans, such as Healthy Families, provide mental health coverage to working families. This private coverage is generally limited to outpatient care for those well enough to make and keep occasional appointments with therapists or psychiatrists. Short-term inpatient crisis care can also be provided when someone has attempted suicide, has become so disoriented as to be a threat to their own safety or that of another, or is so gravely disabled as to be incapable of self care.

*Public* mental health care serves those whose mental illnesses make them unable to live a normal and productive life. For children, this means individuals who require intensive services such as in-home wrap-around care, out-of-home placement, or special education mental health services. Adults who receive public mental health care services are typically unable to work and often wind up homeless.

The public system is often described as a *fail-first system* as people only enter it after a failure in school or society leaves them disabled—but the underlying cause of their failure is their untreated mental illness.

The ultimate Catch-22 is that it takes a healthy mind to recognize an unhealthy one. As a result, those who need mental health care the most often cannot be counted on to seek and obtain care in a timely way before they become disabled. It is often those in systems *outside* of mental health who recognize when people need mental health care and subsequently make the appropriate referral for timely care. While family members sometimes recognize that there is a “problem,” they often don’t understand the mental health implications of the problem and consequently don’t seek help from mental health providers.

As a result of these factors, mental health and substance abuse problems are often ignored (or not recognized) during the early period of their onset—the very point at which they can best be treated. When people with potentially severe mental illnesses are allowed to go untreated for several years, they all too often wind up in the criminal justice system, where treatment begins in settings that cost the most and offer the least chance for success.

For an individual to regain a productive life, treatment in the community mental health public system can cost tens of thousands of dollars, often over many years. But these costs are *far less* than the costs associated with incarcerating or institutionalizing an individual in a psychiatric facility. Despite the possibilities for cost savings and improved care, for decades numerous Legislatures and governors have not provided sufficient funding for the community mental system. Consequently, thousands go untreated—and the LA County jail is now considered the largest mental health institution in the United States. Moreover, an estimated one-third of homeless individuals and a far higher percentage of the chronically homeless have severe mental illnesses.

Proposition 63 (the Mental Health Services Act), which was approved by the voters in 2004 and set a 1% surcharge on incomes over \$1 million, has begun the process to address this large unmet need, but it will take many years to grow the program to meet the need.

Proposition 63 also begins prevention and early intervention programs to address this pattern of delayed response and neglect by putting in place mechanisms to ensure that those in a position to help take the right steps in each situation. However, public funding can only do so much, health plans also have to do their part.

## **POLICY OBJECTIVE #1**

### **Expand mental health and substance abuse service requirements for health plans.**

#### ***Background***

One-third to one-half of the patients who see a primary care office for any reason have an undisclosed or undiagnosed mental health and/or substance abuse disorder. However, assessing patients for these conditions is not a routine part of most visits—even though all health plans acknowledge that it should be and many are working to establish or expand this policy within their networks.

For children, school officials are usually in the best position to detect mental health problems. However, schools do not have systems in place to screen and treat for mental health conditions—and most children’s mental health conditions are not identified and treated.

When mental health problems are *identified* early in their onset, the care that is available in nearly all private health plans is typically adequate to treat most conditions. However, there are still gaps in coverage in some plans.

Based upon federal legislation enacted and signed in 2008, effective on October 1, 2009, all health plans for employers with more than 50 employees will be required to provide mental health and substance abuse benefits comparable to other health benefits (referred to as *parity*). For employers with 50 employees or less, California law requires coverage for severe mental illness—but does not include post-traumatic stress disorder, attention deficit disorder and most other anxiety disorders that fall short of being a panic disorder or obsessive compulsive disorder.

Finally, individual health insurance is virtually impossible to obtain for anyone who has ever had a history of mental illness, as anyone who has ever sought treatment or medication is usually deemed to have a pre-existing condition. This is a form of discrimination: If applied to physical conditions it would be comparable to saying that anyone who had ever seen a doctor for any medical condition now has a pre-existing condition even if they are now healthy. It is estimated that 20% of the population is likely to have a mental disorder each year and 50% over a lifetime.

#### ***Recommended Actions***

- A. The legislature should require all health plans to adopt a plan (with a five-year timeline for implementation) requiring all of their primary care clinics to 1) routinely screen every patient at primary care settings for mental health and substance abuse, and 2) include professionals on site who can perform initial evaluation and counseling and determine the need for more extensive care.
- B. The legislature should pass legislation to require that where schools are identifying children needing mental health care, health plans must either place their own clinicians (or contract providers) on campus (as counties often do for Medi-Cal enrollees), or offer to reimburse those already providing services on campus through the schools or counties.
- C. The legislature should pass and the Governor should sign legislation (which was twice passed by the legislature but vetoed by Governor Schwarzenegger before the federal law was amended) to amend California law to match federal law by adding substance abuse parity and closing the limits in mental health benefits for the employers with 50 or fewer employees so that everyone has the same coverage.
- D. In the absence of comprehensive health care reform that guarantees group coverage to *all*, the legislature should mandate that a history of seeking mental health treatment or having a prescription for a mental health medication shall not be a basis for any health plan determining someone to have a pre-existing condition nor be a basis for denying coverage for an individual.

**POLICY OBJECTIVE #2**  
**Eliminate outdated Medi-Cal limits.**

***Background***

While mental health is carved out from (and not included in) managed care mental health plans, substance abuse treatment is not. However, studies show that co-occurring mental illness and substance abuse disorders should be the expectation and not the exception and that the only successful treatment for co-occurring disorders takes place in integrated programs. Other studies show that that people with severe mental illness have five times the incidence of heart disease, obesity, diabetes, hypertension and other severe medical conditions as compared to the average population, and that as a result, people with severe mental illness die on average 25 years earlier.

It is difficult to coordinate all required care for Medi-Cal recipients, primarily due to the regulations related to the carve out of mental health from the rest of health care under Medi-Cal that limits the ability to provide comprehensive integrated care. Moreover, Medi-Cal coverage for substance abuse disorders under fee-for-service plans is very limited; and under managed care plans, there is virtually no required coverage.

Kaiser Permanente has Medi-Cal contracts in Sacramento and Solano counties that do not require it to provide substance abuse care. However, Kaiser still provides that care based upon their data showing that the savings in emergency room costs exceed the cost of the providing substance abuse care. Other studies show that *not* treating a mental health or substance abuse problem will exacerbate all health problems.

Despite this research, the California Department of Health Care Services to date has been opposed to allowing provision of mental health care *on the same day* when other care is being provided—using the rationale that allowing same-day care would lead to increased state costs.

The Department's position is based upon the outdated assumption that when more options for care are provided, the result is increased utilization. While offering increased mental health and substance abuse services may indeed increase direct costs for outpatient service utilization, the Department's position fails to take into account the savings—due to reduced hospitalization and other health problems, as well as indirect savings such as reduced incarceration—when mental health and substance abuse problems are treated in a timely manner.

***Recommended Actions***

A. Require the Department of Health Care Services to amend the state Medicaid to:

1. Expand the very limited substance abuse coverage under Medi-Cal fee-for-service and the negligible coverage under Medi-Cal managed care to provide comprehensive substance abuse coverage under Medi-Cal; and,
2. Eliminate rules that prohibit different forms of treatment on the same day. Currently, billing for Medi-Cal recipients by a single legal entity for outpatient mental health cannot occur on the same day as billing for physical health care, substance abuse treatment, physician-administered medications; or outpatient services provided in a hospital setting by a mental health provider with an existing relationship with a patient.

### **POLICY OBJECTIVE #3**

#### **Expand criminal justice diversion programs.**

##### ***Background***

The Los Angeles County Jail is the largest mental institution in the United States, and tens of thousands of people with serious mental illnesses are in our state prisons. The overwhelming majority would not be incarcerated if they had access to timely and appropriate mental health care. Mental health, law enforcement and judiciary experts and associations agree that these individuals should not be in the criminal justice system—they should be getting treatment.

Criminal justice system officials should refer for treatment instead of incarceration, whenever:

- an individual has public or private health insurance or public mental health system funding is available; and
- it is determined that the criminal behavior is not a serious or violent felony and more than likely would not be occurring if the person were receiving appropriate mental health and/or substance abuse treatment *and* the individual agrees to participate in and complete the necessary treatment.

Programs, such as mental health courts established in many counties, have demonstrated that when public funds are made available these programs have been successful in using mental health and substance abuse treatment to divert individuals away from the criminal justice system. However, such funding is very limited and the state needs to provide funding to expand these programs—especially to treat people who are most likely to end up in state prison at enormous state cost.

California also does not maximize *non-governmental* support for counties. For example, Minnesota requires private health plans to reimburse counties for the health care provided to their enrollees when incarcerated *and* for crisis care provided by county facilities during hours in which such care is not made available through the health plan's own network of providers.

In addition to these efforts to support county programs and keep people out of state prison, more could be done to prepare prisoners to deal with probation and re-entry into their communities. It is now well documented that two-thirds of prisoners are incarcerated *not* as a result of a crime, but as a result of a parole violation after serving time for a previous offense. The average stay in a prison is less than two years, meaning that most prisoners will soon be part of local communities. However, corrections officials are not yet implementing the model recovery-oriented, client-centered services that have become the standard in county mental health systems of care—meaning that the prison system is not preparing parolees for success after incarceration. Moreover, even when these model programs are in place, a parolee's success will still be limited due to a criminal record limiting their opportunities for employment.

##### ***Recommended Actions***

- A. The legislature should provide a budget augmentation to support the Department of Corrections to offer incentive funding for county mental health departments to establish a comprehensive continuum of court-related interventions, including proactive outreach, pre-booking diversion, pretrial mental health courts, and procedures to expunge criminal records (in appropriate cases as set forth below). The funding should be similar to the recently eliminated AB 2034 program offering integrated care.
- B. The legislature should require private health plans to reimburse counties for the health care provided to their enrollees when incarcerated, and for crisis care provided by county facilities during hours in which such care is not made available through the health plan's own network of providers.
- C. The legislature should establish authority and procedures to direct judges to have crimes committed by a person with a serious mental illness expunged and their criminal record be eliminated, if:
  - 1) A preponderance of evidence establishes that the crime was more likely than not committed because the person was not able to receive adequate and appropriate mental health care;
  - 2) The person has not committed a crime or been incarcerated any time during the past three years;
  - 3) The person has now benefited from successful treatment, and appears no longer likely to exhibit the behaviors responsible for the crime(s); and
  - 4) The crime was not a serious and violent felony.