

Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members

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IN BRIEF

Effective coordination of physical and behavioral health services is critical to ensuring quality of care, particularly for low-income populations with high prevalence of chronic conditions and mental illness. Recent changes in how Medi-Cal, California's Medicaid program, promotes access to and coordination of mental health care provide new incentives for collaboration between two historically siloed systems: Medi-Cal managed care and county mental health. Based on lessons from implementing these changes, this brief describes promising practices to improve collaboration across systems, and to provide a more seamless experience of care for beneficiaries. These insights, while gleaned from California, can inform physical and mental health care integration in other states as well.

All over the country, policymakers, payers, and providers are increasingly aware of the need to better integrate physical and behavioral health care. At the state level, approaches to integration are taking different forms — some efforts consolidate the management of physical and behavioral health — including both mental health and substance use services — benefits through “carve-in” arrangements, while others are working to improve coordination and share accountability across separately managed systems.

California provides an example of both strategies in action. In 2014, the state rolled out a set of enhanced mental health benefits to be covered by Medi-Cal managed care plans (MCPs), creating a newly integrated benefit for individuals with mild-to-moderate mental health needs. Around the same time, the Cal MediConnect demonstration implemented new requirements and incentives for collaboration between Medi-Cal Medicare-Medicaid Plans (MMPs) and select county mental health plans (MHPs) for individuals with serious mental illness (SMI) who are dually eligible for Medi-Cal and Medicare.¹ Under both initiatives, health plans and counties needed to build new infrastructure and strengthen relationships to coordinate care more effectively for individuals with mental health needs, particularly since individuals' needs can fluctuate from mild to moderate to severe.

MEDI-CAL DEFINITIONS

- **Medi-Cal Managed Care Plans (MCPs):** Contract with the California Department of Health Care Services (DHCS) to manage physical and some behavioral health services for Medi-Cal members.
- **Medi-Cal Medicare-Medicaid Plans (MMPs):** Contract with DHCS and the Centers for Medicare & Medicaid Services under the Cal MediConnect financial alignment demonstration program to manage Medicare and most Medi-Cal benefits – including physical, most long-term services and supports, and some behavioral health services – for dually eligible Medi-Cal members who choose to enroll.
- **County Mental Health Plans (MHPs):** Contract with DHCS to manage specialty behavioral health services for Medi-Cal members who are eligible to receive care through the specialty system.
- **Managed Behavioral Health Organization (MBHO):** Contract with Medi-Cal MCPs to manage “mild-to-moderate” health benefit package; most MCPs that subcontract for these benefits work with Beacon Health Strategies (Beacon).

Based on experiences from implementing these Medi-Cal initiatives, this brief draws from interviews conducted with health plans, counties, and other system stakeholders to highlight promising practices for: (1) successfully integrating mental health benefits into health plan benefit packages; and (2) building partnerships between health plans and counties to coordinate care for individuals who receive treatment in the county mental health system.

Given the array of new Medi-Cal initiatives that will promote further physical-behavioral health integration — such as the Drug Medi-Cal Organized Delivery System and the Whole Person Care pilots under the Medi-Cal 2020 waiver — the lessons from these 2014 behavioral health reforms should continue to inform efforts to improve care coordination across health plan and mental health county-led systems. In addition, these insights may be relevant to initiatives in other states that are working to improve coordination of physical and behavioral health care.

Background

For the two decades before 2014, Medi-Cal-funded mental health services were almost exclusively provided through county MHPs, and were only available to members with serious mental health conditions and functional impairments. This meant that Medi-Cal members who did not meet medical necessity criteria to access county-based, specialty mental health services were limited to mental health treatment available from their primary care providers (PCPs).² In recognition of this treatment gap, and further spurred by enhanced behavioral health benefit requirements for the Medicaid expansion population, the California Department of Health Care Services (DHCS) expanded Medi-Cal mental health benefits in January 2014.³ The 2014 reforms added a new set of mental health benefits to be managed directly by the MCPs for members with *mild-to-moderate* mental health needs, while maintaining the separately managed county MHPs for *severe*, or specialty, mental health care.⁴ In July 2015, the 1915(b) waiver that authorizes this county-based carve-out of specialty mental health services was renewed for another five years.

EXHIBIT 1: Division of Mental Health Care Services between MCPs and County MHPs in California Since 2014⁵

System	Medi-Cal MCPs	County/MHP Outpatient	County/MHP Inpatient
Services Covered	When provided by a licensed mental health care professional acting within the scope of their license: <ul style="list-style-type: none"> Individual and group psychotherapy; Psychological testing used to evaluate a mental health condition; Outpatient services — medication monitoring; Outpatient laboratory, medication, supplies, and supplements; and Psychiatric consultation. 	<ul style="list-style-type: none"> Mental health services, including: assessment, plan development, therapy, rehabilitation, and collateral; Medication support services; Day treatment intensive and day rehabilitation; Crisis residential and adult crisis residential; Crisis intervention and stabilization; and Targeted case management. 	<ul style="list-style-type: none"> Acute psychiatric inpatient hospital services; Psychiatric health facility services; and Psychiatric inpatient hospital professional services if the beneficiary is in a fee-for-service hospital.

* Medications in the Medi-Cal MCP benefit exclude anti-psychotics. These are provided FFS and managed by DHCS.

Even before the January 2014 addition of mild-to-moderate mental health benefits, MCPs and county MHPs were required to establish Memorandums of Understanding (MOUs) to coordinate services for members receiving county specialty mental health services.⁶ However, the January 2014 reforms amended MOU requirements to address how plans and counties will coordinate mild-to-moderate and as well as specialty mental health services. Such agreements are intended to support MCPs and counties working together to ensure that members receive timely and medically appropriate mental health services. For example, under the 2014 benefit expansion, each MCP is

required to ensure that all members receive mental health screening by their PCP.⁷ Members with positive screening results may be treated by the PCP within the PCP's scope of practice (e.g., prescribing anti-depressants) or referred to a network mental health provider. If individuals appear to have a mental health condition that is beyond the PCP's scope of practice, the beneficiary is evaluated by a mental health provider using a tool identified in the MOU between the MCP and county. In some cases, primary care practices have hired or partnered with mental health providers to provide this screening onsite, as well as to deliver an array of mild-to-moderate services (e.g., brief intervention, counseling by LCSW). Once screened, if the level of impairment is deemed mild to moderate or the recommended treatment does not otherwise meet medical necessity criteria for the Medi-Cal specialty mental health services listed in Exhibit 1, then the MCP must provide access to outpatient mental health services through a contracted network provider. Meanwhile, members who screen positive for significant impairment, including those with uncertain diagnoses are uncertain, are referred to the county MHP.

Cal Medi-Connect

In April 2014, California began implementing Cal MediConnect as part of the federally authorized Financial Alignment Initiative for Medicare-Medicaid members. Under the program, contracted Medicare-Medicaid plans (MMPs) in participating counties receive a capitated payment to provide Medicare and most Medi-Cal services to eligible members. To avoid destabilizing the existing county-based behavioral health systems, Cal MediConnect maintains the mental health and SUD treatment carve-outs for enrolled members who meet medical necessity criteria to access specialty mental health and SUD services, and requires the MMPs to coordinate care with the county MHPs.⁸ Cal MediConnect MMPs provide mild-to-moderate mental health services for members who do not meet the criteria for specialty mental health services.

Until Cal MediConnect began in 2014, county MHPs did not have an official channel to access Medicare information or engage with Medicare providers. Cal MediConnect MMPs, county MHPs, and departments for alcohol and drug services must sign Cal MediConnect MOUs that seek to improve the alignment of behavioral health services for Medicare-Medi-Cal members and begin to bridge the gaps between Medicare and the county behavioral health system. These MOUs, which have similar requirements as those required between MCPs and MHPs, facilitate information sharing across acute care services covered by Medicare and the specialty mental health services to improve care for Medicare-Medicaid beneficiaries.

Opportunities to Inform Ongoing Integration Efforts

With the advent of several reforms to advance whole person care across service sectors in the Medi-Cal program, coupled with the carve-outs for specialty mental health and substance use treatment services, it is essential for MCPs, MMPs, and county entities to establish effective mechanisms for care coordination. The Medi-Cal reforms hold promise for expanding access to a broad continuum of behavioral health services for members who need them. However, to deliver on that promise, all stakeholders have to work together to mitigate systemic barriers to integration and ensure there is no wrong way to access care. The following sections summarize the relevant successes and challenges of implementing the mild-to-moderate mental health benefit in managed care plans and a continuum of mental health benefits across health plans and county providers. Findings from key informant interviews outline promising practices and current issues stakeholders continue to work through in managing these new benefits and improving collaboration across the Medi-Cal program for individuals with mental health needs.

Promising Practices for Incorporating the Mild-to-Moderate Mental Health Benefit

With only a few months between announcement and launch of the January 2014 changes, MCPs had to quickly decide how to incorporate the mild-to-moderate benefit into their existing benefit structure. Specifically, MCPs had to assess their capacity and organizational preference to either manage the new benefits internally or subcontract with a specialized managed behavioral health organization (MBHO). They also needed to develop strategies for working with physical and mental health providers, and for mitigating challenges with coordinating care on the ground. MCPs have employed an array of approaches to integrate the new benefits and communicate the changes to members and providers. Key insights from these experiences, as outlined below, can inform efforts to promote seamless, coordinated access to a broad array of behavioral health and social services that influence Medi-Cal members' overall health.

Promising Practices for Incorporating the Mild-to-Moderate Mental Health Benefit

1. Maximize collaboration with subcontractors
2. Leverage data to maximize accountability and coordination
3. Take time to build capacity before managing benefits internally
4. Streamline credentialing processes to ease provider burden and ensure access to services

1. Maximize collaboration with subcontractors

Due in part to the tight timeframe in which MCPs had to build their capacity to manage these new services, all but two of the plans interviewed (and the majority of plans statewide) chose to subcontract with an MBHO that had the clinical expertise, provider network, and administrative resources to manage the new benefit.[†] For plans without existing behavioral health infrastructure or that prefer to work with partners specializing in managing behavioral health benefits, subcontracting can be a valuable interim or long-term implementation strategy. Given the significant upfront financial and other resource investment involved, subcontracting can buy MCPs valuable time to develop this capacity internally.

MCPs and Beacon Health Options (Beacon), the principal MBHO partner among subcontracting MCP interviewees, spoke to the importance of aligning subcontracted activities with other internally managed operations to ensure smooth operations. For example, embedding subcontracted personnel on-site with other internal staff performing similar functions (e.g., utilization management) can enable close working relationships and facilitate ongoing communication. Accordingly, Beacon embeds staff on-site with MCPs as part of its standard practice.

In addition, establishing routine meetings and mechanisms for face-to-face communication between MCPs and Beacon can ensure that issues are addressed as they arise — such as in monitoring call wait times, network adequacy, timely payment of provider claims, and resolution of grievances and appeals. MCPs and Beacon alike report that their close contact was essential for the quick ramp-up of new members and new benefits and continues to be important for strong program management. One plan credits the joint provider outreach by MCPs and Beacon as key to building provider networks — particularly with safety net providers and tribal clinics that were already in the plans' primary care networks, but also had capacity to deliver behavioral health services.

In an environment that is increasingly focused on cross-system partnerships and coordination of services managed by separate agencies (e.g., medical, mental health, SUD, and social services), the practices outlined above can facilitate a seamless experience of care at the member level.

[†] Of the interviewees, all plans that chose to work with an MBHO subcontracted with Beacon Health Options.

2. Leverage data to maximize accountability and coordination

Medi-Cal MHPs that subcontract for mild-to-moderate mental health services must comply with an array of reporting and audit requirements to ensure effective oversight of delegated entities. Accordingly, subcontractors must submit encounter data at least monthly, as well as report key utilization metrics and network participation, among other requirements. Annual state audits review oversight practices such as meeting agendas and minutes, corrective action plans and associated follow-up. While there is a large degree of consistency in these requirements across programs, some variation exists based on which agency holds state-level oversight responsibility (e.g., Department of Managed Health Care for most MHPs, DHCS for some County-Organized Health Systems.)

Interviewees cited a number of best practices to maximize accountability and coordination through these reporting and data-sharing activities. For example:

- **At the state level**, aligning delegation and associated reporting requirements across state agencies and programs can reduce administrative burden and facilitate implementation of standardized reporting processes across entities.
- **Among MCPs**, integrating oversight of subcontractors within each functional area (e.g., medical management, care management) — as opposed to creating separate oversight units specific to delegated mental health services — can promote collaboration and more integrated management of physical and mental health benefits.
- **At the subcontractor level**, sharing encounter data with MCPs as frequently as weekly can ensure that plans have access to timely information on the continuum of member needs.

Despite the data-sharing requirements for delegated entities, there are no current mandates for routine data sharing and integration between MCP and county MHPs. Also absent are mechanisms for integrating data on anti-psychotic medications, which are covered under fee-for-service by DHCS. Interviewees agreed that integrating these data would significantly enhance opportunities for coordinated management.

In highlighting the critical role of data sharing between subcontractors and plans to promote integration, interviewees acknowledged that the process of merging data from different organizations can be time and resource-intensive, often competing for limited analytics resources with other organizational priorities. As the Drug Medi-Cal Organized Delivery System waiver rolls out, and as Whole Person Care pilots potentially look to integrate an even broader array of service data at the individual level, MHPs and county entities can leverage and perhaps further bolster existing analytic capacity to support data integration. Particularly given the potential to develop more accurate insights into member needs, such investments are likely to have a significant payoff.

As one health plan interviewee described efforts to improve mental health benefit coordination: “We have ‘outdated plumbing’, like the old days with separate hot and cold faucets and you have to put the water in the mixing bowl to get the right temperature. We can’t expect DHCS to continue to be the mixing valve to turn on spigots of funding in different areas and expect the member to run around to collect the aspects of care that they need. The system needs to evolve more rapidly toward getting the mixing valve closer to the member. We’re moving in that direction, piece by piece.”

3. Take time to build capacity before managing benefits internally

Despite many of the plans’ initial decisions to subcontract, managing mental health benefits internally is a common long-term goal. Before the new benefits were announced, Inland Empire Health Plan (IEHP) had been developing its internal capacity to manage mental health services over several years. In 2010, recognizing the significant opportunity to reduce administrative costs associated with subcontracting for certain business lines, IEHP began moving the management of mental health benefits internally, including for its Medicare and Healthy Families members. By 2014,

IEHP was well positioned to leverage its existing infrastructure from these efforts to bring in the mild-to-moderate mental health benefit for Medi-Cal members.

With 2016 marking the third year of mild-to-moderate mental health benefit implementation, IEHP's experience provides valuable insights for other plans that might be considering moving subcontracted benefits in-house in the future. Reflecting on its own efforts, IEHP leadership suggests that plans take two to three years to build internal capacity before taking on direct management of behavioral health benefits. IEHP leadership further credits the success of this gradual and ongoing effort to:

- **Garnering executive leadership support for the myriad of systems changes that needed to be developed and implemented:** During this key time of transition when IEHP first integrated behavioral health benefits into its service array, a behavioral health integration "SWAT team" met weekly, including the health plan CEO and chief medical officer.
- **Investing in staff training and development:** In addition to hiring clinical staff to provide behavioral health expertise, IEHP also invested in extensive bi-directional training, in which existing staff learned about providing mental health benefits while newly hired behavioral health staff were educated about IEHP administration and physical health services to foster internal integration and shared understanding.
- **Building key elements for a mental health infrastructure, including:**
 - Hiring staff with appropriate clinical expertise;
 - Developing utilization and medical management protocols;
 - Assembling adequate provider networks;
 - Upgrading IT systems; and
 - Fostering an internal culture of integration.

4. Streamline credentialing processes to ease provider burden and ensure access to services

The 2014 reforms required plans to quickly create new provider networks for mild-to-moderate mental health care. As a result, MCPs and Beacon needed to implement streamlined processes for provider credentialing that would increase provider participation and allow members to begin receiving services as soon as the new entitlement went into effect. This need was all the more acute considering the mental health provider shortages throughout much of the state. The credentialing strategies undertaken by MCPs were designed to ensure access to services during the rollout of the new benefit as well as to help reduce administrative burdens and broaden member access to services.

For example, Partnership Health Plan (PHP) allowed Beacon flexibility in provider credentialing during the initial rollout of the mild-to-moderate mental health benefit. Because new providers were being quickly integrated into the PHP provider network, Beacon could not credential the providers before they began seeing patients. Providers signed interim agreements with Beacon to provide services while the official credentialing process was taking place. This allowed PHP members to receive mental health care unimpeded by administrative processes. Meanwhile, San Diego County assured timely credentialing by working with its MCPs to establish a single credentialing authority. For counties with several plans, streamlining credentialing processes can ensure that providers are ready when needed to treat consumers and improve access to services. This approach is also consistent with new federal Medicaid managed care regulations that would establish minimum provider credentialing standards, with the goal of reducing duplicative efforts by individual MCPs.⁹

Promising Practices for Establishing Medi-Cal Managed Care Plan-County Partnerships

The policy changes enacted in 2014 have placed a new premium on effective collaboration between health plans and counties. The increasing focus on high-cost populations reinforces the need for improved care coordination for individuals with SMI, particularly given recent Medi-Cal data highlighting the prevalence of SMI among the highest utilizers of hospital and emergency department services.¹⁰ Furthermore, the Cal Medi-Connect demonstration introduced a new concept to test health plan-county collaboration: shared accountability. The MOUs required between MMPs and MHPs included provisions under which both entities are eligible to earn incentive payments if they meet quality metrics that advance care coordination across the systems, such as decreased rates or emergency department utilization for individuals with SMI.

Health plans and county partners needed to invest significant resources to build relationships and develop new processes, particularly for determining which system bears responsibility for treating an individual member, managing transitions in care across systems based on members' changing needs, and ensuring coordination of physical and behavioral health care services. These investments will need to continue as new reforms under Medi-Cal 2020 are implemented. In particular, the Drug Medi-Cal Organized Delivery System, Medicaid Health Homes, and the Whole Person Care pilots all demand increased collaboration between MCPs, counties, and providers to better coordinate substance use disorder treatment and social service delivery (such as housing and related supports) with other physical and mental health services. As the 2014 reforms have demonstrated, coordinating care across multiple systems requires the development of new tools, infrastructure, and communication strategies to address systemic barriers to integration. Following are several approaches that can be useful in addressing both ongoing and emerging system needs.

Promising Practices for Establishing Medi-Cal Managed Care Plan-County Partnerships

1. Establish clear definitions for mild-to-moderate and severe
2. Establish clear policies and procedures to facilitate smooth transitions across systems
3. Develop tools and infrastructure to facilitate data exchange
4. Collaborate on outreach strategies for members and providers
5. Mitigate philosophical and organizational differences between physical and mental health systems and providers

1. Establish clear definitions for mild-to-moderate and severe mental health needs

Although medical necessity criteria for accessing specialty mental health services through the county MHPs have existed for many years (see Exhibit 2), the criteria leave substantial room for interpretation. Most counties have independently defined the threshold for determining "significant impairment." The availability of covered services for individuals with mild-to-moderate mental health conditions created the need to distinguish between individuals with moderate versus severe needs. Without exception, MCP/MMP interviewees commented on the wide variation among counties in determining eligibility for specialty services. There are particular challenges for health plans operating across multiple counties, each with their own definitions.

Because members may move in and out of needing a particular level of care, determining who qualifies for which level of care at a given point presents a care coordination challenge for many plans and providers. It also exacerbates a key limitation of the current Medi-Cal system design — whereas separate delivery system and management approaches for mild-to-moderate and severe might work well for a statically defined population, the acuity of an individual's behavioral health needs is inherently dynamic. Interviewees noted that it is difficult to define a "bright line" between mild-to-moderate and severe at any point in time on an individual basis. It is even more challenging when the distinctions differ based on which county one lives in. To mitigate the challenges

associated with establishing this "bright line," interviewees cited the need to establish a clear understanding between health plan and MHP partners in each county about where the line between moderate and severe would be drawn.

EXHIBIT 2: Eligibility for County MHP Reimbursement of Specialty Mental Health Services

A beneficiary is eligible for services if he or she meets all of the following criteria:

- Meets medical necessity for one or more included diagnoses for a serious mental illness;¹¹
- Has a significant impairment in an important area of life functioning, or a reasonable probability of significant deterioration in an important area of life functioning / a reasonable probability of not progressing as individually appropriate (for members under 21 who meet criteria for EPSDT);
- The focus of the proposed treatment is to address the impairments;
- The expectation that the proposed treatment will significantly diminish the impairment, thus preventing significant deterioration in an important area of life function; and
- The condition would not be responsive to physical health care-based treatment.

San Diego County and its health plan partners have worked collaboratively to clearly define a common language for what constitutes *mild-to-moderate* versus *severe* mental health needs. From this framework, they created a severity analysis grid, which is used to determine a patient's needed level of care, especially when deciding whether to transition a patient from one level of care to another. Similarly, LA Care collaborated with the Los Angeles County MHP to jointly develop a screening tool to help determine if a patient should receive *mild-to-moderate*, *severe*, and/or drug Medi-Cal services. So long as a psychiatrist, PCP, or Beacon intake specialist uses this tool to screen a patient, the plan or county cannot dispute the patient's status. Ideally, over time, consortia of plans and counties could develop common definitions and protocols that transcend county lines and streamline efforts to coordinate care at the regional or state level.

2. Establish clear policies and procedures to facilitate smooth transitions across systems

Transitioning patients across MCP/MMP and county-managed behavioral health systems poses challenges to all involved — most significantly to the members themselves. Interviewees identified an array of emerging practices to ensure that members do not encounter service disruptions as their needs fluctuate between mild-to-moderate and severe:

- Use a transition of care form that the health plan or county can initiate to begin discussions about shifting an individual's care back to the health plan if needs have been stabilized, or to the county system if more intensive treatment is required;
- Allow patients to continue receiving care from the MCP/MMP if the county temporarily does not have space or if there is a categorization or billing dispute;
- Integrate providers in community-based clinics into the health plan's network to ensure patients are not required to change providers in order to receive mental health services;
- Permit patients to receive care with their PCP if they express resistance to receiving care from the county;
- Ensure that support services not covered by Medi-Cal are not dropped when a patient transitions out of county services; and
- Encourage patients to see transitioning into plan-provided services as a step to work toward in the recovery process.

San Diego County uses its Access & Crises Line to assist MCPs and their providers with the referral process. This streamlines an often time-consuming or inefficient referral process, and increases the likelihood that providers will play an active role in helping patients access the care they need. Where available, information about specialty mental health program walk-in hours is included with the provided contact information. The MCPs have been valuable partners for the county in educating their network providers about how to access and use the referral line.

More generally, as MCPs and counties expand their collaboration to a broader array of behavioral health and social service provisions, clear definitions and mutual understanding of which system is responsible for what and for whom will be essential to ensuring accountability and coordinating care effectively.

3. Develop tools and infrastructure to facilitate data exchange

A fundamental component of integrated care is the ability for payers to facilitate information exchange about physical and behavioral health diagnoses and services among all providers involved in an individual's care. The systematic exchange of physical and behavioral health information can be critical to support population health management efforts. However, a number of barriers exist that prevent seamless data exchange across separately managed systems, including:

- Philosophical differences among physical and mental health providers about data privacy;
- Constraints imposed by federal and state privacy laws such as HIPAA and 42 CFR Part 2; and
- Lack of interoperability and varying levels of information technology capability among MCPs and counties.

All interviewees acknowledged these challenges and described several joint MCP-county activities underway to mitigate. As a first step, plans and counties have been collaborating to address information sharing at the individual patient level. Accordingly, most plans and counties have already or are in the process of developing standard release of information forms, though there are differing viewpoints about the circumstances under which the releases need to be signed. The releases facilitate care coordination during in-person or phone meetings, but simply having releases signed does not ensure systematic and timely information exchange across systems and treating providers. This larger vision requires considerably more interoperability across information systems than exists today — particularly given that some providers or counties continue to use paper files rather than digital records.

However, plans and counties are beginning to develop solutions to enable more seamless information exchange, even where electronic health records are not widely available. IEHP, for example, has granted mental health providers in one of its counties access to its web-based provider portal system and is in the process of linking the county to the system as well. In turn, the county is building “crosswalks” from its system to IEHP's to eliminate redundant work. This system also alerts PCPs when there is a mental health report available and tracks whether or not the PCP downloads the report, allowing IEHP to target its provider education and outreach efforts accordingly. Another plan has created a platform that allows Beacon employees to pull up general information about a beneficiary's primary care without having to contact PCPs.

MCPs and counties have also effectively exchanged information by employing designated staff to serve as contacts for providers' and members' questions. LA Care employs staff specifically to coordinate between counties, Beacon, and physical health care providers. Likewise, San Diego County has a staff member dedicated to coordinating data.

4. Collaborate on outreach strategies for members and providers

As plans added new mental health benefits, reaching out to their members to clearly explain the changes was critical to support access to and use of the new services for eligible beneficiaries. Likewise, plans noted that clear communication with providers about new policies and procedures that affect their day-to-day responsibilities (e.g., billing, working with care coordinators) was essential to making the system work.

Counties can be valuable partners in this outreach effort, helping to educate consumers and providers about system changes and how to contact MCPs to access services. For example, San Diego County created cards with contact information for each plan, including phone numbers for physical health, mental health, transportation, and member services. Health Plan of San Joaquin sent out provider alerts explaining the new benefits and suggestions for how providers could build relationships with Beacon. In its provider education, Health Plan of San Joaquin emphasized the opportunities for increased access to mental health services, including telephone consults with psychiatrists.

5. Mitigate philosophical and organizational differences between physical and mental health systems and providers

Health plans and counties operate with different practices and procedures and are often driven by different incentives. Developing working relationships that include all perspectives equally is an important, ongoing collaborative effort. Interviewees noted that at times, adopting a whole person care mindset in which treatment plans are driven by both medical care and mental health can require “letting go of the reins” — which can be challenging for both systems. Counties need time and training to build knowledge about managed care contracting and operations, while many health plans have a learning curve with recovery-based models of care for individuals with mental health needs.

There are also differing standards and viewpoints for data sharing and privacy, with mental health system stakeholders generally more sensitive to issues of privacy and stigma than their physical health care system counterparts. Interviewees discussed approaches they employed to address these differences, including:

- Engage leadership as champions to demonstrating their commitment to effective coordination;
- Invest in outreach and education efforts for internal staff, providers, and members;
- Explain to members the benefits of information sharing as an important component of supporting recovery-focused care using clear communication strategies; and
- Develop personal and trusting relationships with partners across and members enrolled in the systems.

Several interviewees noted that bringing all parties to the table early and often — e.g., to discuss mutually acceptable standards for sharing information — is key to an integrated system’s success, and an ongoing focus. Many health plan and county partnerships have instituted regularly scheduled in-person meetings for staff at all levels to support this continuing dialogue. In some instances, plans’ chief executive officer or chief medical officer participate in the conversation and ensure that leadership understands the change processes. These forums can be used to develop and refine processes and procedures, build relationships, and address particularly challenging cases. In particular, these meetings are sometimes used to help determine if patients should be re-considered for specialty mental health services or if they no longer need that level of care.

Similarly, interviewees acknowledged several philosophical and organizational differences that exist at the provider level. For example, mental health providers who are newly contracting with MCPs/MMPs needed time to get acclimated to operating in a managed care environment — including how to get credentialed, how to bill and get paid on time, and how to manage reporting requirements.

Several interviewees noted that physical and mental health providers have their own terminologies and approach to treatment and recovery differently. Much like issues at the plan level, physical health providers are more likely to rely on medical models with set treatment parameters. In contrast, mental health providers' recovery-oriented model views outcomes on a continuum and relies more heavily on consumer-driven treatment decisions. A few plans regularly facilitated discussions across providers—via structured trainings or informal meetings or phone calls as issues arose—to help assuage conflicts and develop relationships among providers who cared for the same members. Plans can also oversee provider efforts to improve communication. One plan monitored PCPs' documentation of coordination with mental health providers when members presented with mental health concerns to ensure communication and coordination were occurring.

Conclusion

Health plans, counties, and other stakeholders have worked hard to adapt to the changing mental health care landscape in California by implementing new requirements that increase beneficiary access to mental health services and more effectively coordinate physical and mental health care. System partners are developing approaches to bolster cross-collaborative relationships, improve coordinated care planning and management, and promote information exchange across systems. There are some limitations with how far the system might progress under the current design for mental health services that distinguishes between mild-to-moderate and severe conditions, but stakeholders are hopeful that the series of reforms underway will facilitate a transition to a more integrated system across program partners and the full spectrum of behavioral health conditions. Current efforts provide a strong foundation and promising practices for Medi-Cal stakeholders to replicate and expand upon to continue to improve physical, behavioral health, and social service coordination efforts in the future.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

- ¹ The seven counties are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
- ² S. Arnquist and P. Harbage. "A Complex Case: Public Mental Health Delivery and Financing in California." California Healthcare Foundation, 2013.
- ³ Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013), effective January 1, 2014, mental health services included in the essential health benefits package adopted by the State, pursuant to Health and Safety Code Section 1367.005 and the Insurance Code Section 10112.27, and approved by the United States Secretary of Health and Human Services under Title 42, Section 18022 of the United States Code.
- ⁴ California Department of Health Care Services (2013). "All Plan Letter 13-021." Available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf>.
- ⁵ Ibid.
- ⁶ Title 9, Chapter 11—Medi-Cal Specialty Mental Health Services Regulations. 1810.370. MOUs with Medi-Cal Managed Care Plans.
- ⁷ Ibid.
- ⁸ M. Herman Soper and B. Ensslin. "State Approaches to Integrating Physical and Behavioral Health Service." Center for Health Care Strategies, 2014.
- ⁹ 81, no. 8 *Fed. Reg.* 27498-27901 (May 6, 2016). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.
- ¹⁰ DHCS - Research and Analytic Studies Division. *Understanding Medi-Cal's High Cost Populations*. March 2015. Available at: <http://www.chcs.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20D/PDF%20DataSymposium03042015Watkins.pdf>.
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