Research Brief

The Coordination of Behavioral Health Care Through Cal MediConnect

Pi-Ju (Marian) Liu, PhD
Carrie Graham, PhD, MGS
Mel Neri
Austin Marshall
Winston Tseng, PhD
Brooke Hollister, PhD

University of California, San Francisco and Berkeley

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

In 2014, California implemented a Dual Financial Alignment Demonstration called the Coordinated Care Initiative (CCI).[1] The purpose of this demonstration was to test the efficacy of integrating Medicare and Medicaid benefits through a capitated managed care system. Medi-Cal (California's Medicaid program) managed care plans in seven California demonstration counties created a new product called Cal MediConnect (CMC).[2] Dually eligible beneficiaries in those counties were passively enrolled into CMC plans, with the ability to "opt out." Those who remained enrolled received all Medicare and Medi-Cal benefits, including medical services and managed long-term services and supports (MLTSS) through one health plan. Another major goal of the CMC program was to coordinate behavioral health services, including mental health services and substance use disorder (SUD) treatment. Although specialty mental health services remained "carved out" and continued to be provided by County Behavioral Health (County BH) departments, CMC plans were tasked with coordinating that care.[3,4]

Researchers from the University of California (UC) have conducted an evaluation of the impact of the CMC program on beneficiaries and health systems.[5] The following research brief includes results from an in-depth examination of the perspectives of various health system stakeholders regarding the efforts of CMC plans to coordinate behavioral health services for their members. Data for this research was collected through 27 online survey responses and telephone interviews with key stakeholders, including CMC plans, County BH departments, and community behavioral health providers who serve dually eligible beneficiaries.

Findings fall into five broad categories, including:

1. Health plan models for behavioral health coordination.
2. Promising practices in coordinating behavioral health services.
3. Streamlining communication between CMC plans and behavioral health providers.
4. Increasing access to behavioral health services.
5. Key challenges in behavioral health care coordination.

Key findings include the following:

- **There was great variety across plans and counties in how they approached coordination of behavioral health services for CMC beneficiaries.** Although the coordination of behavioral health was required through the demonstration, CMC health plans had great discretion over how they structured this service. Many CMC plans developed internal capacity within their care coordination departments for behavioral health care coordination that included coordinating more closely with County BH departments. Other CMC plans worked with third-party delegated agencies that had extensive experience coordinating behavioral health care for vulnerable populations.

- **Interdisciplinary care team (ICT) meetings were one of the most successful approaches to behavioral health care coordination.** The terms of the CMC demonstration required that plans conduct ICT meetings to coordinate care across agencies. Almost all CMC plans elaborated on the effectiveness of ICT meetings in bringing all stakeholders together to discuss beneficiaries' medical and behavioral health needs. Though collaborations between behavioral health and medical providers were in place before CMC was implemented, these ICT meetings were the first standard, formal meetings that took place, which subsequently led to better communication and more collaboration across CMC plans, County BH departments, and providers.

- **CMC plans connected beneficiaries to behavioral health services through intensive outreach.** Many CMC plans hired more care coordinators with expertise in behavioral health care coordination. These behavioral health care coordinators met in-person with beneficiaries, connected them to resources, and in some cases, accompanied them to scheduled appointments in order to assist with needed follow-through. Some CMC plans even reached out to beneficiaries who might have had behavioral health conditions but were not actively seeking behavioral health services.

- **Although the level of integration differed, several CMC plans took additional steps to integrate care for "mild-to-moderate" behavioral health services.** Medi-Cal health plans have historically delegated mild-to-moderate behavioral health services to an outside "delegated" health care group with expertise in providing both behavioral health services and, in many cases, behavioral health care management. Coinciding with the implementation of CMC, some plans began building their own behavioral health provider networks to provide behavioral health benefits and care coordination directly, especially for those beneficiaries in need of mild-to-moderate benefits.

- **The CMC program encouraged plans to coordinate more closely with County BH departments as they continued to provide "carved out" specialty behavioral health care to members.** Strategies such as ICT meetings, relationship building, and co-location of designated "liaisons" across agencies helped to enable better coordination for those beneficiaries receiving behavioral health services, though some challenges remain.

- **Communication between CMC plans and County BH departments was improved through promising practices such as formal and informal meetings and the co-location of providers, though data sharing remained a major challenge.** The findings from Phase I of the UC evaluation found that CMC plans experienced difficulties in communicating with County BH departments.[6] Subsequently, many CMC plans and County BH departments initiated new practices that promoted and improved communication. Joint operational meetings provided an opportunity for CMC plans and County BH departments to discuss details of the program and beneficiaries' needs. Co-locating behavioral health and medical providers in the same care site fostered trusting relationships and more opportunities to collaborate on care coordination. Though data sharing remained a barrier to communication, CMC plans and County BH departments made progress in overcoming this challenge.

- **County BH departments and CMC plans remained unclear about their division of service and financial responsibility for some behavioral health services due to imprecise definitions and delineation.** CMC plans were required to coordinate all behavioral health services, but County departments retained responsibility for services to individuals with specialty mental health services. To add an additional challenge to the already complex service provision structure, the definition of mild-to-moderate versus specialty mental health services was not consistent across the demonstration counties. In particular, CMC plans working across multiple counties were not able to use one standard effectively for referring beneficiaries across counties to appropriate levels of care. Both CMC plans and County BH departments also identified challenges navigating the financial payment systems, primarily whether the CMC plans or County BH should pay for the Medi-Cal portion when the distinction was not well-defined.

Five recommendations were drawn from these results and are discussed more fully in the report:

1. CMC and future pilots involving behavioral health care should better integrate behavioral health and continue to invest in and encourage relationship building, shared learning, and collaboration with behavioral health service providers.

2. The California Department of Health Care Services (DHCS) should issue guidance to all CCI County BH systems clarifying CMC plans' roles in coordinating beneficiaries' behavioral health and medical needs.

3. All entities should collaborate to create more streamlined electronic data-sharing systems to allow health plans and County BH departments to exchange beneficiary treatment data to help ensure efficient care coordination.

4. DHCS should continue to clarify and delineate responsibilities for behavioral health services through issuance of Mental Health and Substance Use Disorder Services Information Notices and All Plan Letters.[7]

5. CMC plans and County BH departments should continue to test innovations to identify more efficient strategies for integrating and coordinating medical care and behavioral health.

INTRODUCTION

In 2014, California became one of 13 states to implement a Dual Financial Alignment Demonstration called the Coordinated Care Initiative (CCI).[1] This demonstration was designed to test the integration of Medicare and Medicaid benefits through a capitated managed care system. In California, Medi-Cal (California's Medicaid program) managed care health plans in seven demonstration counties created a new product called Cal MediConnect (CMC) through which the health plans administered both Medicare and Medi-Cal benefits.[2] Dually eligible beneficiaries in demonstration counties were passively enrolled into CMC plans, with the ability to "opt out." Those who were enrolled received Medicare and Medi-Cal benefits, including medical services, managed long-term services and supports (MLTSS), and comprehensive care coordination, including the coordination of behavioral health services, through one health plan.[3,4]

Behavioral health services for dual beneficiaries typically include mental health services and substance use disorder (SUD) treatment. Coordination of behavioral health can be very challenging for those dually eligible for Medi-Cal and Medicare because all of these services are provided and financially covered by different agencies.[8]

CMC plans are responsible for all Medicare-covered services. Mental health services covered by Medicare include inpatient services (e.g., emergency department visits, inpatient care in some psychiatric hospitals), outpatient services within the scope of primary care, mental health services such as individual and group therapy, psychological testing, and medication management. SUD benefits covered by Medicare include detoxification, alcohol and drug services in intensive outpatient treatment centers, and group or individual counseling by a qualified clinician, as well as screening, brief intervention, and referral to treatment for people with or at risk for alcohol use disorders.[9]

The Medi-Cal portion of behavioral health is more complex. In 1995, California implemented the Medi-Cal Mental Health Managed Care program, which created County Behavioral Health (County BH) departments. These County BH departments then became responsible for inpatient and various specialty mental health services for serious mental illness (SMI), including psychiatric hospital services, residential treatment services, and crisis intervention. In other words, specialty mental health services were "carved out" of Medi-Cal.[10] In 2010, the Patient Protection and Affordable Care Act both expanded Medicaid coverage and identified behavioral health as one of the 10 essential health benefits.[11] Additionally, in 2014, Medi-Cal managed care (MMC) health plans began covering "mild-to-moderate" outpatient behavioral health services, whereas specialty mental health services continued to be carved out.[10,12,13] In California, Medi-Cal coverage was expanded to approximately 3.4 million low-income adults who were not previously eligible.[14,15] For SUD treatments covered by Medi-Cal, intensive outpatient and residential treatment services, as well as narcotic treatments, are the responsibilities of counties' alcohol and drug programs through Drug Medi-Cal.[12,13,16]

With the "carved-out" specialty mental health services and part of the SUD benefits provided by county agencies, opportunities for fragmentation and duplication of care were numerous, and care coordination between medical and behavioral health posed challenges. The CMC program in California attempted to address these challenges by requiring CMC plans to coordinate all behavioral health services for dually eligible members across the multiple agencies providing care.[17]

Phase I of the University of California (UC) evaluation of CMC revealed some preliminary findings about how CMC plans were addressing the challenge of coordinating behavioral health services in the first year of the demonstration. Key informant interviews with CMC plans conducted during Phase I (2015-2016) showed that some plans were taking steps to integrate behavioral health more fully with primary care and improve its relationship and communication with County BH departments.[6] In a survey of CMC beneficiaries conducted in 2016, results showed that those who were users of behavioral health services were more likely to report receiving care coordination from their CMC plans compared to non-behavioral health users. Behavioral health users enrolled in CMC were also more likely to report increased access to behavioral health providers, such as psychiatrists, more frequent appointments for therapy, and easier access to psychiatric medications compared with beneficiaries who opted out of CMC.[18]

In Phase II of the UC evaluation, researchers more closely examined the efforts of CMC plans to coordinate behavioral health services.[5] This research brief describes the progress many CMC plans have made toward better coordination of behavioral health services, including new integrated models of care, successful strategies, and ongoing challenges.

METHODS

Data collected for this research brief include 27 online survey responses and telephone interviews with stakeholders from CMC plans, the in-network behavioral health providers from CMC plans, and County BH departments.

Online survey with CMC plan. In October 2016, CMC plans were emailed an online survey asking targeted questions about their efforts to coordinate behavioral health services for CMC beneficiaries. CMC plans were asked to describe: (1) their current models of behavioral health services, (2) existing collaborations with behavioral health services, (3) challenges or barriers in coordinating behavioral health services, and (4) referrals for County BH departments and in-network providers to interview. Seven of the 11 CMC plans completed the online survey, and five CMC plans participated in follow-up and in-depth telephone interviews.

Telephone interviews with key informants. Between February and April 2017, researchers conducted 20 in-depth telephone interviews with key informants. Key informants represented County BH departments, CMC plans, and their in-network behavioral health providers who provide behavioral health services to dually eligible beneficiaries in CCI counties. Interviews were conducted with various individuals within the organizations who had firsthand knowledge of and experience with facilitating behavioral health care coordination. All interviewees had worked with CMC enrollees. Interviews were transcribed and content analysis was conducted. Key themes that emerged from the telephone interviews are summarized below.

FINDINGS

Health Plan Models for Behavioral Health Coordination: Delegated vs. Integrated

Delegated behavioral health models. Historically, most MMC plans have provided behavioral health services by "delegating" those services to an outside behavioral health care group, which would provide all mild-to-moderate services, from initial intake calls to referring members to providers in the group's network. They oversee all clinical responsibilities, including receiving and processing claims from behavioral health providers. The delegated groups' case management team works closely with the plans' care coordinators as a team. At the same time, the delegated group works closely with County BH departments to ensure the coverage of beneficiaries' specialty mental health services.

When asked why they continued to use a delegated behavioral health model, most CMC plans said they had been using this model for decades and it worked well for them. The delegated behavioral health care groups also argued that they have experience and expertise in coordinating behavioral health services. Although these CMC plans had not developed an internal capacity for providing behavioral health, their delegated behavioral health care groups focused solely on behavioral health services and had developed the expertise to work with beneficiaries efficiently.

> *"So I think that's the argument really for [delegation]. … It's all we do. … I just think it gets ignored when it's all carved in, in one place."*
> *– CMC Plan's Delegated Health Group*

Integrated behavioral health models. Despite the history of delegation, some CMC plans chose to use a more integrated approach to behavioral health even before the CMC demonstration in order to develop more internal capacity for providing behavioral health directly to beneficiaries. When asked why they developed more internal capacity to provide behavioral health, most plans reported the improvement of care coordination as the main reason. As one CMC plan stated:

> *"Trying to get care plans and participation on interdisciplinary care teams … is near impossible when you carve out mental health to a managed behavioral health organization." – CMC Plan*

In most cases, those CMC plans that used more integrated behavioral health models began the process of integrating medical and behavioral health before the implementation of CMC, with the levels of integration differing by health plan. Although no CMC plan had a fully integrated model that co-located behavioral and medical health in the same care site, some health plans were working toward developing an even more fully integrated model (see Case Study 1).

Key informants noted several differences between integrated behavioral health models and delegated models. First, CMC plans with integrated models often developed their own networks of behavioral health providers with whom they contracted directly, rather than contracting with one large behavioral health group that maintained their own network. Second, CMC plans that used integrated models also handled behavioral health providers' credentialing and processed the claims internally, which may have enabled better oversight over the providers. Another difference noted by respondents was how integrated models provide care coordination. Integrated models often develop more internal capacity for behavioral health care coordination, rather than delegating this responsibility to an outside entity. These integrated models have also developed stronger relationships and worked more directly with County departments to oversee utilization and quality of specialty mental health care.

Case Study 1: Inland Empire Health Plan – Moving Toward a Fully Integrated Behavioral Health Model

Some CMC plans went beyond the requirements of CMC to "coordinate" behavioral health and, instead, worked toward fully integrating behavioral health with medical care. Inland Empire Health Plan (IEHP) began moving toward an integrated model approximately seven years ago, with the gradual progress as described by one of the plan's staff:

> *"IEHP used to carve out behavioral health to another entity to manage. We would say, 'Here are the funds. You handle all of it.' … They brought it in-house and started with a small team of seven. … Since then, the department has gone through multiple … metamorphoses because now this behavioral health department that was a team of about seven is now a team of about 80." – IEHP*

IEHP's 2015 initiative called "Behavioral Health Integration and Complex Care Initiative (BHICCI)" has been a key factor in promoting integrated care. IEHP issued grant funding to each participating clinic site where ICTs were formed. These ICTs included treatment providers from primary care, specialty care, mental health, and SUDs. There are currently 12 health care organizations with 32 pilot clinics participating. As part of the BHICCI, clinics were building care teams that consisted of a behavioral health clinician, nurse care manager, medical assistant, and a primary care physician. Together they made up the main core of the care team that was responsible for a cohort of complex members who had at least one chronic physical health condition and one mental health and/or substance abuse disorder. In support of patient identification for BHICCI, IEHP provided participating clinics with analytical reports that identified patients by risk level and, in essence, those individuals in greatest need for integrated health services. In addition to this support, clinics were provided with coaching support for core practice change initiatives.

> *"In essence, the beauty of this program in terms of creating an array of health homes is that when the member walks in to see their doctor about their high blood pressure or to check on their diabetes and make sure that it's being managed appropriately … they can also go right next door and see their behavioral health clinician at the same time at the same visit without an authorization."*
> *– IEHP*

> *"We now have behavioral health integration in all our medical clinics. We routinely screen anybody age 12 and older for depression and substance abuse. We're available for all our medical patients if they need to talk to somebody. We were doing this already, irrespective of the CCI mandate."*
> *– IEHP's provider*

Some of the strategies IEHP used to bolster their behavioral health program included:

- Providing salary support to psychiatrists as a financial incentive to attract them to join the clinic.
- Developing an e-consult model for primary care doctors who can seek advice from a psychiatrist online.
- Focusing on doing wraparound programs and preventative aspects of care to ensure that beneficiaries see a psychiatrist within 10 days (seven days after hospital discharge).
- Partnering with county mental health providers to reach beneficiaries in rural areas.
- Expanding home health programs that send mental health professionals to a beneficiary's home to increase their access to mental health services.

Promising Practices for Behavioral Health Coordination

Coordinating Behavioral Health Care

Developing capacity for internal behavioral health care coordination. As part of the CMC program, care management is available for all beneficiaries who need it. Most CMC plans, especially those with more integrated behavioral health models, specifically chose to train or hire behavioral health care coordinators. These coordinators worked closely with other care coordinators from the medical department, and were often trained to recognize symptoms of common mental health conditions. When beneficiaries needed specific behavioral health services, behavioral health care coordinators connected them to resources and, if needed, accompanied them to appointments. Most CMC plans reported that the coordination of care for beneficiaries who use both medical and behavioral health services had improved primarily because of the new internal capacity for behavioral health care coordination.

> *"Previously, I think, everyone worked in their silos a little bit more. But now it's a lot more constructive, and I think the medical piece is being shared more with the mental health [piece], which has been very helpful for allowing the member to see the whole picture." – CMC Plan*

Quite a few health plans mentioned that coordinating with County BH departments was more efficient and positive because their internal care coordination department worked directly with county providers rather than through a delegated health care group. However, another explanation from respondents was that health plans with an integrated model had been collaborating with County BH for a longer period of time, so the positive relationship was the result of trust built over time.

Related challenge: Coordinating carved-out benefits. Although CMC plans were tasked with coordinating behavioral health, most CMC beneficiaries who needed specialty services still primarily accessed providers through County BH departments. As is the case in CMC, coordinating care when the plan was not directly responsible for providing the care (but was instead responsible for paying for it) was an ongoing challenge. In addition, identifying and referring beneficiaries in need of specialty mental health services was a complex process, especially for CMC plans and behavioral health services working across multiple counties. Furthermore, different County BH departments often had different interpretations about what services were categorized as SMI versus "mild to moderate," further complicating whether the service should be provided through the plan or the county.

Collaborating closely with psychiatric hospitals and providing transition support. Some CMC plans reported that they had developed a closer relationship with psychiatric hospitals through their

efforts to coordinate behavioral health. One CMC plan sent clinical social workers to participate in twice-weekly meetings regarding their members in psychiatric hospitals. Some CMC plans trained behavioral health care coordinators to provide intensive "transitional care" support to beneficiaries who were discharged from an inpatient psychiatric hospital to outpatient care. These care coordinators worked closely with the psychiatric hospitals' discharge planners to ensure it was an appropriate discharge. They also called beneficiaries within 24 hours of discharge and arranged outpatient, after-care psychiatry, and other services.

> *"Here in [county name], we're making an inpatient visit. Often the nurse case manager will go with the care coordinator to see the member. Also, upon discharge, we'll do the same thing, so that we can coordinate the behavioral health and the medical aspect of the member's care to make sure that we are working together to facilitate whatever the member needs." – CMC Plan*

Related challenge: Case management caseload. Some respondents reported that behavioral health care coordination often requires a very time-intensive approach. Behavioral health care coordinators often relied on in-person approaches (such as face-to-face meetings) to communicate care plans or accompany members to their appointments. To address this, some CMC plans allowed more flexibility with behavioral health care coordination caseloads, adjusting staff caseload accordingly and sometimes hiring more staff to help with the increased caseloads. Other CMC plans decided to contract in-person outreach to an outside health group to be able to adequately deliver the necessary behavioral health care coordination.

> *"We're going to try to identify new members who could benefit from that really high-touch, intensive approach that our regular complex case managers really can't accomplish. These are people working with members who have a lot of psychosocial issues and who need a lot of prompting and life skills coaching as well as help scheduling transportation and appointments.… The more staff that you have doing fieldwork and face-to-face work… those are much more resource intensive, and those folks can't have a caseload of 80 when they're doing that kind of work. But that's really what the needs and the demands of the population have been." – CMC Plan*

Interdisciplinary care team (ICT) meetings. ICTs were an important part of the CMC care management process because they brought together providers and beneficiaries to set care priorities. ICTs often included CMC care coordinators, representatives from County BH departments, other behavioral health and medical providers, and, when possible, the beneficiary and/or caregiver. Both CMC plans and County BH departments mentioned that communication between entities and primary care physicians had occurred prior to CMC, but the ICT meeting was the first formalization of these meetings and subsequently led to better communication and collaboration across entities.

> *"CMC has laid the groundwork for how we collaborate. That's the one thing that the Whole Person Care [pilot] can learn from CMC. … It's not just CMC that benefits; it's everything we do in the future with Medicare beneficiaries who have [CMC plan names]. We now have a foundation for how to communicate. We've got formal and informal joint operations, functions, and meetings. If there's a problem for a beneficiary, we know who to contact on either of the health plans' teams—all because of this process and the ICT meetings. So we now have names and phone numbers and we use them." – County BH Department*

Training behavioral health providers. Not all County BH providers were familiar with the concept of care coordination, so CMC plans trained County BH staff on topics such as working with CMC plans to coordinate care. One County BH department mentioned that this training was useful in understanding how to work with the health plans and their beneficiaries. Training was also provided to other CMC in-network behavioral health providers. CMC plans did not experience much resistance from their in-network behavioral health providers to coordinate care, but needed to educate them on what care coordination meant since they were not used to the concept of sharing treatment plans with primary care physicians.

> *"So every single staff member there went through training three different times, and we did that at other places too. … It was by their request every time, and after we would leave, they would start thinking and have more questions. And then the directors would be calling saying, 'Can we do this again?' Sure enough, all the health plans would go right back there and meet with them all to make sure they were very thoroughly trained and ready to help take care of this population." – CMC Plan*

Related challenge: ICT buy-in from behavioral health providers. CMC plans reported that although ICTs have improved their ability to coordinate behavioral health for members, there was room for improvement. Because care coordination with health plans was a new concept for County BH departments in some locations, and CMC beneficiaries only consisted of a small percentage of their clients, not all County BH providers were used to spending extra time meeting with other providers and CMC plans. As a result, some providers resisted attending ICT meetings or only attended the part of the meeting pertaining to their area of care.

Streamlining Communication Between CMC Plans and Behavioral Health Providers

Individualized Care Plan (ICP). As part of ICT meetings, an ICP must be revised and updated for all behavioral health users following the health risk assessment (HRA) process. Many respondents described how shared forms and tools were used to create a new care plan that was shared among entities (e.g., behavioral health providers, primary care physicians, CMC plans). Many respondents described how the new care plan forms immensely improved patient-provider communication and coordination of care. CMC plans stated that all providers became more involved in the beneficiaries' care through the sharing of ICPs to develop treatment plans.

> *"So [CMC plan] developed a really nice tool for [County BH] to use, and it's really a nice matrix: The … health plans send them a care plan. Then they help fill out and complete that care plan. That care plan gets sent back to the health plan, and it gets presented at our care team meeting. They're invited to participate. And then [providers] signs off. They get a copy, and the primary care doctor gets a copy, so there's total coordination." – CMC Plan*

Joint operation meetings. Streamlined communication also happened through "joint operation" meetings between CMC plans and County BH departments. These meetings facilitated conversations about collaboration and integration of services across CMC and other initiatives. They were also an opportunity to sit down and go over any challenges that entities had working together, as well as any contractual or data-sharing problems. When CMC was first implemented, some counties often discussed the line between mild-to-moderate versus SMI. Later on, conversations were about specific beneficiaries' services and care plans. CMC plans and County BH departments mentioned that they also had in-person joint operation meetings with providers. Even though joint operation meetings started taking place before CMC existed and were not new, respondents reported that they became more efficient and formal after CMC.

"We have joint operation meetings quarterly. We participate in the behavioral health commission meetings in the older-adult systems of care committees. We have delegates to go to the adult systems of care, children's committee, and veterans' committees. We also have representation in pretty much most of the significant county meetings. It's that level … of relationship … because of CMC and because these members are a lot sicker than the others that we have." – CMC Plan

Increased informal communication. In addition to more formal ICT meetings and joint operation meetings, many respondents noted that the relationships that were formed in these formal meetings resulted in more frequent informal communication about coordination of care. Oftentimes, because of a relationship between CMC staff and County BH staff, bureaucracy was avoided and problems were solved via these more informal communications, such as a quick phone call or email.

"I think we do a lot of our collaboration with behavioral health providers really on an ad hoc, informal basis where the case manager or our psychiatrist is reaching out to those folks individually to say, 'Hey, can we talk about this member?' Or, 'I want to share this information with you.'" – CMC Plan

Staff liaisons. In order to coordinate behavioral health services effectively, two CMC plans created "staff liaisons" who were tasked with establishing relationships and communicating with County BH departments. The health plan staff liaisons were co-located within the County BH building, where they worked directly with a County BH staff liaison to the health plans. These County BH staff liaisons were the designated contacts for the health plans.

"There's been a good partnership regarding how we can share information. The liaison that [County BH] has working for us, or working for [CMC plan] but in our system, … has an office in our managed care section where she can go. We always know where to find her. With her, we've been able to get the information we need." – County BH Department

CMC staff liaisons worked on memorandums of understandings, clinical practice guidelines, and care coordination barriers and also assisted with referrals to the appropriate health care entities– both providers in the county behavioral system and the CMC plan's network of providers.

Co-location of providers to improve collaboration. As mentioned, another promising practice has been co-locating medical, mental health, and substance use providers at the same site. No CMC plans reported full co-location of all services, but pilot programs have been developed to test whether co-location can produce positive outcomes for beneficiaries. Some of the models included: (1) co-locating CMC plan staff in the same building as the delegating behavioral health group, (2) co-locating behavioral health providers and licensed clinical social workers (LCSWs) in medical clinics so that both medical and behavioral health needs could be addressed at the same time, and (3) co-locating providers from both mental health and substance abuse in the same location so beneficiaries efficiently receive both types of services. Co-location was not only beneficial to members seeking services–one CMC plan also reported that its close proximity allowed everyone to join meetings in person, fostering trust and familiarity among all the different care teams. Another noted benefit was that regular communication enhances the care plan and consequently improves beneficiaries' access to services.

"Across the country, we have models where we've co-located and models where we haven't. The benefit of co-location is in being able to have, let's say, a nurse on the medical side, who has a really complicated case, walk over to somebody's desk and say, just because of the proximity, 'Hey, I've got this really complicated case. Is there something behavioral health can do?' So we have found that sort of familiarity breeds a certain level of collaboration that we're interested in. It's not the only way to do it, but we do co-locate. I would say across the country, we probably co-locate with maybe 10 percent of our customers." – CMC Plan's Delegated Health Group

Data-sharing innovations. Data sharing across health care entities has been a nationwide problem of the U.S. health care system. CMC plans and County BH departments reported working throughout the demonstration to improve data sharing. Many CMC plans had been working with County BH departments and County Council (legal advisors to each county) to educate all entities about CMC plans' new roles and responsibilities around care coordination. Some CMC plans found that ingrained barriers were more likely to be overcome when County BH departments learned more about CMC plans' roles in coordination. Multiple CMC plans reported that one way to achieve this goal was for County Council to issue All County Guidance Letters to County BH departments explaining how CMC plans are different from traditional managed care plans. All County Guidance Letters should also stipulate that all of a beneficiary's providers (medical and behavioral health) should be allowed to share treatment plans and attend the ICT meetings, which can help to facilitate data sharing (see Case Study 2).

In addition to getting approval from County BH systems to share data, some CMC plans started building electronic data systems (EDSs) that allow providers (both behavioral health and medical care) to share treatment plans more efficiently (see Case Study 3). Even though there are still challenges to data sharing, several respondents reported that CMC's care coordination mandate has advanced the conversation about the need for data sharing.

"I actually collect a lot of information frequently from the county as they make referrals out to either the Federally Qualified Health Centers or to the severe mental health clinics. I get that information, and I can have staff follow up with those members to make sure they get there. I help with the coordination of care. That would have never happened if we didn't have the data-sharing agreement. We wouldn't know who the members are, and we wouldn't be able to follow up." – CMC Plan

Related challenge: Existing barriers to data sharing. Despite efforts and innovations, data sharing across CMC plans and behavioral health providers was still cited as a major challenge. One challenge was the issue of confidentiality and trust. Some behavioral health providers questioned whether all medical care providers knew how to use and protect the beneficiaries' behavioral health records. In some institutions and hospitals, even medical providers in the same facility were denied access to behavioral health data for this reason. County BH departments suggested that additional training should be required before data sharing to ensure the confidentiality of beneficiaries' behavioral health information.

"Do people know how to use that data properly and … protect people? In an ideal world, everybody could share it, and our health records wouldn't need to be confidential at all. But … we also assume everybody knows what to do with that data and that it will help things. My honest reflection is that I'm not sure it will always help things. I think it can cause problems too. I don't know what the solution is there, but my view is there is a lot of dialogue that still needs to happen, and the solution is not just opening up data sharing. There's a lot more to it."
– County BH Department

Case Study 2: Overcoming Data-Sharing Challenges

CMC plans in San Diego County have made great progress in improving data sharing across entities, including behavioral health providers. The CMC plans in San Diego and the county mental health plan did share some of the same problems as other counties regarding data sharing. However, they resolved it by using the *Coordination of Care Form.* In 1998 when mental health was contractually carved out of health plans' Medi-Cal contracts, health plans in San Diego developed the Coordination of Care Form and held conferences for both behavioral health and primary care providers to encourage the adoption of this form. At first, there was resistance to using the form because it created additional work for providers. However, once the County BH department issued a county letter in 2012 mandating the completion of the form, data sharing was improved.

> *"Our County Council reviewed the original Coordination of Care Form. Due to font size requirements and information needing to be added to the Release of Information section, the form turned into four pages. They made use of this form mandatory in 2012 for all Medi-Cal beneficiaries. So when CMC started, what we said was that since they're already using that form for Medi-Cal, all the health plans will accept it—CMC, too. So that form gives us the tools we need to coordinate care with our primary care providers and to present at our interdisciplinary care teams, which leads to the development of the Individual Care Plan." – Community Health Group*

A second challenge to data sharing was the regulatory requirements about privacy. County BH departments pointed out that the *Health Insurance Portability and Accountability Act* is only one of the regulations they are required to adhere to, in addition to many additional mandates to manage beneficiaries' protected health information appropriately.

> *"There have been challenges in exchanging clinical information across the systems … that I would say is based on an appropriate concern for ensuring the confidentiality of the clients that [our providers] serve."*
> *– County BH Department*

Lastly, incompatible information technology (IT) systems posed a barrier to data sharing. Because of the large number of chronic conditions among CMC members spanning multiple medical, mental health, and SUD providers and agencies, coordinating care across all of these entities posed a particular challenge for data sharing in CMC demonstration counties. When multiple County BH departments, CMC plans, and community providers attempt to share data through incompatible data systems, respondents reported that additional programming for effective data transfer was needed. Some agencies still used outdated paper-and-pencil records that limited effective data sharing.

> *"Every county has a different infrastructure and a different understanding about how exactly this was going to look. Some counties weren't particularly well-resourced on their IT side. So it was a logistical nightmare if we, for example, send you our member list and you match that up with people from your system and send that back to us." – CMC Plan*

Increasing Access to Behavioral Health Care

Connecting members to behavioral health services. More than one CMC plan mentioned that it used behavioral health professionals, either internal or contracted, to reach out to beneficiaries who were not seeking behavioral health services. Once a member was identified through the HRA or CMC plan's utilization data as having unmet behavioral health needs, care managers might meet with them to educate them about the services that were available. One health plan partnered with its pharmacy to identify beneficiaries with depression and helped beneficiaries find appropriate counseling, medication, or caregiver resources when appropriate.

> *"Those people with more moderate or severe mental health and substance use issues are very difficult for us to reach. Sometimes when we reach them, they're difficult to engage. About a year ago, we implemented a new program, a very high-touch, field-based, face-to-face intervention to provide intense care coordination with some of our highest utilizers and most difficult-to-engage folks. We started out really small with that." – CMC Plan*

Related challenge: Availability and access of psychiatrists. Almost all CMC plans mentioned that lack of psychiatrists had been a statewide issue.

> *"[Appointments with psychiatrists] get backed up, so sometimes we can't offer a new appointment for several weeks because we have all these people scheduled, and then by the time we get them in and their appointment arrives, they don't show up." – CMC Plan Provider*

Case Study 3: New Platforms for Data Sharing

Some plans have improved data sharing through the use of EDSs. IEHP provides standard education and training sessions to help providers navigate their web portal. Both primary care and behavioral health providers use the EDSs to upload their treatment plans. After the health plan's review, the final authorization and treatment summary is made available to all of the beneficiary's providers. Having the treatment plans shared in the same place allows the plans' behavioral health department to approve services more efficiently, because all information is readily available in the system. The system also informs providers about approved services so that primary care and behavioral health providers know what has been approved by health plans. Riverside County BH mentioned that their read-only access to the IEHP portal helps the providers with the medication reconciliation process, instead of relying on patient report only. Moreover, IEHP provides financial incentives to encourage providers to complete the treatment plan and upload it to the health plan's portal.

> *"One of the things [IEHP] implemented probably more than two years ago was a[n electronic] coordination of care form that providers fill out after they see a patient the first time. The form basically lets IEHP know of any additional needs that someone other than the mental health provider can address. That's good. That's a helpful step toward integrating, especially for the patients I see who need so much integration of their medical issues and their mental health issues." – IEHP Provider*

In addition, due to Medicaid expansion in California and with more Medi-Cal beneficiaries needing behavioral health services, it will be challenging for CMC plans to ensure there are enough psychiatrists to care for all their members. One CMC plan noted that their beneficiaries were often sicker and more vulnerable compared to beneficiaries with Medi-Cal only and were less likely to know about or actively seek behavioral health services.

> *"I think the access issues that are coming to CMC may not necessarily occur because of CMC. They may occur instead because of the expansion of mental health benefits throughout the state of California … If anything, it's protecting access for the CMC line because now you have these millions of Medi-Cal members that may be calling to secure services. There is an access issue in general simply because there are more people on Medi-Cal. The CMC population gets impacted because, whereas before, they could go see a psychiatrist within 14 days, or 10 days, now they may have to wait three weeks." – CMC Plan*

Other Challenges to Coordinating Behavioral Health Care

Financial challenges. Even for CMC plans that had good relationships with County BH departments, the crossover billing mechanism for financial payment was still challenging because CMC billing was not streamlined. County BH departments had to be paid by the CMC plan for the Medicare-covered mental health services, as CMC plans were the Medicare primary payer. Only after the Medicare portion was processed could County BH departments then submit the specialty mental health service claims to the state for Medi-Cal reimbursement. Additionally, some County BH departments worked with several CMC plans, which meant they had to navigate through the different billing systems across the different health plans.

> *"Well, [CMC plans] don't pay for the severe Medi-Cal [SMI]. That's still our job as the county mental health plan. As such, we're responsible for the severe level. … They would then pay the Medicare portion of the SMI, and we pay the Medi-Cal portion of it. So they actually have to pay us first. It's either we bill them or bill the intermediary, but the intermediary is one system. Now we have three systems we have to potentially bill for Medicare." – County BH Department*

One of the most challenging problems in billing cited by respondents was to distinguish the mild-to-moderate behavioral health services from specialty mental health services when no clear guidelines were provided. The distinction was important, because County BH departments covered Medi-Cal specialty mental health services financially. Coverage was interpreted differently by health plans and County BH departments, which affected the Medi-Cal portion of payment. The definition of specialty mental health services also differed by plan and county, adding another challenge in working with other entities to coordinate care.

"Looking at our evidence of coverage. I think from not just the plan perspective, but also the member perspective—trying to really understand the behavioral health benefits and what's covered through the health plan versus what's covered through the county, there's a lot of gray area there. I think it's very confusing for everybody involved. … If we within the health plan can't feel 100 percent confident about it, how could we expect the members to be confident about it? How can we expect people in the community who are trying to help either provide treatment to members or help get them into care?" – CMC Plan

To further complicate the issue, beneficiaries' behavioral health conditions changed over time. When beneficiaries' health improved or worsened, billing on the Medi-Cal portion could change depending on whether the beneficiaries had to switch to a community or County BH provider. DHCS attempted to address this confusion by issuing Mental Health and Substance Use Disorder Services Information Notices and All Plan Letters[7] to clarify CMC plans and County BH departments' service responsibilities, but one respondent reported that it was not helpful and would have liked to see a more nuanced explanation.

"I can understand why [DHCS] didn't want to, or couldn't, flip the switch so that we're going to go from 100 percent carved out to 100 percent carved in. This pseudo-diagnostic cutoff is not well-defined. Again, people don't necessarily stay forever in one category or another. And when do you decide, OK, I stay with the county versus I go to my health plan provider? We'd like to see things like that be a lot clearer." – CMC Plan

Challenging populations. Behavioral health care coordination was especially challenging for certain groups of dually eligible beneficiaries. Identifying the challenging populations allows all entities to work on addressing unmet behavioral health needs. According to the respondents, the following groups were mentioned as the most challenging CMC beneficiaries to serve:

- ***Beneficiaries with substance use disorders:*** The timing of providing substance use services can be challenging because if services are not readily available when beneficiaries ask for help, the opportunity to intervene can be lost. Respondents reported that if there was a long wait for an initial appointment, adherence to appointments declined.

- ***Beneficiaries who were homeless:*** Identifying and providing services to beneficiaries who were homeless was a major challenge for CMC plans in general, but this challenge was even greater for homeless beneficiaries with behavioral health needs, especially considering the high co-occurrence rate between substance abuse, mental illness, and homelessness. To improve services for homeless beneficiaries, one County BH department provided drop-in clinics, and CMC plans provided shelter and sent care coordinators to assist beneficiaries with housing challenges.

- ***Beneficiaries with dementia:*** Dementia did not fall under specialty mental health. Yet much of the treatment could require that sort of expertise. More than one County BH department mentioned that they did not have the expertise to work with beneficiaries with dementia. One CMC plan reported that they worked with the Alzheimer's Association so that their care coordinators could attend specialized dementia care trainings. As mentioned in our Phase I evaluation findings,[6] more resources are needed to support these beneficiaries and their caregivers.

RECOMMENDATIONS

1. **CMC and future pilots involving behavioral health care should better integrate behavioral health and continue to invest in and encourage relationship building, shared learning, and collaboration with behavioral health services.** Working relationships between CMC plans and County BH departments have evolved and improved over the course of the demonstration, especially due to the care coordination and ICT meetings mandated by the program. This increased contact between agency staff should continue to be encouraged and improved. Future efforts at health system reform should continue to prioritize the improvement of communication and trust building across agencies, including highlighting best practices such as co-location of staff and convening ICT meetings.

2. **DHCS should issue guidance to all CCI County BH systems clarifying CMC plans' roles in coordinating beneficiaries' behavioral health and medical needs.** Problems with data sharing were caused not only by IT incompatibility, but also by lack of open communication across agencies. Letters from County Councils to County BH departments, which clarified the evolving role of CMC plans in coordinating behavioral health services, were useful for improving each agency's understanding of the other's role and facilitated the trust that allowed for data sharing. But despite these All County Guidance Letters, problems and misinformation still remain. An All County Letter from DHCS explaining the role of CMC in coordinating behavioral health might help clarify any lasting misconceptions and encourage data sharing across entities.

3. **All entities should collaborate to create more streamlined electronic data-sharing systems to allow health plans and County BH departments to exchange beneficiary treatment data to help ensure efficient care coordination.** Once all entities agree to share data, they then must confront the challenge of creating data

systems to enable data sharing. Different technology platforms have posed challenges for County BH departments to share data with health plans effectively. Building one data system for all health plans and county departments might not be realistic, unless DHCS takes the lead at the state level. Alternatively, health plans should consider building a "data bridge" between data systems. The data bridge concept allows bidirectional data extraction to happen even when the two entities use different data systems. The cost of implementation can be high, but some county agencies have started exploring this possibility to increase interagency collaboration. Health plans must also build secure portals for data exchange.

4. **DHCS should continue to clarify and delineate responsibilities for behavioral health services through issuance of Mental Health and Substance Use Disorder Services Information Notices and All Plan Letters.**[7] These documents provide behavioral health service and financing guidance to county officials and providers regarding the definitions and delineation of mild-to-moderate behavioral health services versus specialty mental health services. DHCS should provide further clarification through issuing more detailed guidance letters and collaborative training to provide CMC plans and County BH departments with more clarity about how to divide responsibilities. Because mild-to-moderate services, specialty mental health, and substance use disorder treatment may all be provided through different agencies, definitions of each type of service are of paramount importance to avoid confusion around service provision and reimbursement. Further research is needed to understand how each County's budget may be impacted by a clearer definition of specialty mental health services.

5. **CMC plans and County BH departments should continue to test innovations to identify more efficient strategies for integrating and coordinating medical care and behavioral health.** The promising practices mentioned in this report, including ICT meetings, co-location of providers, and data-sharing strategies, were all aimed at more effectively coordinating beneficiaries' behavioral health services. Best practices to improve collaboration, coordination, and integration of care for beneficiaries with behavioral health needs should continue to be evaluated and shared, so that beneficiaries receive the level of care coordination and the type of service provision that are tailored to their needs. CMC plans should explore sustained funding sources to continue to support and implement programs that have demonstrated increased levels of behavioral health care coordination and also led to a more integrated behavioral health model.

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