



Improving Mental Health Services Integration in Medi-Cal: Strategies for Consideration

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Executive Summary

Purpose

This paper, commissioned by the Blue Shield of California Foundation, describes some of the current challenges facing California's system of mental health services, explores strategies for improving mental health integration, and proposes scenarios for changing aspects of law, policy and organizational practices that could promote improved integration.

Full Integration by Ending the "Carve Out"

The most effective way to address the problems of siloed care is to consolidate the responsibility for delivering the full range of mental health services, from mild to severe, within a single entity. Such an approach would align incentives such that the entity paying for mental health services would be encouraged to provide early intervention and care coordination services so as to reduce long term costs for both physical and mental health conditions. The most ambitious and effective solution would be to integrate physical health, mild and moderate mental health, and specialty mental health under a single entity, presumably Medi-Cal Managed Care Plans (MMCPs). Although these changes are substantial, they would not necessarily result in increased state costs to the extent current service levels are maintained. In the near-term, utilization rates for physical health services for the SMI population could increase as a result of increased access to care, but these increases could be offset by long-term savings as a result of avoided hospitalizations and reduced emergency department use.

Integrating all Medi-Cal physical and mental health services would, however, be a Herculean task and would likely require a ballot initiative, legislative and regulatory actions, approval from the federal government, and actions by Boards of Supervisors, all of which pose political and administrative challenges. In spite of the large potential benefits, these obstacles mean that full systemic integration is a very challenging scenario, at least in the near-term.

Given the many obstacles to "full integration," this paper presents several short and medium-term strategies for improving the system of delivering mental health services and better integrating physical and mental health care, particularly for those with severe mental health needs. These strategies can help move the state toward full integration as a longer-term goal.

Strategies to Develop and Advance Integration Solutions

Several strategies could help to improve integration and patient care, regardless of whether any of the other strategies suggested in this report are adopted. These "overarching" strategies include developing an improved understanding of the impact of the current bifurcated system and studying and drawing conclusions from related pilot programs already underway, such as Whole Person Care and the Health Homes Initiative.

In addition to these overarching strategies, a number of strategies could be employed to help optimize the present environment (even in the absence of more comprehensive integration efforts) or put in place the needed foundations for developing longer-term reform. For example, developing improved Memoranda of Understanding (MOUs) or contracts between counties and health plans could help to more clearly delineate roles and responsibilities and reduce confusion and redundancy. Enabling health plans and counties to share providers could allow patients with moderate mental health conditions that need to move between the MMCP and the MHP to stay with the same provider, while expanded use of tele-psychiatry can help to alleviate workforce shortages. And, counties and plans could be encouraged to implement a “No Wrong Door” policy such that patients would receive needed care at their first point of contact with the health care system, with payment arrangements worked out behind the scenes between the county MHP and the MMCP. Finally, support for developing counties’ “managed care” functions and capacity could help counties to better plan for and manage financial risk, develop a panel approach to health management, and implement comprehensive quality improvement strategies.

Beyond these sorts of efforts aimed at better coordination among counties and plans, existing reporting and quality improvement programs could be leveraged to monitor progress and incentivize reform. For example, both MMCPs and MHPs currently work with External Quality Review Organizations (EQROs) to submit quality improvement and performance measurement reports to DHCS. DHCS could add integration-related metrics to managed care and county contracts and include them in quality reporting. In addition, MMCPs and MHPs already undertake Performance Improvement Projects (PIPs). DHCS could encourage specific PIPs with a mental health integration focus and provide tools for acting on these strategies. These efforts to leverage existing reporting and quality improvement efforts could be combined with an effort to leverage the new Medicaid managed care regulations to promote reform.

Finally, as the state prepares for the coming expiration of the current 1915(b) waiver (in 2020), much work can be done to encourage a cultural shift toward integration that benefits current patients and builds a foundation for potential future financial integration with the next waiver.

Solutions for Partial Integration

Beyond these strategies to optimize the current environment and lay the foundation for future integration efforts, some interim solutions aimed at partial integration nevertheless have the potential to improve patient care and outcomes in the shorter term. One potential solution would be selected pilot projects wherein counties would contract with MMCPs, who would assume financial and care responsibility for services the counties currently deliver. Under this scenario, the providers could remain the same (through a contract arrangement) but the financial risk management occurs with one payer. This consolidated financial management would improve incentives for early intervention and coordinated patient care both across the mild to severe continuum and between mental and physical health.

An alternative to this arrangement would be a pilot approach in which counties could assume responsibility for all mental health services (mild to severe). This would leverage county mental health service investment and expertise and could align financial incentives for early intervention and follow-up care after crisis. Yet another alternative would be for county MHPs to assume full responsibility for all physical and mental health services for the SMI population, thereby addressing the separation between physical and mental health providers for this population.

Each of these approaches has certain limitations, but, because they could be implemented voluntarily through contracts between plans and counties, they have the ability to be implemented in the near term on a pilot basis. If carefully evaluated, the results could be used as important tools for informing longer-term structural reforms.

Funding for Integration Efforts

Funding for integration strategies could come from several sources, but the two most promising are funds from the Mental Health Services Act (MHSA) and foundation funding. Both the local as well as state portions of MHSA funds represent a relatively flexible funding source for mental health services. Foundation funding could also be used to incentivize integration, support research and analysis, or to provide technical assistance for counties and plans interested in exploring integration strategies.

1. Purpose

This paper, commissioned by the Blue Shield of California Foundation, describes some of the current challenges facing California's system of mental health services, explores strategies for improving mental health integration, and proposes scenarios for changing aspects of law, policy and organizational practices that could promote improved integration.

These strategies are presented for consideration by health philanthropies, Medi-Cal managed care plans and county specialty mental health plans, state agencies such as the Department of Health Care Services and the Mental Health Services Act Oversight Commission, and other organizations and advocates focused on mental health.

This paper was completed in Fall 2016, before the change in administration in Washington. While specific changes to Medicaid are uncertain as of this writing, the recent American Health Care Act and related proposals clearly intend to constrain federal Medicaid contributions. To the extent federal Medicaid funding is reduced, California would face serving beneficiaries with fewer federal resources, and consequently, would likely expand the use of value-based strategies. Many of the proposed strategies in this paper could allow the state to optimize the use of limited resources while improving access to, and the quality of health services.

2. Approach

To research and write this paper, we undertook an extensive literature review, including academic papers, state and federal contracts, policy documents and other reports. We also conducted 36 interviews with representatives from the following:

- County mental health directors and experts
- California Department of Health Care Services leadership
- Mental Health Services Act experts
- Advocates for Medi-Cal beneficiaries
- Consultants with expertise in behavioral health and Medicaid
- Behavioral health care providers
- Public hospitals and community health centers
- Medi-Cal managed care plans
- Managed behavioral health organizations
- County financing experts
- Centers for Medicare and Medicaid Services
- Health philanthropy executives and program officers

3. Introduction

Although significantly strengthened by the Affordable Care Act (ACA) and other recent policy changes, California’s health care safety net remains a fractured system that makes it difficult to meet all of a safety net patient’s physical and mental health needs. The system designates responsibility for the physical health and “mild-to-moderate” mental health conditions of Medi-Cal beneficiaries to Medi-Cal managed care plans (MMCPs) and responsibility for providing services for “severe mental illness” to county specialty mental health plans (MHPs).¹ This system can be characterized by misaligned incentives and potentially large gaps in patient care. Exemplary coordination efforts can improve the patient experience, but they are expensive and often not cost-effective. Further, beneficiaries’ experience of this coordination depends on relationships between payers that vary over time and across counties and managed care plans.

This fragmented system of delivering care has evolved over several decades. This long history means that many policies, customs, and systems may be entrenched, while recent policy changes mean that many who work in this may be subject to “policy fatigue.” As a result, implementing large-scale structural changes to this care delivery system may be difficult. Legal restrictions on funding streams, lack of institutional capacity among health plans, bureaucratic inertia, and even a shortage of qualified mental health providers all serve as obstacles in the path of fundamental structural changes.

The remaining sections of this report present an assessment of the challenges caused by the current fragmented system, identify the contextual factors that may hinder reforms, and outline some potential strategies to improve integration. These challenges, context, and strategies focus on improving the system of delivering mental health care services, particularly by integrating services for those with mild-to-moderate conditions with services for the severely mentally ill (SMI) and integrating both physical and mental health services in one system. There also may be potential for improvements in the broader behavioral health system (i.e. mental health plus substance use disorder treatment). Because the substance use disorder system is currently undergoing a separate reform effort, however, discussions of behavioral health integration broadly are not a focus of this report.

4. Service Delivery Challenges with the Current System

California’s current system effectuates two partitions in service delivery, one along the continuum of mental health services and the other between mental and physical health services for patients with severe mental illness. The bifurcation of mental health care for mild-to-moderate and SMI patients can create counter-productive incentives for patient care. For example, counties’ have a financial incentive to avoid identifying patients at the “high-

¹ For an overview of the system, the most recent paper is: Lewis K, Coursolle A. Mental Health Services in Medi-Cal. National Health Law Program. Issue Brief. January 17, 2017. <http://www.healthlaw.org/publications/search-publications/Mental-Health-Services-in-Medi-Cal>

moderate” level as SMI.² However, managed care plans are responsible for providing mild-to-moderate services, but do not bear the costs of providing mental health services (at the severe end of treatment continuum) to the SMI population.³ Consequently, counties have limited ability to intervene early and prevent a serious mental health crisis, or provide follow-up care after a patient is stabilized following such a crisis. Medi-Cal managed care plans can experience a savings (at least in terms of mental health costs) once a patient enters the county specialty mental health system.⁴

In addition to misaligned financial incentives, the limited clinical rationale for the current separation of mental health services makes it difficult to establish clear criteria for assigning patients to one care system or another (e.g. responsibility for “high-moderates”).⁵ While Memoranda of Understanding between MHPs and MMCPs require dispute resolution, this mechanism may be insufficient to develop delineated responsibilities or encourage patient care coordination. Consumer confusion over payer responsibility can also lead to delays in care.

The bifurcated system of treatment also disregards the dynamic nature of mental illness. Interviewees described how conditions can fluctuate along the mental illness spectrum, resulting in a “ping pong” dynamic as a patient moves between the MHP and MMCP, with the result being poor continuity and coordination of care. Admittance to the county MHP generally requires a referral for an interview, treatment authorization, and ultimately referral to a provider. Transfer from the MHP to a MMCP provider for mild-to-moderate services is also referral-based. Patients with mental illness can have difficulty following through with referrals, exacerbating the difficulties associated with transitions among providers.⁶ Moreover, with little or no data exchange there is limited capacity for MMCP and MHP providers to track referred patients and ensure good patient care coordination.⁷

² Some counties may “ration” specialty mental health services by applying an overly rigid interpretation of the medical necessity criteria. See page 26 of “A Complex Case: Public Mental Health Delivery and Financing in California,” California HealthCare Foundation, 2013. <http://www.chcf.org/publications/2013/07/complex-case-mental-health>.

³ The cost of a mental health crisis in the form of an Emergency Department visit would be borne by the MMCP, but is substantially less costly relative to the cost to the county of providing inpatient psychiatric care.

⁴ Some cases of severe mental illness cannot be prevented with mild and moderate services, and some mild and moderate conditions left untreated will not accelerate to severe mental illness. However, high quality preventative and mild and moderate services for some conditions such as depression, eating disorders, and trauma can prevent crisis and a need for specialty mental health services. High quality MCP services following a mental health crisis are most critical to prevent entrance to the county system, but no financial incentive puts pressure on the MCP to ensure the quality of these services.

⁵ Part of the defining criteria for severe mental illness, “functional impairment,” leaves some room for interpretation, and may vary by county.

⁶ Some counties retain some moderate patients even when a case could be made for their transition to a MMCP provider for fear that these patients would destabilize and return to the county after an attempt to transition.

⁷ MMCPs and counties do not exchange patient data because separate data systems are incompatible and due to concerns about protecting patient privacy and associated legal restrictions.

Mild and Moderate Services in Areas with Workforce Shortages

In some counties, a lack of available mental health providers compounds service delivery problems. In particular, a shortage of psychiatrists can lead to competitive behaviors by MHPs and MMCPs (e.g. disallowing co-certification) to monopolize a provider's availability. Some remote areas have so few psychiatrists that tele-psychiatry is the only access option. Some interviewees reported that the local MMCP was not providing sufficient mild-to-moderate services due to workforce shortages.⁸

Inadequate Physical Health Care of Patients with Severe Mental Illness

In addition to aforementioned coordination and transition challenges, the SMI population frequently does not receive adequate physical health care.⁹ This is particularly consequential given the high prevalence of comorbidities and behavioral and social risk factors in the SMI population.¹⁰ Despite these high risk factors, data supports interviewee assertions that many SMI patients do not receive adequate primary care. For example, individuals treated for SMI and diabetes use the emergency department twice as much as individuals treated only for diabetes. Similarly, inpatient stays are twice as common for diabetes patients with SMI as compared to diabetes patients without SMI.¹¹

In response to the deficiencies in providing primary care services to SMI patients, some counties have taken the initiative and used Mental Health Services Act (MHSA) funds and Substance Abuse and Mental Health Services Administration (SAMHSA) grants to fund clinics to provide primary care for their SMI patients even though MMCPs are financially responsible for the physical health care for these patients to the extent they are eligible for Medi-Cal.

Why do MMCPs Struggle to Adequately Provide Care for the SMI Population?

The SMI population's physical health care is expensive. Of the most costly five percent of Medi-Cal beneficiaries, 45 percent are treated for severe mental illness.¹² Interviews suggest that MMCPs struggle to meet SMI patients' health needs because this requires intensive

⁸ Interviewees reported that some counties provide mild to moderate services in the absence of MMCP services.

⁹ Numerous interviewees emphasized that most MCPs are not providing primary care and/or are not meeting the physical health needs of the SMI population.

¹⁰ Parks, J. Svendsen D, Singer P, Foti ME, Mauer B. 2006. "Morbidity and Mortality in People with Serious Mental Illness," National Association of State Mental Health Program Directors, Series of Technical Reports, October.

<http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf>

¹¹ "Understanding Medi-Cal's High-Cost Populations," DHCS Research and Analytic Studies Division, 2015, Slide 38. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20D/PDF%20DataSymposium03042015Watkins.pdf>

¹² "Understanding Medi-Cal's High-Cost Populations," DHCS Research and Analytic Studies Division, 2015, Slide 14. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20D/PDF%20DataSymposium03042015Watkins.pdf>

coordination that can include outreach and engagement, clinical information sharing, medication reconciliation, and patient and family engagement.¹³ Such care coordination requires financial investment typically not covered by Medi-Cal (except by recent pilot programs).^{14,15,16} Perhaps more importantly, delivering physical health care to the SMI population requires primary care provider willingness to treat an often stigmatized population.

5. Obstacles to Reform

Given the myriad problems with the current bifurcated system of delivering mental and physical health care, why does such a system persist? Perhaps the simplest answer is “history.” In other words, the system’s evolution over many decades and the associated inertia make reform difficult. Truly integrating mental health care and physical care service delivery would require state legislation to revisit “Realignment” and might also require a ballot initiative.

Overview of Current Funding Mechanisms

Estimated behavioral health funding totals over \$8 billion for fiscal year 2016-17. The main funding sources comprising \$7.5 billion of these funds are the federal matching funds for Medi-Cal mental health services (\$3 billion), MHA funds (\$1.7 billion), the 2011 Realignment for behavioral health services (\$1.4 billion), and the 1991 realignment for mental health services (\$1.3 billion).¹⁷ The 1991 and 2011 Realignments created dedicated revenue sources for behavioral health that are outside of the annual state budget. The 1991 Realignment funds have been used for services such as locked long-term psychiatric facilities and indigent physical

¹³ “Care Coordination for Persons with Complex Mental Health, Substance Use and Medical Conditions: The Case for Health Plans and Other Payers,” Integrated Behavioral Health Project, California Mental Health Services Authority, page 1. <http://www.ibhp.org/uploads/file/BusinessCasePayersFinal.pdf>

¹⁴ *ibid*

¹⁵ For a discussion of Medicaid reimbursement for care coordination, see “Reimbursement of Mental Health Services in Primary Care Settings,” U.S. Department of Health and Human Services, SAMHSA, 2008, page 20. http://www.integration.samhsa.gov/Reimbursement_of_Mental_Health_Services_in_Primary_Care_Settings.pdf Care coordination is billable to Medi-Cal for patients age 21 and under, see “A Complex Case: Public Mental Health Delivery and Financing in California,” California HealthCare Foundation, 2013, pages 23-34; and “MHSD Information Notice No.: 13-11,” Department of Health Care Services. <http://www.dhcs.ca.gov/formsandpubs/Documents/13-11.pdf> Several non-Medi-Cal funding strategies and pilot initiatives have addressed care coordination for mental health patients in California in the past decade, such as MHA-funded Full Service Partnerships, foundation-funded pilots, and SAMHSA grants. Most recently, Health Homes and Whole Person Care pilots are funding care coordination not currently reimbursable under Medi-Cal such as joint care plan development and interdisciplinary care team meetings. (See “A Complex Case: Public Mental Health Delivery and Financing in California,” California HealthCare Foundation, 2013, pages 29, 34-35. <http://www.chcf.org/publications/2013/07/complex-case-mental-health>.)

¹⁶ Recent pilot programs, Whole Person Care and Health Homes, are aimed in part at addressing the need for better care coordination for patients in participating areas.

¹⁷ Mary Ader and Tom Renfree, “Update on the 2016-17 State Budget,” County Behavioral Health Association of California Memorandum to CBDHA members, July 6, 2016, http://www.cbhda.org/wp-content/uploads/2014/12/CBHDA_Memo_Members_2016-17_State_Budget_07-06-16.pdf

health care, and for the Medi-Cal state share match. The 2011 Realignment funds drug and alcohol treatment, Medi-Cal managed care programs for mental health, and Medi-Cal's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

The state retains limited authority in directing the use of realignment funds beyond ensuring that funds are used in a manner intended by the realignment statutes.¹⁸ In addition, current law prohibits the state from passing mandates that would lead to increased county costs without additional funding (Proposition 30).¹⁹ Because the current system of funding mental health services is based on a series of ballot propositions and other state laws and regulations, making significant changes to this system would require revisiting many of these historical funding arrangements, including some established by voters.

It's Not Just Realignment

Fully integrating mental health care would also require changes in the state's Medicaid Section 1915(b) Specialty Mental Health Waiver. Since 1995, this waiver established county-operated health plans for specialty mental health services thereby "carving out" these services from Medi-Cal managed care plans.²⁰

Beyond legal and financial issues, institutional factors also act as obstacles to reform efforts. Ending the "carve out" would transfer SMI responsibility from the counties to MMCPs, potentially dislocating the county mental health workforce and other providers. Moreover, many county Boards of Supervisors may resist relinquishing control the financing streams, providing these services and employing this workforce.

Managed Care Plans Have Limited Capacity to Deliver SMI Services

Many MMCPs may lack the expertise and capacity to manage the SMI population. These patients have complex mental health needs, and counties have deep experience with this population. In contrast, most MMCPs have limited expertise and capacity, having only recently

¹⁸ Realignment 2011 (AB 114) transferred responsibility and funding for mental health services for students with disabilities in schools from the county to the department of education. Now, mental health services for these students are funded by the state general fund via Proposition 98, federal IDEA funding, and MHSA. Counties continue to fund mental health services for non-special education students through EPSDT and MHSA funded early prevention programs. See page 25 "A Complex Case: Public Mental Health Delivery and Financing in California," California HealthCare Foundation, 2013.

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ComplexCaseMentalHealth.pdf> and http://www.dhcs.ca.gov/services/MH/Documents/CSI_2013_06_03c_AB_3632_AB_114b.pdf.

¹⁹ "Locally Sourced: The Crucial Role of Counties in the Health of Californians," 2015.

<http://www.chcf.org/publications/2015/10/locally-sourced-crucial-role-counties>

²⁰ "A Complex Case: Public Mental Health Delivery and Financing in California," California HealthCare Foundation, 2013, page 13.

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ComplexCaseMentalHealth.pdf>

assumed responsibility for mild-to-moderate services. Counties and advocates may have concerns about if the MMCP capitation model sufficiently incentivizes high-quality care.²¹

System Reform Fatigue and Uncertainty

There may be limited appetite among county and health plan leadership to take on such a system transformation given other changes currently underway, such as the Whole Person Care pilots, Health Homes Program, and the Drug Medi-Cal Organized Delivery System pilots. Not only has implementing these changes consumed leaders' attention in many organizations, but some interviewees claim the expanded service need has contributed to a shortage of available mental health providers.

In addition, uncertainty may serve as another important obstacle to change. Both MMCPs and MHPs will likely be concerned about the uncertain cost of integrating systems and the extent of potential savings. And, of course, the most uncertain eventuality currently is the extent of any forthcoming changes to the Affordable Care Act and Medicaid that may come from Washington. Ultimately, without a significant incentive to change the current system, the current legal, regulatory, cultural and institutional barriers to reform are likely to prevail.

6. Policy Strategies and Mechanisms for Stimulating Reforms and Improvements

The obstacles to reform notwithstanding, it is clear that the current bifurcated system of delivering mental health services is not serving patients well. Potential improvements to this system span a continuum from strategic and near-term improvements to comprehensive and long-term transformation. Below we present solutions along this continuum in four categories:

1. Overarching strategies to develop and advance integration solutions
2. Strategies to optimize the present environment
3. Partial integration approaches
4. Long-term change

²¹ For contract strategies to hold MMCPs accountable for providing quality behavioral health, see "Ensuring Access to Behavioral Healthcare through Integrated Managed Care: Options and Requirements," National Council for Behavioral Health, 2014. http://www.thenationalcouncil.org/wp-content/uploads/2014/11/14_Managed-Care-2.pdf; See examples of other states that integrate health care under managed care plan attach financial rewards and penalties to performance metrics: KanCare Final Evaluation Design, Kansas Department of Health and Environment, Division of Health Care Finance, March 2015. http://www.kancare.ks.gov/download/KanCare_Final_Evaluation_Design_Revised_March_2015.pdf And "Attachment II, Exhibit II-C – Effective Date: July 15, 2015, Serious Mental Illness Specialty Plan," Florida Agency for Health Care Administration, July 2015. https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/Exhibit_II_C-Serious_Mental_Health_Illness_2015-07-15.pdf

These strategies are presented for consideration by health philanthropies, Medi-Cal managed care plans and county specialty mental health plans, state agencies such as the Department of Health Care Services and the Mental Health Services Act Oversight Commission, and other organizations and advocates focused on mental health.

6.1 Overarching Strategies to Develop and Advance Integration Solutions

We present three strategies that would optimize the present environment and advance longer-term change. Detailed below, these include data collection and analysis, drawing lessons from on-going pilots, and helping counties better use MHSA funds.

6.1.1 Improve Quantification and Understanding of Integration Issues

Although problems with the bifurcated system are well known, data to quantify their extent has not been widely or systematically collected. More comprehensive data are needed to assess the continuity of mental health care, measure the extent to which physical health conditions of individuals with SMI are addressed, and estimate the cost of coordinating services (see Appendix A for a discussion of current data collection efforts).²² The data recommended below would systematically illuminate integration challenges and point to solutions:

- *Continuity of Care* - Little is known about the extent, severity and costs of delayed care. The National Health Law Program presents several case examples that illustrate the nature of problems for patients moving in a bifurcated mental health system.²³ But, additional data are needed to understand how many people are not receiving the needed mental health care services. In addition, data are needed to know how many people are being treated or given an in-take assessment for mental health services by the county specialty mental health plan (MHP) and referred to the MMCP for services but do not receive services (and vice versa). Metrics of follow up care after a crisis and the number and frequency of recurrent mental health crises may also contribute to understanding the extent of problems stemming from the bifurcated system. Discerning which problems are most widespread and contribute most potently to patient health and higher costs would help direct policy attention and resources.
- *Physical health needs of SMI population* - Individuals with SMI can die, on average, 25 years earlier than those without SMI, mostly from treatable health conditions.²⁴ More

²² Statewide data collection efforts focus on the care quality provided by MHPs and MMCPs separately. Evaluations of care coordination pilots and demonstrations may yield information improving integration. See Appendix A.

²³ Lewis K, Coursolle A. Mental Health Services in Medi-Cal. National Health Law Program. Issue Brief. January 17, 2017. <http://www.healthlaw.org/publications/search-publications/Mental-Health-Services-in-Medi-Cal>

²⁴ Parks, Joe, Dale Svendsen, Patricia Singer, Mary Ellen Foti, and Barbara Mauer. 2006. "Morbidity and Mortality in People with Serious Mental Illness," National Association of State Mental Health Program Directors, Series of Technical Reports, October.

<http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%2008.18.08.pdf>

specific data on difficulties in meeting the physical health needs of individuals with SMI are needed. Data sharing efforts between MHPs and MMCPs could yield information on the extent to which physical health care is available and accessible to the SMI population by using specific metrics, such as the percent of the SMI population with a physical health diagnosis that saw a provider for that condition within a specified period.²⁵

- *Costs of coordination* - The costs of coordinating care across two systems are likely greater than the costs of coordinating care within a single system. Quantifying these costs would require development of a methodology to identify coordination costs occurring in MHPs and MMCPs.
- *MMCP and MHP landscape* - Evaluating MMCPs in terms of their capacities to manage behavioral health is an important step for exploring strategies that prepare MMCPs for taking on full financial risk for the SMI population. Criteria would need to be developed to evaluate MMCP behavioral health capacity (such as staff with behavioral health expertise, provider panels, incorporating a recovery model), among other criteria to be developed.²⁶

Another useful data collection effort would identify MHPs that contract out their behavioral health services. Such plans may be more suitable or interested in participating in a pilot that aligns financial responsibility for all health care in the MMCP. Finally, data collection that compares the supply of behavioral health providers to service need by MHP, MMCP, and managed behavioral health organizations (MBHO) would identify areas with workforce shortages.

6.1.2 Draw Lessons from Related Medi-Cal Pilots and Initiatives for High-Need Patients

There are numerous pilots and initiatives, either underway or on the cusp of implementation, that will advance care coordination for high-need Medi-Cal beneficiaries. Most, if not all, of these include independent evaluations and required monitoring by DHCS and CMS. These include: the Whole Person Care pilots,²⁷ Health Homes Program for Patients with Complex

²⁵ See a Webinar hosted by the California HealthCare Foundation that highlights research by university researchers that used Medi-Cal data to study the characteristics and needs of the SMI population. DHCS staff discussed implications of the findings for policy. "Webinar -- Using Medi-Cal Data to Improve Care for Serious Mental Illness," California Health Care Foundation, January 12, 2016, <http://www.chcf.org/events/2015/webinar-medical-mental>

²⁶ This would could build on work that identified counties where plans offer mild to moderate services in-house vs. through a subcontracted MBHO in the California Health Care Foundation report, "The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions," August 2016, <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CircleMediCalMentalHealth.pdf>

²⁷ California Department of Health Care Services, "Whole Person Care Pilots," webpage, <http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>

Health Needs,²⁸ Drug Medi-Cal Organized Delivery System pilots,²⁹ and the Coordinated Care Initiative.³⁰

In addition to these statewide pilots and initiatives, there are numerous local or regional collaborations whose clinical, financing, policy and operational innovations could render lessons to improve mental health integration and financial risk sharing. Furthermore, the Medicaid Innovator Accelerator program's work on integration could also render valuable lessons.³¹ The field at-large would be well-served by a "meta-analysis" of the evaluation results and findings from these many pilots with related objectives and myriad approaches to achieving those objectives.³² This work might include:

- Compiling an inventory of these numerous pilots and initiatives, reporting and evaluation requirements, and evaluators (if contracted)
- An analytical approach for the "meta-analysis" that would extract transferrable financing, policy and operational lessons for mental health integration
- An expert group to advise on development of the analytical approach for the meta-analysis and priority research questions
- Collecting and analyzing evaluation findings and results using the meta-analysis approach
- Translating findings and meta-analysis into actionable strategies and programs for counties and plans, providers and advocacy groups.

6.1.3 Targeted MHSA Funding for Integration Efforts

MHSA funds represent a relatively flexible funding source for mental health services and could potentially incentivize multiple proposed solutions, although some obstacles to their use exist. While the state has limited authority over counties' use of MHSA funds, it does, however, retain three percent of the funds for use in statewide programs. These funds could be used to provide an incentive for counties to pursue integration strategies. Currently, the law allows the state to

²⁸ California Department of Health Care Services, "Health Homes Program," webpage, <http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx>

²⁹ California Department of Health Care Services, "Drug Medi-Cal Organized Delivery System," webpage, <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>

³⁰ California Department of Health Care Services, "Medi-Cal's Coordinated Care Initiative (CCI): The Duals Demonstration," webpage, http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal_CCI.aspx. While the CCI has been statutorily discontinued in the 2017-2018 Budget, many of the features of the demonstration will continue. Moreover, the evaluations may offer valuable lessons.

³¹ Medicaid, "Physical and Mental health Integration," webpage, <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/physical-and-mental-health-integration/physical-and-mental-health-integration.html>

³² This is not a "meta-analysis" as formally defined: a method for systematically combining pertinent qualitative and quantitative study data from several selected studies to develop a single conclusion that has greater statistical power. Instead, we envision an approach that would look collectively and systematically across like-pilots and extract important lessons for better care coordination for high-need populations.

collect unspent local funds, but requires the state to redistribute these funds to counties. Changes to this arrangement could allow the state to gain authority over unspent local MHSA funds and direct these funds toward furthering integration or other reform efforts. In addition, the legislature retains the authority to amend the MHSA consistent with its purpose with a two-thirds vote.

Under the current system, counties have considerable flexibility in the use of locally allocated MHSA funds, and could use them for integration activities if desired or encouraged to do so. Under current MHSA funding allocation, counties can use up to five percent of their funds for innovation related purposes. Counties can also use funds for case management or other activities which further integration, including technological needs such as improved data systems to monitor and track patients.

6.2 Optimize Present Environment

These strategies would be undertaken over the next three years before the current 1915(b) waiver expires in June 2020. They focus largely on incremental improvements and build upon ongoing innovations, pilots and initiatives. They are also framed within existing policies, rules and regulations. Finally, they would build the groundwork for and yield evidence to support longer-term improvements. These strategies were designed before the new administration in Washington took office and any looming changes to the Affordable Care Act were implemented.

6.2.1 Revisit the Stakeholder Process to Improve Understanding and Develop Next 1915(b) Waiver

California has a well-established tradition of inclusive stakeholder processes to inform the development, implementation and evaluation of Medi-Cal policies and waiver programs. Typically, these have been jointly funded by foundations, sponsored by the executive branch, and hosted by DHCS. While this approach is generally valued, some interviewees perceived it as overly formulaic, “too thin and too wide,” or not managed in a constructive manner. Numerous interviewees advised keeping the stakeholder process but bringing more focus and rigor to it. Interviewees lamented that stereotyping of managed care plans and counties prevented candid discussions of what is working well and ways to promote good public policy.

A small group of experts could lay the groundwork necessary to support a more productive stakeholder process. This might include smaller convenings between counties and plans to encourage better understanding of their respective goals, the community mental health infrastructure, and their respective capacities and constraints around improved mental health services.³³ These discussions might also include presentations on the convoluted history of

³³ One interviewee referred to such meetings as “peacekeeping” events.

mental health carve outs and county-state realignments and discussion of the results from the evaluation “meta-analysis” referenced above.

This small group of experts could also propose scenarios for the optimal path forward with new financing and risk-sharing models that align incentives between plans and counties (as discussed in later in this paper). These scenarios or models could be vetted with important stakeholders (e.g. Administration, DHCS, county behavioral health directors and plans) and then packaged to introduce for discussion into a broader stakeholder process.

6.2.2 Support Organizational and Cultural Changes to Integrate Behavioral Health in Managed Care Plans

In the current environment with funding streams segregated by services, much work can be done to encourage a cultural shift toward integration that benefits current patients and builds a foundation for potential future financial integration.

MMCPs could be encouraged to develop a better understanding of and overcome the obstacles to providing better health care to patients with mental health needs. These obstacles may include a limited time with patients, lack of co-located mental health professionals in primary care clinics or primary care providers in mental health clinics, and limited awareness of the benefits of early intervention and prevention for mental health issues.

To build physicians’ awareness and skills in meeting the physical needs of patients with mental illness and appropriately referring patients to behavioral health services, MMCPs could offer training to providers in evidence-based practices that address these areas. MMCPs could also develop incentive strategies for physicians to gain experience treating SMI patients and plans that address the obstacles to care and bring about cultural changes through training and incentives for physical health care providers.

Building MMCP capacity to take on financial risk for the SMI population requires a major reorientation from a traditional medical care model to a recovery-oriented model. Progress along this road would benefit mild and moderate patients as well. To take on SMI, MMCPs would need to develop a deep understanding of behavioral health and treatment modalities and cover non-traditional services of engagement, outreach, and care coordination. For example, MMCPs use telephonic outreach, which may not be effective for many SMI patients who need more direct outreach mechanisms. Also, some MMCPs may think of “care coordination” as coordinating medical services, but SMI patients need coordination of physical health, mental health, and social support services that fall outside of MMCP covered services (such as housing).³⁴

³⁴ National Council for Behavioral Health. 2014. “Ensuring Access to Behavioral Healthcare through Integrated Managed Care: Options and Requirements,” http://www.thenationalcouncil.org/wp-content/uploads/2014/11/14_Managed-Care-2.pdf

6.2.3 Implement “No Wrong Door: Pay and Chase” Policies

Currently, neither MMCPs nor MHPs has a financial incentive to quickly resolve disagreements in coverage for a patient. To reduce disputes and confusion, the state could require the entity that first sees a patient to provide care regardless of whether the patient needs mild-to-moderate or severe mental health services. In the event a provider in the MMCP first receives an SMI patient, the MMCP in this scenario would provide and pay for care until the patient is receiving services from the MHP. In this case, the MMCP would have the financial incentive to pursue reimbursement from the county for the initial care provided or funded. The patient would not experience a protracted waiting period during a dispute between MMCP and MHP.

6.2.4 Incentivize Coordination

The last 1115 waiver renewal stakeholder process developed ideas that incentivize care coordination through shared risk and shared savings models.³⁵ One idea would create an incentive pool to distribute funds to MMCPs and MHPs for meeting performance goals in areas such as care coordination and quality of care for the SMI population (this is similar to CalMediConnect described in the section “Integrate financial risk”). This incentive could encourage MMCPs and MHPs to jointly fund strategies and personnel such as medication managers and case managers to coordinate care and prevent crisis and transfer to MHPs.

Another incentive proposal would encourage MMCPs to integrate physical and mental health services at the provider level by offering supplemental capitation payments for co-located team based care. The supplemental payments would be offered at different tiers that accommodate different infrastructure capabilities of providers. For widespread adoption, DHCS would need to contractually require MMCPs to offer these tiered supplemental payments.

6.2.5 Improve MOUs and Contracts Between Counties and Plans

Current MOUs between counties and MMCPs can be very general and vague. Changes that would improve their use as an improved integration and accountability tool include more precise language on roles and responsibilities (particularly for care coordination), specific data reporting and sharing requirements, and more rigorous quality improvement standards. While individual counties and plans can make MOUs more precise and more accountable on their own, clearer and more rigorous requirements (or even templates) from DHCS could encourage improvements in all counties. The National Health Law Program has proposed numerous recommendations to improve integration, including improvements to MOUs and contracts.³⁶

³⁵ Department of Health Care Services. 1115 Waiver Renewal - MCO / Provider Incentives Expert Stakeholder Workgroup. <http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-MCO-Provider-Incentives.aspx>

³⁶ Lewis K, Coursolle A. Mental Health Services in Medi-Cal. National Health Law Program. Issue Brief. January 17, 2017. <http://www.healthlaw.org/publications/search-publications/Mental-Health-Services-in-Medi-Cal>

MOUs and contracts can also be used for purposes beyond the general improvements discussed above. A strategy to align incentives without altering the payer structure is to develop a system of shared accountability by designing and deploying MOUs or contracts that set quality of care standards and attach financial rewards and penalties to performance outcomes. This strategy could encourage care coordination of a patient's mental and physical health and allow for improved transparency and accountability. Financially rewarding and penalizing behavioral health providers for performance measures of their patients' whole-person well-being will incentivize those providers to coordinate with primary care providers. Similarly, rewards and penalties attached to performance metrics and data sharing requirements could encourage plans and counties to pay for warm hand-offs of mental health patients transitioning between MMCPs and MHPs. This accountability system could encourage MHPs and MMCPs to jointly hire and fund staff to provide services to and coordinate care for these patients.

6.2.6 Develop MHPs “Managed Care” Functions and Capacity

While county MHPs are labeled as “health plans,” many lack well-developed functions and capacities embodied in a traditional managed care plan to address financial risk, a panel approach to health management, and comprehensive quality improvement strategies. In California's 1915(b) waiver, MHPs are classified as Prepaid Inpatient Health Plans (PIHP) and are paid on a non-risk basis.³⁷ In addition, MHPs must comply with specific Medicaid managed care rules, particularly for the availability and timeliness of services. In the June 2015 waiver renewal, CMS reaffirmed MHPs access and quality requirements, directed the state to come into compliance by 2020, and required a MHP dashboard with indicators on quality, access, timeliness, and translation/ interpretation capabilities.³⁸

Developing deeper and more sophisticated capacity would allow counties to better comply with the new federal Medicaid managed care rules, better manage their Realignment and other mental health resources, and improve patient care management. The development of such capacity could also help to build a foundation for long-term reform by allowing county MHPs and Medi-Cal managed care plans to align financial and organizational incentives and enter into shared risk arrangements to better integrate and coordinate care.

Moreover, such capacity would allow county MHPs to manage services and financing for the SMI population beyond mental health. For example, managed care plans could contract with

³⁷ California Department of Health Care Services, “Section 1915(b) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs and FFS Selective Contracting Programs,” June 10, 2015, [http://www.dhcs.ca.gov/services/MH/Documents/1915\(%20b\)_SMHS_Waiver.pdf](http://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf)

³⁸ Centers for Medicare and Medicaid Services, letter of approval and special terms and conditions for California's request to renew the Medi-Cal Specialty Mental Health Services Waiver, addressed to the California Department of Health and Human Services, June 24, 2015, http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf

MHPs that have more fully developed administrative and management capacity to provide mild-to-moderate mental health services. Such capacity development could also help MHPs to assume financial risk and responsibility for the full continuum of behavioral and physical health for the SMI population (these integration scenarios are discussed later in the paper). This managed care capacity development for MHPs could include all or some of the following:

- Plan design, financial risk management and rate development
- Panel management and population health
- Quality measurement and improvement tools and processes
- Data sharing/health information exchange
- Network development, adequacy assessment and monitoring
- Provider enrollment, accreditation and support
- Treatment planning, utilization management, and care coordination
- Billing and ICD-10 capacity
- Consumer involvement/member services

6.2.7 Improve Integration via Medicaid Quality Requirements and Reporting

Medicaid programs with managed care plans are required to meet numerous quality assurance standards, including having an assessment and improvement strategy, external quality review, quality measurements and reporting, and Performance Improvement Projects (PIPs).³⁹ As Prepaid Inpatient Health Plans (PIHPs), county MHPs are required by the 1915(b) waiver to meet many of these managed care quality standards. California's Medi-Cal managed care plans work with the External Quality Review Organization (EQRO) to submit their quality improvement and performance measurement reports to DHCS.⁴⁰ County MHPs also work with a behavioral health EQRO on quality assessment, monitoring and improvement.⁴¹

Improved behavioral health integration could be promoted using these quality requirements and tools. Specifically, DHCS could add integration-related metrics to managed care and county contracts and include them in reporting in the Performance Outcomes System and the Medi-Cal Managed Care Performance Dashboard.⁴² Medicaid managed care plans in Florida, Kansas and Arizona are currently use numerous quality and performance measures focused on persons with mental health needs.⁴³

³⁹ Social Security Administration, "Provisions Relating to Managed Care," Section 1932 of the Social Security Act, https://www.ssa.gov/OP_Home/ssact/title19/1932.htm

⁴⁰ California Department of Health Care Services, "Medi-Cal Managed Care - Quality Improvement & Performance Measurement Reports," website, <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>

⁴¹ California Department of Health Care Services, "1915(b) Medi-Cal Specialty Mental Health Services Waiver," website, [http://www.dhcs.ca.gov/services/MH/Pages/1915\(b\)_Medi-cal_Specialty_Mental_Health_Waiver.aspx](http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx)

⁴² California Department of Health Care Services, "Medi-Cal Managed Care Performance Dashboard," website, <http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>

⁴³ Center for Health Care Strategies. Integrating Behavioral Health into Medicaid Managed Care: Design and

Furthermore, MMCPs and county MHPs must undertake PIPs as part of their quality improvement strategies. DHCS could encourage specific PIPs by plans and make mental health integration the focus and provide toolkits for undertaking them.⁴⁴ For example, CMS developed PIP Toolkits for improving children’s oral health as part of a national Oral Health Initiative.⁴⁵ DHCS could use these as a model to develop toolkits focused on integration and shared quality improvement between managed care and county SMH plans.

6.2.8 Leverage New Medicaid Managed Care Regulations to Promote Reform

As noted earlier, MHPs are classified as Prepaid Inpatient Health Plans (PIHP) and already must comply with a subset of Medicaid managed care rules (their non-risk payment model exempts them from other rules). CMS clearly articulated its compliance expectations in the last 1915(b) waiver renewal by requiring MHPs to meet and monitor standards for timely availability of services. The new Medicaid managed care rules present opportunities to approach behavioral health quality more comprehensively and increase plans’ accountability.

MHP’s exemption from specific rules may end since the new final rules unify requirements for all types of managed care plans, including PIHPs.⁴⁶ Several new rules have the potential to improve the availability and coordination of behavioral health services. These requirements include network adequacy, continuity of care for beneficiaries with “special health care needs”, and quality measurement and improvement.

For network adequacy, states must establish time and distance standards for many providers, particularly adult and pediatric behavioral health providers (including SUDS providers).⁴⁷ DHCS has proposed non-physician mental health and SUDS network adequacy standards that would

Implementation Lessons from State Innovators. April 2016. http://www.chcs.org/resource/integrating-behavioral-health-into-medicaid-managed-care-design-and-implementation-lessons-from-state-innovators/?utm_source=Integrating+Behavioral+Health+into+Medicaid+Managed+Care&utm_campaign=PH-BH+Brief+4-14-16&utm_medium=email.

⁴⁴ The 2015 1915(b) waiver Special Terms & Conditions requires a PIP for MHPs that cannot establish a baseline measure for timeliness of care. This PIP requirement would compete with PIPs focused on improving integration.

⁴⁵ The Center for Health Care Strategies, under the direction of Mathematica Policy Research, developed the toolkits available here: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/pip-manual-for-states.pdf> and <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/pip-template.zip>

⁴⁶ Federal Register, “Medicaid and Children’s Health Insurance Program Programs: Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability,” <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>

⁴⁷ Code of Federal Regulations, “Availability of services,” Title 42, section 438.206, <https://www.law.cornell.edu/cfr/text/42/438.206>

take effect starting in the July 1, 2018 plan contract year. There are both time and distance and timely access standards that would vary based on county population size.⁴⁸

Other regulations require managed care plans, including MMCPs and PIHPs, to coordinate care by developing treatment plans for enrollees who require long-term supports and services or have special health care needs.⁴⁹ The rules leave to states' discretion whether SMI patients are designated as having special health care needs. Finally, the rules require quality assessment and improvement, along with external quality review. The state must develop and implement a quality plan by May 2019.

6.2.9 Expand Use of Tele-Psychiatry to Address Workforce Shortage

In many rural and Central Valley counties in particular, a severe workforce shortage of mental health professionals (particularly psychiatrists) exacerbates the challenge of providing a continuum of mental health services. In some counties, the managed care plan or behavioral health managed care organization has been unable to develop an adequate network to provide mild-to-moderate mental health services. In some instances, the county may use other county resources to provide mild-to-moderate care that the managed care plan is not providing due to workforce shortage. Expanded use of tele-psychiatry could help to address this workforce shortage.

6.2.10 Encourage Health Plans and Counties to Share Providers

In most counties, the MHP and MMCP providers are separate networks. If, however, providers could be encouraged to see patients in both the health plan network and the county specialty mental health plan networks, a patient that needed to move between the MMCP and the MHP could stay with the same provider.

While such an approach would improve continuity of care for patients, sharing providers would also result in billing and administrative complications for providers. In areas with a workforce shortage, both plans and counties may resist sharing providers because they feel protective over scarce resources necessary to meet the needs of patients for which they are separately responsible. Interviewees from MMCPs and MHPs also expressed concern about competing for workforce with the rates they can pay. In spite of these constraints, provider sharing has the potential to improve care coordination and continuity of care.

⁴⁸ Department of Health Care Services. Medicaid Managed Care Final Rule: Network Adequacy Proposal. February 2017. http://www.dhcs.ca.gov/services/Documents/NetworkAdequacy_SAC.pdf

⁴⁹ Code of Federal Regulations, "Accessibility considerations," Title 42, section 438.206(c)(3)

6.3 Solutions for Partial Integration

While a successful, full integration of services for both physical and mental health is a long-term goal, some interim solutions aimed at partial integration nevertheless have the potential to improve patient care and outcomes in the shorter term. Several such “partial integration” solutions are discussed below.

While even partial integration is probably not entirely achievable before 2020, much of the conceptual groundwork and key operational aspects could be worked out over the next two or three years. Furthermore, this conceptual groundwork would identify policy and regulatory details of partial integration that would have to be “blessed” by the executive and legislative branches and included in the next 1915(b) waiver renewal application. Partial integration solutions may look increasingly attractive to the state, MMCPs and MHPs as a means to comply with the new Medicaid managed care rules. And while the Medicaid horizon remains murky, reforms from Washington will very likely reduce available federal funds and press states to pursue more value-based strategies, including care coordination and better care management.

6.3.1 Integrate Financial Risk

One potential solution advancing full integration would be to develop pilots in interested counties wherein MMCPs would assume financial responsibility for the full range of mental health services (mild to severe). Although more than one approach to such pilots could be developed, the idea would be for counties to contract with MMCPs to assume financial and care responsibility for the services counties currently deliver, using the same funding sources (e.g. realignment and MHPA funds). This scenario would not require regulatory or legislative changes if counties voluntarily contract financial risk for mental health services to MMCPs.

MMCPs could, in turn, contract back with counties and other existing providers for services, at least as an interim step to minimize disruptions to patient care.⁵⁰ Under this scenario, the providers remain the same but the financial risk management occurs with one payer. This consolidated financial management would improve the incentives to provide early intervention and coordinate patient care, both across the mild to severe continuum and between mental and physical health. As a result of the improved patient care and alignment of incentives, costs for the system would potentially decrease. These savings could be shared jointly by counties and health plans, or reinvested in providing enhanced levels of patient care.

For such a plan to work, several important elements would need to be put in place. First, given the institutional obstacles and the uncertainty associated with such a change, counties and plans would likely need an initial financial incentive to pursue reform and to cover the costs of managing the transition. These funds could come from foundation support or, potentially, from state MHPA funds.

⁵⁰ This may be easier in counties that already contract out many of their behavioral health services.

Second, counties and plans would need to enter into a contract specifying respective plans' responsibilities, payment mechanisms, reporting, and other requirements. This contracting would include specific measures of patient care, care coordination and continuity, and financial metrics assessing overall costs. Counties and plans might benefit from assistance in developing model contracts, reporting mechanisms, and other requirements.

Implementation of such a shared responsibility model could be based on successful aspects of the Coordinated Care Initiative (Duals Demonstration project).⁵¹ Under this model, the managed care plan provides the full continuum of physical and behavioral health services through a capitated rate.⁵² This arrangement is governed by a MOU that details specific performance metrics. Under the terms of the pilot, DHCS will withhold a portion of capitated payments from managed care plans until plans meet specified performance metrics, with savings expected to accrue from expected savings due to preventable hospitalizations.⁵³

This example of shared accountability could be adapted to a county MHP - MMCP joint effort such that counties would withhold a percentage of the capitated rate until MMCPs meet performance metrics, with counties receiving a percentage of savings if costs amount to less than the prescribed rate. Converting multiple funding streams into a capitation rate can be challenging, but managed care plans have done so to include behavioral health services (e.g. Value Options Maryland and Colorado Behavioral Health Organization).⁵⁴

Challenges - While this model has some promise as a means of addressing the problems associated with a bifurcated system of delivering care, some interviewees expressed concerns. For example, some interviewees believe that MMCPs are adequately experienced in addressing the local politics that might be necessary for ongoing negotiations over the financial

⁵¹ While the Coordinated Care Initiative is formally discontinued in the 2017-2018 budget, the Administration proposed continuing programmatic components of the demonstration aimed at reducing costs and improving health outcomes.

⁵² In addition to SMHP services, Medicare Part D and Drug Medi-Cal are also excluded from the capitated rate.

⁵³ California Department of Health Care Services, "Duals Demonstration Memorandum of Understanding," webpage, <http://www.dhcs.ca.gov/Pages/demoMOU.aspx> ; California Department of Health Care Services, "Coordinated Care Initiative: Evaluation Outcome Report," http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCI_Outcomes-Evaluation_April2016.pdf ; "Memorandum of Understanding (MOU) between The Centers for Medicare and Medicaid Services (CMS) and The State of California," <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf> ; "Template Language for memorandum of Understanding between Duals Demonstration Health Plans and County Behavioral Health Departments," <http://www.calduals.org/wp-content/uploads/2013/02/Local-BH-MOU-Template-02-15-13.pdf> ; Example MOU in LA County: http://lacdmh.lacounty.gov/News/Board_Correspondence/Adopted_Board_Letters/Adopted%20BL_DMH_PH_PSS_MOU%20with%20Health%20Net%20and%20LA%20Care_081313.pdf

⁵⁴ National Council for Behavioral Health. 2014. "Ensuring Access to Behavioral Healthcare through Integrated Managed Care: Options and Requirements," http://www.thenationalcouncil.org/wp-content/uploads/2014/11/14_Managed-Care-2.pdf

arrangements. In other cases, interviewees expressed reservations about MMCP's ability to provide high quality mental health services, regardless of financial incentives. Further, the traditional medical model may not adequately meet the needs of the SMI population, and some doubt the ability of MMCPs to embrace a recovery model. Finally, some expressed concern that the regulatory compliance of the MMCPs would create an even greater administrative burden than the county currently experiences.

In spite of the potential obstacles, pursuing a pilot in carefully selected counties with willing and capable partners on both sides could help build a case for additional pilot communities and eventually broader integration across the state.

6.3.2 County MHPs Assume Full Responsibility for Mild, Moderate, and Severe Mental Health Services

An alternative to full integration (whether on a pilot or statewide basis) is a scenario wherein counties assume responsibility for patients needing mild, moderate or severe mental illness services. The advantages of this scenario include leveraging decades of investment in county mental health services and seamless provision of services along the mental health care continuum. Such an approach not only has the potential to fill gaps in care, but it would align financial incentives for early intervention, provision of follow-up care after crisis, and elimination of payer dispute and confusion. In some counties with particularly well-developed mental health systems and integration of county services (e.g. County Organization Health System counties), this approach may also be worth exploring with shared accountability contracts for care coordination like CalMediConnect (see section "Integrate financial risk").

MMCPs could subcontract mild-to-moderate services to MHPs instead of to a MBHO as many currently do without legislative or regulatory changes. Circumventing MMCPs entirely would require a change in statute and financing mechanisms.

Challenges - A significant limitation in this approach is the continued bifurcation of health care and mental health services. While mental health services – though likely not SUDS – would be integrated and managed in a single system, patients physical health needs would be met by separate MMCPs.

6.3.3 County MHPs Assume Full Responsibility for All Services for SMI population

As described earlier, one of the challenges confronting SMI patients is the separation between physical and mental health providers. This challenge could be addressed by creating a system in which counties assume the responsibility for physical health care as well as mental health care for the SMI population. In this scenario, the PMPM for physical health for this population would be passed through from MMCPs to MHPs. Counties would then contract with hospitals and other health care providers for provision of physical health care services for the SMI population.

This would make it easier to provide whole person care to the SMI population by joining the full financial risk with the knowledge base of MHPs. This scenario would work best in counties where MHPs already have strong relationships with FQHCs and physician networks, a well-developed county clinic network, or a county organized health system with a county hospital.

Challenges – While this approach would better integrate health and mental health services under one system, it reinforces the segregation of SMI patients into county SMPs. This could have the consequence of further stigmatizing this population and complicate any transitions back to MMCPs should the model not work.

6.4 Longer-term Change: Full Integration by Ending the “Carve Out”

The most effective way to address the problems of siloed care is to consolidate the responsibility for delivering the full range of mental health services, from mild to severe, within a single entity. Such an approach would align incentives such that the entity paying for mental health services was encouraged to provide the best services at the lowest cost, including early intervention and care coordination that would reduce long-term costs and improve patient outcomes. The most ambitious and effective solution would be to integrate physical health, mild and moderate mental health, specialty mental health under a single entity, presumably MMCPs.⁵⁵

With a single entity responsible for all patient care needs, incentives in the system would encourage investments in early intervention to avoid more expensive crises in the future, care coordination to make sure that patients received the care they needed and followed through on referrals and treatment plans, and seamless exchanges of information among a patient’s many providers across networks.

Strong contracts would be necessary to support the influence of financial incentives on MMCP provision of quality behavioral health services.⁵⁶ A 2014 paper by the National Council for Behavioral Health, “Ensuring Access to Behavioral Healthcare through Integrated Managed Care: Options and Requirements,” emphasizes the need for extensive measurement of access and quality of care, especially for beneficiaries with SMI. States with such strong contracts include Kansas and Texas.⁵⁷ Kansas tied financial incentives to performance metrics that include

⁵⁵ For example, the state of Washington is currently integrating all health care services under its Medicaid managed care plans.

⁵⁶ Several interviewees argued that reliance on financial incentives would be insufficient to ensure quality coverage of behavioral health services by MMCPs. Others expressed skepticism that the financial incentives of population health management would provide sufficient quality assurance for behavioral health care, particularly for the SMI population. See section, “Managed Care Plan and Provider Organizational and Cultural Change to Integrate Behavioral Health,” for discussion of how MMCPs would need to change practices to provide quality care for SMI.

⁵⁷ Center for Health Care Strategies, Inc. 2016. “Integrating Behavioral Health into Medicaid Managed Care: Lessons from State Innovators,” <http://www.chcs.org/resource/integrating-behavioral-health-into-medicaid-managed-care-design-and-implementation-lessons-from-state->

five measures for SUD and eight measures for mental health (e.g. increased access to services, improvement in housing status of homeless SMI, and decreased utilization of inpatient psychiatric services).⁵⁸

The National Council for Behavioral Health paper also outlines optimal plan designs for MMCPs to take on behavioral health services. For example, a plan should identify individuals with SMI, SED, or serious SUD and track their care. The state should set higher capitation rates to account for the higher expense of these cases to prevent MMCP from discouraging their enrollment. And, states should require services provided in a recovery model, though some services may be excluded from the capitation rate and provided by braiding other funding streams.⁵⁹

More challenging than designing a strong contract and reorienting MMCPs toward a recovery model for beneficiaries with SMI are the institutional obstacles. Integrating all Medi-Cal health care services in California would be a Herculean task and would likely require a ballot initiative, legislative and regulatory actions, CMS approval, and actions by Boards of Supervisors, all of which pose political and administrative challenges.

First, such a “full integration” policy would require changes to both the 1991 and 2011 realignments to transfer fiscal control for mental health services back to the state.⁶⁰ Second, legislation would be required to assign responsibility for all mental health benefits to Medi-Cal managed care plans. Third, such a change in benefits and managed care requirements would necessitate several other contractual and regulatory changes. The state would have to submit an amendment to its Medicaid State Plan for approval by CMS.⁶¹ Under this full integration scenario, DHCS would amend its Medi-Cal managed care contracts, determine actuarially fair rates for the additional benefits, and assure that plans meet network adequacy for the entire spectrum of mental health services. Finally, a full integration plan would require DHCS to request from CMS a change to the 1915(b) Specialty Mental Health Waiver that currently carves out specialty mental health to the county MHPs.

Although these changes are substantial, they would not necessarily result in increased state costs to the extent current service levels are maintained. In fact, in the long run, it is likely that

[innovators/?utm_source=Integrating+Behavioral+Health+into+Medicaid+Managed+Care&utm_campaign=PH-BH+Brief+4-14-16&utm_medium=email](http://www.innovators/?utm_source=Integrating+Behavioral+Health+into+Medicaid+Managed+Care&utm_campaign=PH-BH+Brief+4-14-16&utm_medium=email)

⁵⁸ Kansas Department of Health and Environment, Division of Health Care Finance. 2015. “KanCare Final Evaluation Design,” March.

http://www.kancare.ks.gov/download/KanCare_Final_Evaluation_Design_Revised_March_2015.pdf

⁵⁹ National Council for Behavioral Health. 2014. “Ensuring Access to Behavioral Healthcare through Integrated Managed Care: Options and Requirements,” http://www.thenationalcouncil.org/wp-content/uploads/2014/11/14_Managed-Care-2.pdf

⁶⁰ “A Complex Case: Public Mental Health Delivery and Financing in California,” California HealthCare Foundation, 2013, <http://www.chcf.org/publications/2013/07/complex-case-mental-health>

⁶¹ California’s State Medicaid Plan (Title XIX).

<http://www.dhcs.ca.gov/formsandpubs/laws/pages/californiastateplan.aspx>

costs would be reduced as a result of investments in early intervention and prevention. In the near-term, utilization rates for physical health services for the SMI population could increase as a result of increased access to care, but these increases would likely be offset by long-term savings as a result of avoided hospitalizations and reduced emergency department use.

In spite of the large potential benefits, challenges in addressing the organizational inertia and political resistance from counties along with decades of policy-making around realignment mean that full systemic integration is a very challenging scenario, at least in the near-term.

Appendix A: Current Data Collection and Reporting Efforts

Current data collection and monitoring efforts can be leveraged to pursue the type of information needed to stimulate reform efforts. Evaluations of the Drug Medi-Cal pilot⁶², the Health Home Initiative, and Whole Person Care⁶³ will likely yield information on continuity of care, care coordination, and challenges unaddressed by the pilots. Since these pilots do not extend statewide and do not test changes in the underlying bifurcated structure that disrupts delivery of the full continuum of mental health services and physical health care for individuals with SMI, additional data collection could illuminate the need for integration at the payer level.

Most statewide efforts to collect data and develop public dashboards focus on the quality of services separately provided by MHPs and MMCPs. A resource for SMHP utilization data for children and youth is publically available. The DHCS Reports and Measures Catalog provides Performance Outcome System Reports for children and youth in the county Specialty Mental Health Plan system.⁶⁴ The measures were developed through a stakeholder process as required by the Welfare and Institutions (W&I) Code Section 14707.5 for EPSDT mental health services.⁶⁵ The measures include penetration rates, defined as the number of youth that received at least one specialty mental health service divided by the total number of youth Medi-Cal beneficiaries. Penetration rates are stratified by demographic characteristics. The utilization data further describe children arriving, exiting, and continuing services in a 2 year period and the time to next SMHP contact after inpatient discharge.⁶⁶ DHCS provides these data at the state and county level. Another Performance Outcome System Report aggregates Consumer Perception Surveys for youth or family members of youth ages 13-17 and limits reporting to the state level.⁶⁷

⁶² California Drug Medi-Cal Organized Delivery System: Proposed Evaluation. UCLA Integrated Substance Abuse Programs. June 2016. <http://www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf>

⁶³ California Department of Health Care Services. Whole Person Care Evaluation Design. November 2016. <http://www.dhcs.ca.gov/provgovpart/Documents/WPCDraftEvalDesign.pdf>

⁶⁴ "Reports and Measures Catalog," DHCS websites, <http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx>

⁶⁵ "Legislative Report: Performance Outcomes System Plan for Medi-Cal Specialty Mental Health Services for Children and Youth," May 2015, Submitted by the Department of Health Care Services, http://www.dhcs.ca.gov/individuals/Documents/POS_LegReport_05_15.pdf

⁶⁶ http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf

⁶⁷ "Performance Outcomes System Initial Reports," Report Run on August 11, 2015, http://www.dhcs.ca.gov/services/MH/Documents/20160412_POS_CPSReports.pdf

The Special Terms and Conditions from the 1915(b) waiver requires DHCS to post SMHP performance data on quality, access, and timeliness.⁶⁸ The Medi-Cal Specialty Mental Health Services (SMHS) Performance Dashboards provide summary data on key performance measures of County Mental Health Plans (MHPs), individually and statewide. Each dashboard includes information in the following domains: quality, access, and timeliness of SMHS, as well as information about the MHP's translation and interpretation capabilities and utilization data. Currently the dashboards are available for children and adults at aggregated at the statewide level. County reports are not yet available.

⁶⁸ "Medi-Cal Specialty Mental Health Services Performance Dashboards," DHCS website, http://www.dhcs.ca.gov/services/MH/Pages/SMHS_Performance_Dashboard.aspx