SPEAKER NOTES

Alameda County's New Mental Health Plan: What's Changed and How It Affects Clients

Summarized by Thomas T. Thomas

Alameda County took over the state's MediCal services on November 1, 1997, for all county beneficiaries. At our September meeting, Dr. Henri Montandon questioned the impact this would have on service levels. Now, at our January 28 meeting, we heard the views of **Dr. Stan Taubman, DSW,** Director of Management Services of the Alameda County Department of Behavioral Care. He explained the present program and how it will work.

"On November 1, Alameda County joined the MediCal Consolidation Plan, a statewide mandate which will affect every county mental health service in California," Dr. Taubman said. "Four other counties adopted it at that time, eleven more on January 1, and by July all of California's fifty-eight counties will be administering MediCal benefits in this way."

Part of Alameda County's response was to create the Department of Behavioral Care, which integrates the former Mental Health Care Services and the Alcohol and Drug Care Services. The new department has a combined budget of $120 million, apportioning $100 million to mental health and $20 million to substance abuse programs.

"We are finding benefits in this," he noted. "We're now able to talk to both kinds of providers. And the providers themselves are able to compare notes and discover that they have many clients in common. We're better able to plan for dual-diagnosis programs."

The major effect of the November 1 consolidation was to bring together the Short-Doyle MediCal Program, which was operated by Mental Health Care Services for people with serious and persistent mental illnesses, and the fee-for-service program, which allowed clients to go to any willing psychiatrist or psychologist and have the state pay the bill.

With the consolidation of these two programs, the county gains control of the funding but also assumes the responsibility—and the risk—of caring for the local mental health population. The state has defined this target population as residents with serious and persistent mental illnesses, such as schizophrenia and severe depression, and children with mental health problems.

One thing that changed in November is the county also became responsible for the full range of mental health services to MediCal beneficiaries. Alameda was granted an additional $4 million to care for people with less serious problems, like mild mood disorders, anxiety disorders, and adjustment disorders.

"Getting control of mental health funding is a good thing for our patients," Dr. Taubman said. "Since 1991 all of these programs have been a political football. Now we have a known level of funding to work with." The available amounts will not grow over the years, he said, and the state no longer has an obligation to cover

deficits in the programs' budgets. However, the level of funding will be adjusted for changes in inflation and in the county's base population.

As part of the consolidation, all of the state's mental health programs are required to operate under the principles of managed care. But, as Dr. Taubman pointed out, the average insurance company has administrative costs and profits equal to about 25 percent of service costs. Alameda County's total administrative burden—for functions like referrals, record keeping, and quality-of-care assessments—are just 7 percent.

"If we manage our programs poorly, and services cost more than available funding, we will have to make up the deficit from other programs in our $120 million budget," Dr. Taubman said. "But if we manage well, and there is a surplus, we can put it aside for future years."

Right now, he noted, the economy is working in the county's favor: inflation is low, employment is up, and welfare reform is shrinking the number of MediCal beneficiaries. Dr. Taubman calculated that Alameda County now has approximately 210,000 MediCal beneficiaries, of which 3 percent—or roughly 7,000—are expected to seek mental health care in any one year.

Existing features of the county's mental health program—like emergency services and acute care—will not change. One thing that will change is access, with a new 800 number to provide referrals and a streamlined case management system.

Formerly, payment authorization was required before a client could see a psychiatrist or psychologist. Now, up to three visits are allowed—time enough for the practitioner to make an assessment and come up with a treatment plan—before the authorization review. Then the authorization is good for six months before it's reviewed again. And the evaluation is by a licensed social worker or nurse, not an administrator. This allows for better assessment of the problem and the appropriateness of care.

Dr. Taubman noted that, under the former fee-for-service program, 70 percent of clients used three or fewer visits per year. So initiating the authorization review only at that point is cost-effective and reduces the department's paperwork.

Frequency of visits will improve, too. Before, the program allowed only eight visits over four months, or one every two weeks. Now, clients can meet with their mental health professional three times a week in crisis situations.

Access to care has broadened as well. Before, the program only paid for care by a psychiatrist or psychologist. Now, the client can see a licensed psychiatric social worker, nurse, or family counselor. "Our mandate," Dr. Taubman said, "is to link the patient to a service provider who is geographically, culturally, and linguistically accessible. If the patient is not satisfied with the practitioner, we are required to provide a new referral."

The Department of Behavioral Care creates a central point for continuity of care if the client moves from one practitioner to another. This improves on the situation with the old fee-for-service program, where the client was completely in the hands of the first practitioner to whom he or she was referred.

Dr. Taubman distributed a sample Specialty Mental Health Quality Concern Log that the service teams keep to record incidents of poor or improper treatment. It accounts for problems such as:

- Diagnosis does not match symptoms or behavior, or no assessment of chief complaint.
- Medication dosage too high or low.
- Medication not matched to likely diagnosis.
- Treatment delayed except for medication, or level of care too low.
- Substance abuse treatment not documented, or no toxicity screen.
- Abusable medication prescribed for patient with substance abuse history.

Dr. Taubman also noted that there is no change in the existing MediCal formulary (that is, the list of medications available for prescription). The cost of psychotropic medications is covered, not by MediCal, but by the client's primary health insurance.

In Alameda County, MediCal beneficiaries under Aid to Families with Dependent Children (AFDC) are usually served through either Blue Cross or the Alameda Alliance for Health. Patients under Supplemental Security Income (SSI) will eventually be offered these insurance programs as well.

The consolidation of mental health programs in Alameda County—especially under the principles of managed care—has raised concerns among many people. Dr. Taubman showed that the situation does offer some benefits to clients in terms of better access and referrals, streamlined payment authorization, and opportunities for better quality management.