

California Behavioral Health Services Needs Assessment and Services System Plan

Work Plan

July 25, 2011

Introduction

The Technical Assistance Collaborative, Inc., in partnership with the Human Services Research Institute is pleased to submit this brief work plan and budget to assist the California Department of Health Care Services (DHCS) to complete a behavioral Health Services Needs Assessment and to develop a Behavioral Health Service System Plan. We understand that both the needs assessment and service system plan are being conducted in part to satisfy federal Centers for Medicare and Medicaid (CMS) Terms and Conditions related to the renewal of California's 1115 waiver.

TAC and HSRI in combination have extensive skills, knowledge and experience that will assure that the California Department of Health Care Services receives products for the needs assessment and service planning activities that are: (a) methodologically correct and reflective of the best research evidence and practice currently available; (b) based on the best data currently available; (c) consistent with federal standards for Medicaid and with federally recognized behavioral health best practices; and (d) responsive to the unique needs, resources, priorities and imperatives of California. In the process of conducting data analyses, document reviews, and key informant interviews we will be cognizant of California's cultural and linguistic diversity, urban and rural characteristics, and variations in local resources and services delivery approaches.

Given the timeframe for these projects and the limited resources available, TAC and HSRI understand that most of the needs assessment and some of the service planning activities will depend on analysis of already existing data such as Medicaid enrollment and claims files and state MHSA data supplied by Counties. We believe this will be the most economical approach to documenting the types of people currently served, the services they receive, and the providers that deliver the behavioral health services. When matched against the population-based needs assessment, we can also quantify the theoretical gap between people in need of services and people receiving services. Service utilization patterns can be compared to preferred behavioral health system templates to assess the degree to which current services meet the needs of California's priority behavioral health service system participants. And, special studies of high cost individuals and/or people with dual or multiple physical health and behavioral health needs and costs. We will not propose carrying out original data collection or large scale surveys in this project.

Despite our principle reliance on existing data sources, TAC and HSRI understand that DHCS values the participation of stakeholders in the needs assessment and service planning activities, particularly among other state agencies such as the Department of Mental Health and the Department of Alcohol and Drug

Programs. Other important stakeholders include representatives of County Mental Health and County Alcohol and Drug provider organizations, and representatives of families and consumers. We also understand that the needs assessment and service planning activity must reflect the Affordable Care Act and other federal and state policy imperatives and funding requirements relevant to future Medicaid and related public behavioral health participants, providers and payers in California.

All the senior staff of TAC and HSRI have extensive public sector experience in behavioral health; all have participated in numerous similar needs assessments and service planning projects in other jurisdictions; and all are fully familiar with the state of the art in public behavioral health and the challenges and opportunities presented by ACA and related policy developments. We have previously submitted resumes, bios and brief descriptions of corporate experience for your review.

Approach to the Scope of Work

TAC and HSRI have reviewed the CMS Terms and Conditions as well as many documents describing public behavioral health services in California. These documents have included input from a variety of stakeholders related to the questions to be addressed in the needs assessment. Based on these preliminary reviews, we have participated in several telephone discussions with DHCS staff and other stakeholders. These discussions have clarified our understandings of the various data sets available for the project, and have assisted us to refine our approach to the work to produce the desired results (deliverables) within the available resources. As we have previously discussed, we have developed a work plan that combines the behavioral health services needs assessment and the behavioral health service plan. This will permit the most efficient use of resources and also make best use of the very brief time available for completion of these projects.

As we have discussed on the phone, our initial work plan assumes that TAC/HSRI will work with DHCS and related staff to define data extracts and specify specific outputs or reports to be produced from the data sets. We are not assuming that raw data will have to be transmitted to TAC/HSRI or that we will spend much time cleaning data and setting up data files for analysis. From our conversations with DHCS data staff, it appears this approach will be feasible, time saving and efficient. However, we are prepared to carry out more of the data extract and analysis tasks if it proves infeasible to these to be done by DHCS or related resources in California. You will note that in several places we have included steps in the workplan for data transmission and creation of analysis files if necessary and convenient for DHCS.

As part of our work with DHCS and its partners in California, TAC and HSRI will assess data quality and reliability while identifying datasets for use in the various analyses. We expect the Medicaid data will be excellent, and will only need to assess completion factors for each type of claim to assure the data being used is mostly complete. For the other datasets there is likely to be some variability in data definitions, time frames for reporting, or other issues that affect data reliability. We are comfortable working with data at varying levels of reliability, but we will need to be clear with DHCS about the relative reliability and predictive quality of the data we are using. We will discuss these issues under each task as applicable.

The following is an outline of our approach to the scope of work broken into discrete tasks:

Task 1 Conduct the Initial on-Site Visit and Project Initiation

TAC and HSRI plan to meet with the DHCS project team on site in Sacramento as soon as possible after the project is approved. We anticipate the initial on site visit to last three days. Two senior staff each from TAC and HSRI will participate in the on site visit. The purposes of this initial site visit include:

- Introduce the TAC and HSRI teams to the DHCS project team, Medicaid data staff, CAMRI staff, and other key project participants;
- In concert with DHCS, DMH, DADP and potentially other agency staff, conduct a review of the existing databases to determine what data can be extracted for which variables for what timeframes from each dataset;
- Meet with key stakeholders from DMH, DADP, county CMHDA representatives, and other state agencies as applicable to discuss their participation in the project;
- Work with DHCS project staff to refine the work plan, analytic approach, and deliverables for each element of the projects;
- Develop a project communications plan and protocols (communications among task and sub-task teams; management of external communications by DHCS project leadership, etc.);
- Identify key informants and other possible sources of collect qualitative information about special population groups, behavioral health access issues and disparities, efforts to increase physical health integration and the implementation of health information technology;
- Develop a list of key informants for face to face and or telephone interviews; and
- If feasible given scheduling issues, participate in a meeting of key stakeholder groups representing the various constituencies of these projects.

Task 2 Quantify the Need for Services

Task 2.a Estimate Need by Population Group

We propose to use synthetic estimation techniques to derive prevalence estimates of psychiatric and substance use disorders for various populations in California. Limitations of these techniques notwithstanding, synthetic estimation techniques are economic to conduct, relatively simple to implement, and comprehensive in that they can address “untreated” as well as the “treated” segments of the population. They are applicable in a reasonably uniform manner to different states and locales, and thus yield reasonably comparable and credible results for purposes of planning and needs assessment.

The project team will utilize as many currently existing epidemiologic studies as possible for the general MH population-- the adult population and the children’s population-- as well as the substance abusing population to do a synthetic estimation of the potential numbers of Californians who may exhibit symptoms or be considered to have a diagnosis for which services might be provided.

Work Plan

1. Identify relevant prevalence studies from which estimates might be derived:
 - a. Epidemiological Catchment Area Study,
 - b. The National Comorbidity Study,
 - c. The National Epidemiologic Survey on Alcohol and Related Conditions,
 - d. The Collaborative Alcohol-Related Longitudinal Project will be reviewed
 - e. Additional national and local studies (including the California Health Interview Survey if possible)
2. Develop draft analysis plan
 - a. Identify diagnostic groups for inclusion, in consultation with CA Project leadership
 - b. Identify the sub-populations for which analyses will be possible (by co-occurring disorder, gender, race, ethnicity, local area)
 - c. Recommend strategy for calculating estimates
 - d. Review proposal with CA representatives
 - e. Create timeline for completion of analysis and draft findings
3. Conduct analyses
 - a. Compile data bases
 - b. Run planned analyses
 - c. Compile draft report
4. Prepare section for inclusion in Interim Report. Sections will include:
 - a. Description of methodology
 - b. Data sources used
 - c. Description of limitations
 - d. Prevalence rates obtained
 - e. Discussion of implications

Task 2.b Quantify Special Populations

The project team will work with various constituent groups (decisions regarding which constituent groups to include should be made in consultation with DHCS, DADP and DMH and CMHDA) within the state to identify special populations of policy relevance. Estimating prevalence among special problems presents its own set of special problems. As the size of various populations diminishes, so too does the robustness of estimates. Recognizing this, the project team will work with the state to identify those special populations that are of high policy interest and try to determine which of these might support further analytic work. Candidate groups might include:

- Residents of jails/prisons (adult and juvenile)
- Individuals with co-occurring psychiatric or substance use disorders and specified medical conditions (both SMI and non-SMI populations)
- Children in out of home placement
- Youth with substance use disorders
- Residents of nursing facilities (adult and aged)
- Immigrant groups

- Veterans or those individuals on active duty/ families of military personnel
- Individuals with co-occurring MH or Sa disorders and developmental disabilities
- Individuals who are homeless

Work Plan

1. Identify potential target populations for which the population size is adequate and there are credible estimates nationally or from other states (CA specific data/estimates should be used whenever possible)
 - a. Compile list of target populations meeting the two criteria above
 - b. Review candidate populations with CA project leadership
 - c. Develop work plan for special population analyses
2. Develop draft analysis plan
 - a. Finalize list of population groups for analysis in consultation with CA Project leadership
 - b. Recommend strategy for calculating estimates
 - c. Review proposal with CA representatives
 - d. Create timeline for completion of analysis and draft findings
3. Conduct analyses
 - a. Compile data bases
 - b. Run planned analyses
 - c. Compile draft report
4. Prepare section for inclusion in Interim Report. Sections will include:
 - a. Description of methodology
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 - e. Discussion of implications

Task 2.c Quantify the Current Participants in Behavioral Health Services

Medicaid Participation

In order to understand the number and types of individuals currently using behavioral health services we will start with persons receiving services through the State Medicaid program. We will attempt to use at least the most recent two years of data to summarize who is currently receiving services. The goal will be to compute the number of individuals served stratified by age, eligibility, diagnosis, county, and if possible level of functioning, cultural or ethnic grouping, provider or practitioner type. We will do this for at least two separate one year periods to determine if they are any changing patterns and to understand why and whether the new patterns would be expected to continue. We recognize that data on expenditures needs to include financing information from the mental health and substance use systems in addition to the Medicaid system.

Work Plan

5. Request most recent 2 – 5 year Medicaid data extract
 - a. Prepare data request/data extract specifications and analytic frameworks
 - b. Develop system to send and receive data (e.g. secure ftp server) if applicable
 - c. Review data questions with Medicaid
 - d. Consider the impact of Short Doyle 2 implementation

6. Prepare Analysis files
 - a. Identify relevant variables for inclusion in summary tables (age, eligibility, diagnosis, by county or region, service type, level of functioning, cultural or ethnic grouping, identified special populations in prevalence task 2.b, provider or practitioner type)
 - b. Identify the variables for which analyses will be possible
 - c. Identify the years to compute Medicaid participation
 - d. Review final proposal with CA representatives

7. Conduct analyses
 - a. Run planned analyses
 - b. Compare to published reports
 - c. Obtain feedback from Medicaid on results
 - d. Compile draft report

8. Prepare section for inclusion in Interim Report. Sections will include:
 - a. Description of methodology
 - b. Data sources used
 - c. Description of limitations
 - d. Participation rates obtained

Task 2.d Calculate penetration rates for behavioral health services

A penetration rate provides an indicator of whether persons with a mental illness and / or substance use disorder are receiving services and whether the system is responsive to various consumer populations. The measure used will reflect the proportion of persons in the population receiving services. The unduplicated number of individuals served is used in the numerator and the population of interest is used in the denominator and the result is a proportion of the population served.

This task will use results from tasks 2.a, 2.b and 2.c to calculate penetration rates.¹ In this task we will attempt to describe penetration by target groups of interest, including cultural and linguistic minorities, dual eligibles, etc. This task will also use at least the two most recent available years to calculate penetration rates for the relevant categories.

State MH/SA participation

To the extent possible TAC and HSRI will use state MH/SUD datasets to quantify the number of unique individuals using state/county funded behavioral health services for the same time period as documents

¹ We understand that penetration rates may be artificially low for a variety of reasons, including the possibility that appropriate services are not available, and thus potential recipients have little incentive to seek care.

for participants in Medicaid behavioral health services. It is understood that MH/SUD data sets may be incomplete due to data transmission challenges and other issues. We are accustomed to working with data sets that are incomplete and will adjust our approach accordingly. The current participants in non-Medicaid services represent a portion of the population that are likely to become eligible for Medicaid in 2014 and may access Medicaid-funded behavioral health services at least those covered in benchmark plans.

If possible, we plan to use the same demographic and geographic variables used to describe the Medicaid behavioral health participant participation. These will include County of residence; age; gender; race/ethnicity; eligibility category; etc. Assuming that we can identify unique individuals and can de-duplicate between the Medicaid participant files and the MH and SA participant files, we will calculate penetration rates for the non-Medicaid and the total behavioral health service populations using the same methodology and categories as described above.

In addition, we will work with DHCS, DMH and DADP to attempt to cross match the Medicaid and non-Medicaid service populations. In most jurisdictions there is substantial overlap between the Medicaid and non-Medicaid service participants. It would be useful to be able to document: (a) the unduplicated total number of people across the primary Medicaid and non Medicaid behavioral health programs (thereby eliminating duplicated individuals who otherwise would inflate the counts of total people served); (b) the number of people in the non Medicaid group also receiving Medicaid behavioral health services (these individuals are likely not in the cohort that will become newly eligible in 2014); and (c) the number of unique individuals consistently using both Medicaid and non Medicaid services may represent some individuals with high risk or high cost service needs for whom best practice service modalities may be appropriate.

We will confirm with DMH each county's plan to use Proposition 63 funds to serve a defined number of individuals with specified best practice services. These individuals and the services they are intended to receive will be tabulated at the County and state levels. In addition, there is likely to be data on special services for special populations, or data related to separate funding streams in addition to Proposition 63. TAC and HSRI will work with DMH and DADP to identify these sources of information, and to determine whether individuals in these datasets are also captured in the county/state MHSA datasets.

Other State Agencies and Funding Sources

It is unlikely that information on unique individuals or specific behavioral health service utilization will be available from other California agencies and funding sources in a manner that could be added to or compiled in concert with the Medicaid and County/State MHSA participant data. It is also unlikely we will be able to de-duplicate people served by these agencies if they also receive Medicaid or state MHSA behavioral health services. Nonetheless, it will be important to identify which other state agencies fund behavioral health services (both with and without Medicaid FFP) and what types of participants receive which types of behavioral health services through these agencies. Agencies and funding streams to be considered include child welfare (Titles IV A and E); juvenile justice; adult corrections; aging services; physical disability services; intellectual disability services; autism services; Education (school-based

behavioral health and special education services); health centers and FQHCs; Veterans Administration, and others as identified by the DHCS project team.

Qualitative information from these agencies/funding sources will assist to describe the universe of behavioral health service recipients, some of whom may ultimately become enrolled in Medicaid, or conversely, may already be using substantial Medicaid resources.

Workplan

1. Prepare Analysis files
 - a. Identify relevant variables for inclusion for summary penetration tables (e.g. age, eligibility, diagnosis, payor source, by county or region, service type, level of functioning, cultural or ethnic grouping, identified special populations in prevalence task 2.b, provider or practitioner type)
 - b. Combine Medicaid and other state data including DHCS, DMH and DADP. This could include data from the EQRO process and any Short Doyle 2 impact.
 - c. Prepare minimum of two years of penetration for each variable identified above
2. Conduct analyses
 - a. Run penetration rate analysis
 - b. Compare to published reports
 - c. Obtain feedback from CA leadership
 - d. Compile draft report
3. Identify Key Informants and data files for MHSA and other agency service participant information
 - a. Conduct analyses as applicable
 - b. Calculate penetration rates for non-Medicaid participants
 - c. Obtain feedback from DMH, DADP and other applicable agency representatives
4. Prepare section for inclusion in Interim Report. Sections will include:
 - a. Description of methodology
 - b. Data sources used
 - c. Description of limitations
 - d. Penetration rates obtained
 - e. Penetration gaps observed

Task 2.e Project New 2014 Medicaid Enrollee Population

States nationally are grappling with plans to accommodate new Medicaid enrollees who are expected to enter the system with the implementation of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Mandates in these Acts require states to expand coverage to individuals under 133% of the federal poverty level by 2014. The project team will work with state representatives to explore the implications of this expansion for California's Medicaid program.

The project team will conduct a literature search to identify estimates of expected increases in Medicaid populations. One such study is the recently released report from the Urban Institute, funded by the

Kaiser Foundation². This report provides state estimates of the increase in the Medicaid population under two scenarios: one using modified CBO projections and a second using an enhanced outreach scenario. Such estimates provide lower and upper boundaries to understand the growth in Medicaid enrollment under health reform. We also know from recent telephone conversations that DHCS staff have already been working on projections for Medicaid enrollment of childless single adults at or below 133% of the poverty level. We will meet with these staff and review their materials to assure we do not duplicate good work that has already been done in this arena. We also understand that California has already enrolled some previously ineligible individuals under the current 1115 waiver, and will explore with DHCS whether that experience could be relevant to these projections. Finally, there are other states that have enrolled all or part of the currently uninsured population under 1115 waivers or the early implementation option under ACA. We will poll these states for data and related information that could assist to make the California projections as accurate as possible. Using data from sources , including California specific data, where available, and national level data such as the National Survey on Drug Use and Health and the recent RWJ funded study conducted by the Urban Institute on the projected health status of new Medicaid enrollees ³, the project team will estimate the proportion of these new enrollees who meet diagnostic criteria for behavioral health disorders.

Work Plan

1. Meet with state representatives to identify the parameters for this task and to collect information already developed by DHCS and other state staff related to projecting 2014 Medicaid enrollment
2. Conduct literature search to identify most recent estimates related to Medicaid expansion and the proportion of new enrollees expected to meet criteria for behavioral health disorders
3. Identify relevant work done to date within California state agencies, associations and universities
4. Prepare estimates of increases in the targeted Medicaid population and the number of new enrollees with behavioral health disorders beginning in 2014
5. Review estimates with California project staff and revise as necessary

Task 3 Quantify Current Utilization of Services

Task 3.a Quantify Current Use of Medicaid Behavioral Health Services

² <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>

³ <http://www.rwjf.org/files/research/68128.pdf>

We will examine what people are now receiving with regard to mental health and substance abuse services through a critical and comprehensive analysis of several utilization data sources. We will divide the population into three groups: Medicaid, non-Medicaid & cross-over or multi-payer systems. We will also create a description of the population served that matches the population-based needs estimates. We will examine utilization patterns across domains such as inpatient, rehabilitation, treatment and acute services and attempt to identify evidence-based or promising services and determine if they are reflected in current utilization patterns. Our approach entails creating a service utilization dataset structure that can be used to evaluate multiple systems and scenarios. We will document the heavy users of mental health and or substance abuse services and track their utilization patterns in ways to establish whether and how these individuals may also be using a disproportionate amount of acute and specialty health services. Underutilizers, such as people who receive one to three service encounters and then disappear from services, will also be identified and analyzed. It will also be important to document how people enter and leave the system and at what rates to understand the flow of how the system operates. This will be important for future system design.

Task 3.b Quantify State/County MHSA Service Utilization

As noted under Task 2, TAC and HSRI do not expect to be able to conduct the same level of analysis of service utilization within the county MHSA systems for non-Medicaid services as will be possible for Medicaid behavioral health service utilization. Nonetheless, we do expect that there will be aggregate data on the numbers of people served by various service categories for both mental health and alcohol and drug services. Thus, we should be able to produce a general analysis of the types of services delivered in the non-Medicaid arena, and hopefully be able to document at some level the numbers of individuals served and the aggregate state/county expenditures for these services.

One critical part of the assessment of non-Medicaid MHSA services will be to identify service types that may be included in Medicaid benchmark plans after 2014. Theoretically, Medicaid should be able to reimburse for most of these services after the currently ineligible people are enrolled in Medicaid. We expect that an estimate of this phenomenon will assist with both Medicaid and non-Medicaid service system planning in anticipation of 2014.

Task 3.c Document Other System Behavioral Health Services and Participants

As noted above, it is unlikely that we will be able to receive detailed information on the amounts and types of behavioral health services delivered under the auspices of other state agencies and funding streams. However, we will document as much as possible the supply of behavioral health services being funded/delivered by these agencies, and document the degree to which they can or should interlock or coordinate with Medicaid and MHSA services. Key informants from these agencies are also likely to provide anecdotal information about needs and gaps in behavioral health services among their client populations. This information contributes to both the needs assessment and the service planning tasks.

Workplan

1. Develop Service Taxonomy⁴ and cross walk to preferred behavioral health system services
 - a. Identify all services provided by Medicaid, DHCS, DMH and DADP
 - b. Prepare a crosswalk of all services into key domains and services
 - c. Review with CA leadership
2. Prepare Analysis files
 - a. Create algorithm for classifying services
 - b. Combine Medicaid and other state data including DHCS, DMH and DADP
3. Conduct analyses
 - a. Calculate current and new users
 - b. Run summary utilization rate analysis by service, domain and payor source
 - c. Run high utilizer and underutilizer analyses
 - d. Run system flow analysis (how people move into and out of the system)
 - e. Compare to published reports
 - f. Obtain feedback from CA leadership
 - g. Compile draft report
4. Interview key informants about participant flow into and out of services and other qualitative service utilization information (this is intended to assist with interpreting the Medicaid and related claims data analyses).
5. Prepare section for inclusion in Interim Report. Sections will include:
 - a. Description of methodology
 - b. Data sources used
 - c. Description of limitations
 - d. Utilization rates obtained

Task 4 Quantify the Universe of Behavioral Health Providers

Task 4.a Medicaid Providers and Practitioners

All Medicaid enrolled providers have a unique provider identification number (PIN). Thus it will be possible to generate a complete list of Medicaid enrolled providers and practitioners that have a PIN and are qualified to provide behavioral health services. These providers and practitioners can be arrayed by county, by service type for which they are approved, and by agency-based versus individual practitioners. We recognize that In Short Doyle 2 there are PINs for both the providers and the certified sites that may complicate this data analysis.

Not all Medicaid enrolled providers and practitioners deliver services (or substantial amounts of services) to Medicaid enrollees. Nor do all providers qualified to deliver preferred practice services actually deliver all of those services. For this reason, the list of providers and practitioners does not represent the actual capacity of the behavioral health system to serve participants. Thus, we will conduct an analysis of number of unique Medicaid participants served by each provider/practitioner for the years for which we have data. We can also tabulate the numbers of units of services provided for

⁴ We plan to use the SAMHSA paper on a Good and Modern Behavioral health System as a basis for the taxonomy. By the time the actual data is available, we also may be able to use specific HCPC codes for essential substance use and mental health services as defined by SAMHSA and CMS.

each applicable service type for these providers/practitioners. This will give a more realistic picture of the functional (as opposed to absolute) capacity of the current Medicaid behavioral health system. In addition, this analysis will identify the major multi-service providers of behavioral health services in each county of the state. This list can be reviewed by DMH and DADP staff to assess the degree of overlap, at least anecdotally, among the Medicaid and non-Medicaid provider networks in the state.

One key element of the provider capacity analysis will be to tabulate inpatient capacity designated for psychiatric inpatient and or substance abuse detoxification and treatment. General hospitals with psychiatric and/or substance abuse capacity can be identified through the PIN tabulation, but it may be necessary to obtain licensed bed capacity information for these facilities from other sources. In addition, there are likely private hospitals, IMDs and related facilities that are not included.

Task 4.b Other Public and Private Providers and Practitioners

As noted above, once a list of Medicaid providers and practitioners has been developed, it should be possible to work with DMH, DADP and their county affiliates to estimate the degree to which Medicaid providers are in the networks of the county MHSAs. In the course of doing this, it should also be possible to obtain information on providers in county networks that are not Medicaid providers. We expect this information will be somewhat anecdotal, but it should give some qualitative sense of the capacity of local systems to provide behavioral health services in addition to the Medicaid providers and practitioners identified above.

TAC and HSRI expect it will be even more difficult to quantify and document the numbers and types of providers and practitioners of behavioral health services that only work in the private sector (commercial insurance and self-pay only) in California. We expect to be able to obtain information from the various licensing bodies for the professional guilds (psychiatrists, psychologists, psychiatric nurses (APRN and RN), LICWS and certified social workers, family counselors, addictionologists, certified addiction counselors, etc.). However, not all the individual practitioners on the lists will be in active practice, and some other types of practitioners not licensed as above could be providing behavioral health services.

Another source of information might be lists of provider agencies that are licensed by various state agencies to provide behavioral health and behavioral health-like services. Again, there is no way to know if these agencies deliver a lot or a little of what they are licensed for, or whether they admit consumers needing behavioral health services as defined by Medicaid and DMH/DADP. Nonetheless, we will explore these various data sources and assess the degree to which it will be possible to estimate the overall number, types and capacities of behavioral health providers and practitioners.

Information from Tasks 4.a and 4.b can be combined to conduct an analysis of where there are current gaps in service delivery capacity throughout California. For example, some rural counties are likely to have few psychiatrists or other licensed clinicians, while others may have many practitioners but they serve only a few Medicaid participants. TAC and HSRI will assess the capacity of the provider system in light of current needs and gaps in the service system. In the context of behavioral health service system planning as described in Tasks 7, 8, and 9 below, we will also consider the degree to which the current

provider system may have to expand or change to accommodate new participant volume after 2014 and new preferred practice service modalities as these are expanded in the future.

Workplan

1. Identify provider types to be identified from the Medicaid provider and claims files
 - a. Discuss data definitions, parameters and report frameworks with DHCS
2. Carry out provider identification and volume analyses as outlined above
 - a. Create county-level reports of providers by service type and volume of participants/services
 - b. Review findings with DHCS and DMH/DADP
3. Cross match the Medicaid provider/practitioner lists with County MHSAs provider lists
4. Identify information sources and registry/licensure information for professional practitioners, licensed providers, etc.
5. Conduct key informant interviews to refine the information obtained through steps 3 and 4
6. Create a master resource list of behavioral health providers and practitioners by county
7. Analyze possible gaps and other issues related to the current supply of behavioral health providers and practitioners at the state and county levels.
8. Prepare section for inclusion in Interim Report. Sections will include:
 - a. Description of methodology
 - b. Data sources used
 - c. Description of limitations
 - d. Findings of the provider analyses

Task 5 Document Specified Behavioral Health System Characteristics

DHCS and various stakeholders have identified several issues that are critical to the assessment of needs and gaps in the current California behavioral health system. These include:

- Identification of current activities and demonstration projects focusing on the integration of behavioral health with physical health, as well as the integration of mental health and substance abuse service systems;
- Documentation of the current information technology capacities of behavioral health system providers and county systems and future plans for adopting advanced health information technology and electronic health records systems; and
- Identification of issues related to access to services, high utilization of services over or under-concentrations of service utilizers, access and delivery issues related to special populations, etc.

TAC and HSRI plan to approach these topics through the following activities:

Task 5.a Physical Health and Behavioral Health Integration

Behavioral health system participants have been focusing for a long period of time on efforts to improve the coordination of physical health and behavioral health. These coordination efforts have concentrated primarily on two population groups:

- Children and youth, who obtain many of their behavioral health services through their primary care provider; and
- Adults with serious mental illness and adults with serious addictive disorders, who frequently have multiple chronic health conditions but also for a variety of reasons have poor access to primary and specialty healthcare.

Physical health and behavioral health integration has received recent impetus in part because of research that shows substantial savings from effective integrated interventions.⁵ This research has been used to plan several federal demonstrations related to integrating and coordinating care, including the Health Home initiative in the ACA; the SAMHSA Integration initiative; and HRSA's recent grants to federally qualified health centers (FQHCs) to expand access to behavioral health services.

TAC and HSRI will work with DHCS and DMH/DADP to identify key informants throughout California who are working on or planning the implementation of behavioral health and physical health integration projects, including primary care initiatives to improve behavioral health interventions for youth as well as special projects focusing on people with serious mental and/or substance use disorders. We will conduct telephone interviews with a limited number of key informants⁶ to document the nature of their integration efforts; the number and types of people to be enrolled or served; the geographic area covered; the types of providers included in the effort; and the financing mechanisms for integrated care. These key informant interviews will not be all-inclusive or definitive, but they should provide a good overview of the current state-of-the-art in health integration efforts in California. This is intended to describe the current baseline as a platform for additional physical and behavioral health efforts to be included in the behavioral health systems plan.

Work Plan

1. Review available research materials and status reports related to California's Health integration projects and plans
2. Identify key informants and develop a key informant interview guide
3. Review interview guide with state project team
4. Conduct key informant interviews
5. Summarize information obtained in key informant interviews
 - a. Describe sample and interview approach
 - b. Summarize information on behavioral health and physical health integration projects and plans in California

⁵ Including the Frequent Users of Health Services initiatives in California

⁶ We expect the California Healthcare Foundation, the California Endowment and the California Institute for Mental Health will be among the key informants to be interviewed (need to include the Alcohol and Drug Policy Institute for SA).

- c. Summarize interviewees' concerns and suggestions regarding future integration activities
- d. Identify strategy for next steps in the California Behavioral Health Services Needs Assessment and Services System Plan

Task 5.b Document Current Behavioral Health Information Technology Activities and Plans

Significant changes are occurring within the entire health care sector related to the collection, storage, transmission and utilization of health information. These efforts nationally are focused on improving system efficiencies, enhancing care coordination, and reducing medical errors. The project team will work with California officials to design a strategy for assessing the current state of such changes in health information technology within the state, obtain information on the vision for additional changes and begin to plan strategies to achieve this vision.

This effort will begin with a series of key informant interviews designed to assess the current status of information technology within the behavioral health system. The project team will work with state representatives to identify a pool of candidate interviewees. Queries will focus on the status of initiatives such as:

- The status of the health information infrastructure
- Development and use of health information exchange technology
- Design, availability and use of electronic health records (including use of incentives for adoption of e-records through the Medi-Cal Provider Incentive Payment Program)
- Utilization of monitoring systems such as the CA Prescription Drug Monitoring Program
- Security of health information technology
- Improvements to date in the collection, storage, security and use of health information
- Many counties subcontract with national vendors for their claims and EHR needs. These counties and vendors will be part of this process.

Following this initial effort, the project team will work with the state to identify next steps that will be most useful to the state as it monitors the development of such initiatives, encourages further development, and considers adjunct strategies that might be necessary including security enhancements, public education efforts, strategies to improve the capabilities of providers and provider organizations, evaluation of the impact of such innovations and the use of this information to assess system performance.

Work Plan

1. Review available materials on the status of California's HIT infrastructure and current initiatives
2. Develop key informant interview guide
3. Review interview guide with state project team
4. Identify potential respondents for key informant interviews
5. Conduct key informant interviews

6. Summarize information obtained in key informant interviews
 - a. Describe sample and interview approach
 - b. Summarize information on the current status of California's HIT infrastructure related to behavioral health
 - c. Summarize interviewees' concerns about current status and future directions
 - d. Identify strategy for next steps in the California Behavioral Health Services Needs Assessment and Services System Plan

Task 5.c Conduct Special Analyses of Behavioral Health System Issues Related to the Medicaid Plan and Medicaid Expansion

TAC and HSRI will work with the DHCS project team to identify specific topics for special studies using the datasets accessed under tasks 2 and 3 above⁷. The purpose of these special studies will be to highlight service access problems, service gaps, access disparities related to special factors, urban/rural variations or other issues of particular importance to California in both the needs assessment and service planning activities. Special studies can be designed to address questions such as:

- What is the average elapsed time from initial contact (assessment) with the behavioral health system and the initiation of on-going services? Does this vary by diagnosis, age, cultural or linguistic group, or geographic area?
- What is the elapsed time from hospital discharge to initiation of services? Is there a possible correlation between elapsed time for accessing services and the probability of readmission?
- To what extent do people accessing mental health care also receive substance abuse treatment, and vice versa ?
- Are there significant regional variations in inpatient utilization, and can these be explained by access or disparity issues as discussed above?
- To the extent these can be identified in the Medicaid claims data, to what degree are evidence based practices being implemented, who is being served, and what are the utilization patterns?

Workplan

1. Identify special studies to be conducted.
2. Work with DHCS project team and Medicaid data staff to clarify data elements to be included in the special studies.
3. Review the results with DHS project staff and perhaps DMH and DADP staff to interpret preliminary results and to see if additional analysis is warranted.
4. Summarize special studies for internal circulation and for inclusion in the interim report.

Task 6 Integrate Behavioral Health Services Needs Assessment Information and Develop the Behavioral Health Services Needs Assessment Report

⁷ Note: we believe that the Medicaid enrollment, claims and provider files will be most useful and reliable for these types of special studies.

TAC and HSRI will assemble all the information collected and reported under tasks 1 through 5 and generate a draft and final interim report of the Behavioral Health Services Needs Assessment. This report is intended to meet the CMS term and condition related to the behavioral health services needs assessment, and will be completed in time for DHCS to submit it to CMS prior to the March 1, 2012 deadline. All of the information to be included in the interim report will have already been seen and reviewed by DHCS project staff, since there will be a deliverable developed for each task as the project progresses.

Pending further discussions with DHCS project leadership, we anticipate this interim report will follow the general outline of tasks 2 through 5, with an introductory chapter providing an overview of the project; the participants included; and the approach and methodology for analysis. There will also be a concluding chapter that summarizes the needs and gaps information, and sets the stage for the service system planning information to be included in the final report.

TAC and HSRI will prepare a complete draft of the final report by January, 2012, to assure that DHCS and its constituent state agencies and designated stakeholders have ample time to review and comment on the draft. This review process assures the data analysis and interpretation is as correct and valid as possible. It also begins to build consensus for service system development strategies to be included in the behavioral health service system plan.

Once the draft interim report has been reviewed, TAC and HSRI will prepare the final version of the interim report. If desired by DHCS, we will also prepare an executive summary and a PowerPoint presentation that can be used with stakeholder groups to summarize the findings and recommendations of the report.

Workplan

1. Work with DHCS project leadership to develop a detailed outline for the interim report.
2. Work with DHCS project staff to review data tables, charts and related methods for summarizing and presenting data.
3. Develop a draft of the interim report for review and comment by DHCS and stakeholders if desired by DHCS.
4. Assemble and integrate all comments into a final version of the interim report.
5. Produce the interim report, executive summary and presentation materials

Task 7 Project Changing Medicaid and Non-Medicaid Service Patterns

Using a clinically based and proven model, the project team has developed a dynamic approach for estimating behavioral health system needs and resources. This approach is based on a simulation that, over time, can estimate changes to consumer outcomes in functioning as services are delivered, and the resource capacity needed to generate and respond to such outcomes. The simulation uses data on consumer global assessment of functioning and evidence-based services collected both nationally and locally by HSRI. The service recommendations can be made by extrapolations from state data and expert judgment. The needs assessment model is sensitive to the dynamic flow of a behavioral health system in assuming that, as services are given, some consumers will improve in functioning, others

deteriorate or remain static. The model generates a dynamic picture of a behavioral health system that can inform authorities over time on who is using resources, how many are likely to get better or stay the same, and how much the system would require in dollars, workforce resources (e.g. case management teams, clinicians, psychiatrists) and reimbursements.

In this task we will project the changing service pattern and costs following the new system implementation. We will simulate the impact of a new system implementation over one year, two years or longer on utilization, costs and projected outcomes based on levels of care. We will describe how patterns of utilization will change as new services are introduced and ineffective services are phased out. As service patterns change, so will costs, which can be discounted through net present value estimates. We will outline our projections for full or partial implementation (full implementation in select counties or select service configurations in all counties over time) and examine changing scenarios. In all cases, we can estimate the proportion of costs to the state behavioral health agency is expected to incur and that which can be absorbed into Medicaid.

Workplan:

1. Produce service utilization data in model format (services by percent and amount)
2. Compare service utilization rates to best practices and make adjustments
3. Convene an expert panel to review (optional)
4. Run simulation scenarios
5. Conduct sensitivity analysis on results
6. Prepare section for inclusion in Final Report. Sections will include:
 - a. Description of methodology
 - b. Data sources used
 - c. Description of limitations
 - d. Recommendations on required service capacity

Task 8 Recommend Medicaid Gap-Filling Strategies

Medicaid gap-filling strategies

TAC and HSRI will use all the data analysis and interpretation derived from the behavioral health needs assessment to prepare draft recommendations and implementation strategies for DHCS related to Medicaid gap filling strategies. In many cases the selection of strategies can be driven by the simulation model described in Task 7 above.

The service needs simulation described in task 7 will form the basis for many of the recommended gap filling strategies. The service capacity required will take into account the phasing-in of evidence-based or promising services, and the impact that the inclusion of such services will have on other existing and new services as well as on what services would be eligible for phasing out. For recommended services that are not yet in place, we could include strategies to implement them in all or parts of counties, and mechanisms for funding through benefit designs for specific populations and groups.

Until the needs assessment is at least partially completed, and until we begin to review the results of the simulation modeling, it will be difficult to specify exactly what gaps and service needs will be identified and prioritized. However, we anticipate that the system-wide gap filling strategies emanating from the simulation model will be augmented by strategies addressing the following types of issues:

- Medicaid access, including outreach and enrollment strategies;⁸ improving access to cultural and linguistic minorities; and improving the timeliness of access to essential services.
- Implementation of new or expanded Medicaid behavioral health services to meet specifications for best practice systems of care and to meet the needs of special populations such as children, transition age youth, people with co-occurring mental and substance use disorders, and other high risk groups.
- Improving and tailoring Medicaid benefits for current and newly enrolled Medicaid participants and special populations.⁹
- Projecting necessary behavioral health system capacity for Medicaid and state/county MHSA services.
- Designing service delivery modalities tailored to the cultural choices and preferences of varying groups now evidencing disparities in behavioral health access and utilization.
- Strategies for health integration based on assess risk factors and prevention approaches.

This basic approach to estimating behavioral health future capacity will also provide a framework for addressing special issues such as health disparities, access barriers, differential regional or county level gaps in basis services, etc.

Workplan:

1. From the outputs from task 7 extract Medicaid only services
2. Flag each service as new, phase out or continuing
3. Produce yearly capacity totals for the state, county and other important subpopulations
4. Recommended implementation strategies
5. Work with DHCS project leadership to identify additional priority gap filling and system development strategies
6. Develop specific implementation strategies
7. Prepare section for final report

Task 9 Establish System Functioning Principles, Standards and Indicators of Performance

⁸ For example, in Massachusetts, which has extended Medicaid eligibility and mandatory health coverage for all citizens, it is still the case that 30% of individuals presenting for substance abuse services are uninsured. These are likely to be individuals that cost other systems a lot of resources, so assuring Medicaid enrollment is an important strategy, even with eligibility at 133% of the poverty level.

⁹ This does not necessarily mean new Medicaid plan or waiver services. It may mean strategies for rationalizing access to and delivery of packages of services by defined need and level of care categories within the current Plan and waivers.

The behavioral health needs assessment focused on several key systems issues, including health integration, health information technology, and access and service delivery issues for specific sub groups of Medicaid participants. The system design recommendations described in tasks 7 and 8 will have direct implications for these issues. In addition, they will have specific implications for workforce development strategies to assure successful implementation and operations of chosen Medicaid and related service system capacities. We understand that counties have conducted extensive workforce assessments and planning under the provisions of MHSa that will be useful to this task.

Under this task, TAC and HSRI will recommend system policy principles, performance standards and indicators of performance that will (a) define performance expectations for system participants and providers related to DHCS priorities for system improvement. For example, DHCS could require that all Medicaid recipients at a level of care necessitating a person centered plan of care have an identified health home and an integrated health and behavioral health care plan. DHCS could also issue standards for timeliness of access for new service entrants or among categories of services (e.g., outpatient and inpatient), and could then measure and publish the degree to which these standards are being met. Assuming that the system design will encourage increased use of evidence based services, the actual performance of providers in delivering these specified services could also be measured and published. In addition, DHCS could issue standards and guidance with regard to HIT and information sharing/electronic health records to foster integrated care, and then could track the extent to which these systems are implemented.

The scope of work for the behavioral health needs assessment and service system plan does not call for a detailed or extensive workforce analysis. However, the combination of the provider and practitioner analysis described in task 4, plus the service design elements of tasks 7 and 8, will provide a basis for identifying workforce issues to be addressed as implementation proceeds. This will most likely be particularly true for strategies addressing rural service access issues; culturally and linguistically competent service provision, and specialized staffing needs for certain evidence based and promising practices to be included in the service system design. TAC and HSRI will summarize these workforce issues, and will suggest strategies for enhancing workforce competencies and capacities for the behavioral health system.

Workplan

1. Work with DHCS project leadership to identify key policy principles and performance requirements to support implementation of the service system design and gap filling strategies.
2. Propose policy standards and performance indicators for the selected policy principles.
3. Identify workforce issues and strategies related to system design and gap filling implementation and on-going operations.
4. Prepare sections for final report.

Task 10 Prepare draft and final report of the Behavioral Health Services System Plan

TAC and HSRI will assemble all the information collected and reported under tasks 7 through 9 and generate a draft and final report of the Behavioral Health System Plan. This final report is intended to meet the CMS term and condition related to the behavioral health services system plan, and will be completed in time for DHCS to submit it to CMS prior to the October 1, 2012 deadline. All of the information to be included in the final report will have already been seen and reviewed by DHCS project staff, since there will be a deliverable developed for tasks 7 through 9 as the work on these tasks is completed.

As with the interim report described under Task 6, and pending further discussions with DHCS project leadership, we anticipate this interim report will follow the general outline of tasks 7, 8 and 9, with an introductory chapter providing an overview of the project; the participants included; and the approach and methodology for analysis. There will also be an introductory chapter summarizing the findings and recommendations included in the interim report. There will be a concluding chapter that summarizes the behavioral health service plan recommendations, including recommended action steps and sequencing for implementation activities. Although the services system plan will focus primarily on the Medicaid behavioral health system, it will also address interactive strategies with the state MH and SA systems and other state systems that both rely on and provide essential support to the Medicaid behavioral health services system.

TAC and HSRI will prepare a complete draft of the final report by August, 2012, to assure that DHCS and its constituent state agencies and designated stakeholders have ample time to review and comment on the draft. To the extent desired by DHCS, TAC and HSRI will be available to present the findings and recommendations to designated stakeholder groups.

Once the draft final report has been reviewed, TAC and HSRI will prepare the final version of the system design report. We will also prepare an executive summary and a PowerPoint presentation that can be used with stakeholder groups to summarize the findings and recommendations of the report.

Workplan

1. Work with DHCS project leadership to develop a detailed outline for the final report.
2. Work with DHCS project staff to review data tables, charts and related methods for summarizing and presenting data.
3. Develop a draft of the final report for review and comment by DHCS and stakeholders if desired by DHCS.
4. Assemble and integrate all comments into a final version of the system design report.
5. Produce and deliver the system design report, executive summary and presentation materials

Task 11 Project Management

The California behavioral health needs assessment and service system plan is a large and complex project with many interlocking and interdependent parts. Given the brief time frame for the project, many of the tasks will have to be conducted in parallel rather than sequentially, and the teams carrying out the task will have to be relatively large. In addition, the project team and other designated state

agency staff in California will want to participate in discussions about data access, data reliability, data interpretation, selection of key informants, and all other aspects of each task. This will require considerable communication and sharing of materials, with quick turn-around times for decisions to be made and actions to be initiated. For these reasons TAC and HSRI propose budgeting a limited amount of resources for project management, communications and progress reporting. This will support monthly team conference calls, periodic project progress reports, monthly financial reporting, cataloguing data and documents collected and included in the project, etc.

Workplan

1. Meet with DHCS project leadership to develop a project management plan that specifies communications processes, reporting expectations, and schedules.
2. Develop project communications and reporting formats.
3. Carry out project management tasks as defined in the management plan
4. Maintain project management liaison with DHCS project management staff on a scheduled and as-needed basis.

Project Management Structure

TAC and HSRI have worked collaboratively on many similar projects. Our customary approach is to have a single overall project manager responsible for all operational aspects of the project. Suzanne Fields from TAC will be the project manager for this project. The Project Manager's responsibilities include:

- Primary liaison and communication with DHCS project leadership;
- Final review and approval of all deliverables;
- Regular communication with and oversight of task and sub task team leaders;
- Oversight of project task progress and performance; and
- Oversight of financial reporting and invoicing.

For each task the project Manager will designate a team leader responsible for carrying out task activities, conducting data analyses, drafting deliverables, etc. Tentative task leader assignments are included in the task summaries at the end of each task description above. The task team leader may draw of staff with specialized expertise from both TAC and HSRI, or perhaps from one of our affiliates. Task Team leaders meet as a group on a regular basis with the Project Manager to review progress and to discuss cross cutting issues and findings.

For this project TAC will be the contracting entity and will manage invoicing to the California Endowment and Deloitte, payments to HSRI, maintenance of all project records and financial back-up information, and data and documents that will become the property of DHCS.

Both TAC and HSRI meet all SAMHSA, CMS and ADA requirements for data systems, electronic communications, barrier free facilities, and related standards. We will sign the Business Associate Agreement provided by DHCS, and will adhere to all requirements with regard to data integrity and security. As we have discussed by phone, we are hoping that most analyses of data with client

identifying information can be conducted by DHCS or its affiliates in California so that it will not be necessary to transmit or manage off-site storage of client information. This process should also eliminate the need to de-identify data elements, since TAC and HSRI will only be working with summary data.