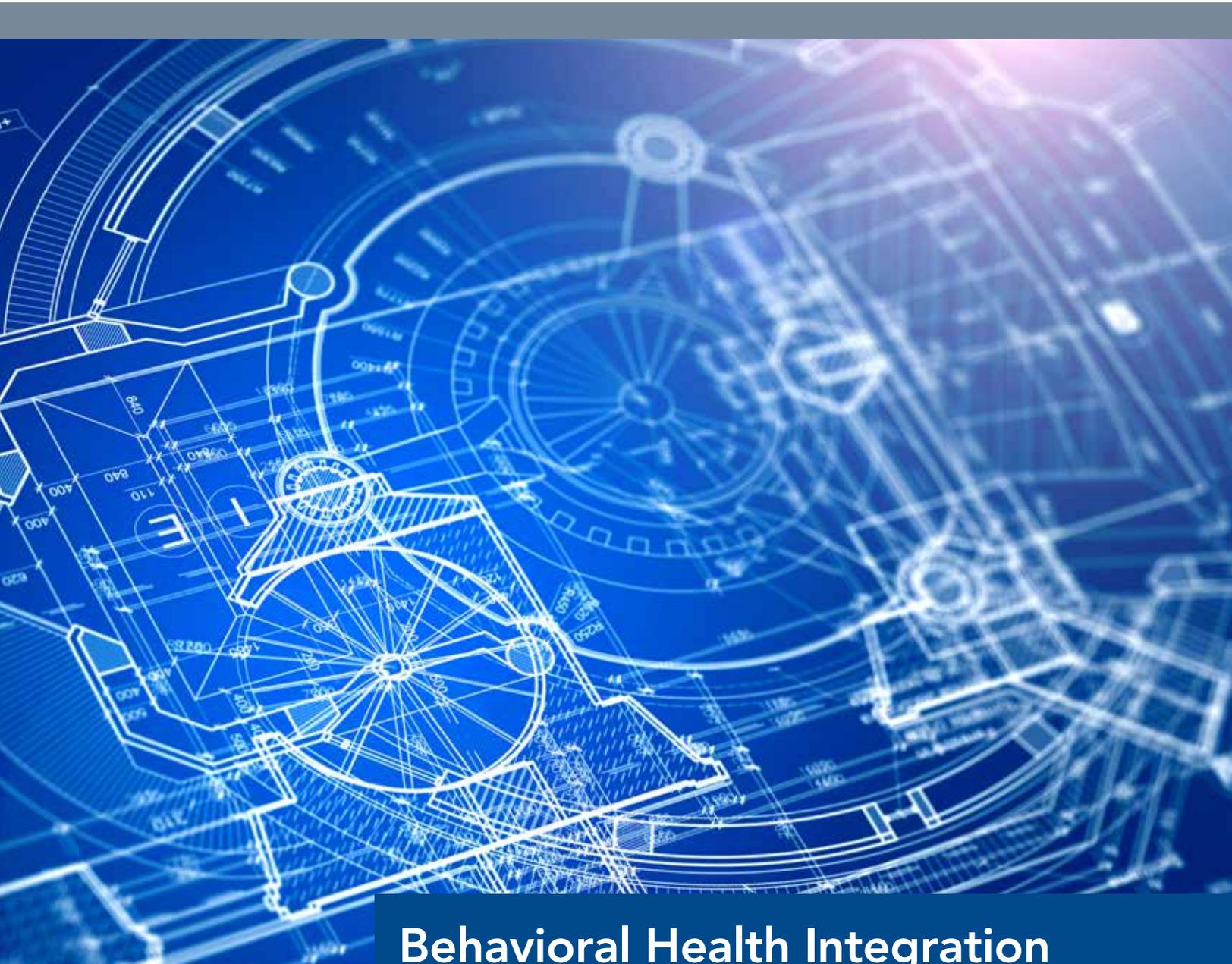




California  
Health Care  
Foundation



# Behavioral Health Integration in Medi-Cal: A Blueprint for California

FEBRUARY 2019

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# Executive Summary

People with behavioral health — mental health and/or substance use disorder — conditions often experience poor health across all domains. While they have higher rates of major chronic illnesses, they are less likely to receive preventive care and often experience a lower quality of care for their physical health needs. Individuals with a diagnosis of serious mental illness (SMI) or substance use disorder (SUD) die on average over 20 years earlier than individuals without such a diagnosis, often from preventable physical illnesses. People with behavioral health diagnoses incur costs that are four times greater than those without, with the difference largely attributable to increased physical health care spending. Among the over 13 million California residents who receive care from the Medi-Cal program, 5% of enrollees account for over half of all spending — and 45% of this high-cost population has a diagnosis of SMI. And, in California as in other states, mental illnesses and SUDs are more prevalent in people with lower incomes.

This paper puts forth an ambitious framework to transform a fragmented system in California in which Medi-Cal enrollees with complex behavioral and physical health needs often fail to receive needed care that must be coordinated across multiple and disparate service delivery systems. This framework builds on areas of strength within the current structures while addressing the systemic barriers to improving care due to the current organization, financing, and administration of physical health care, mental health care, and SUD care in Medi-Cal.

The disparate funding streams and decentralized structures of behavioral health care in Medi-Cal have evolved over decades through a series of legal, political, and financial arrangements. As a result, most beneficiaries who need care for chronic physical, mental health, and SUD issues confront three systems:

- ▶ Managed care plans for physical health services and for non-specialty mental health services
- ▶ County mental health plans for specialty mental health services

- ▶ County Drug Medi-Cal for SUD services, either through the Drug Medi-Cal Organized Delivery System pilot programs or through the traditional (and more limited) standard Drug Medi-Cal programs.

The disconnected responsibilities for these services limit the incentives for each entity to invest in whole-person care as well as prevention and early intervention across the continuum of needs. Fragmentation in the current system often results in critical disruptions in care and a lack of care coordination, which lead to poor health and social outcomes as well as increased health care costs.

It is an axiom in health care that every system is perfectly designed to get the results it achieves. In Medi-Cal, if California aims to meaningfully improve outcomes for people with behavioral health needs, the systems that serve them must be redesigned. Effective redesign must address three pervasive challenges: (1) fragmentation of physical and behavioral health care for people with SMI and/or SUD, particularly for those with co-occurring chronic physical diseases; (2) disparate systems of mental health care for mild to moderate versus severe levels of need; and (3) separation of mental health and SUD services for people needing both types of services.

The recommendations in this paper were developed through a series of three meetings held between June and October 2018 and attended by leaders with deep experience in county behavioral health departments, behavioral health provider organizations, state agencies, Medi-Cal managed care plans, consumer advocacy, policy research, and philanthropy (the “work group”). The meetings were informed by presentations from leaders from other states on different approaches to behavioral health integration in Medicaid, as well as synthesized interview findings from a broad group of California stakeholders.

**Integrated care.** The delivery, coordination, and payment for care related to the full continuum of an individual’s physical and behavioral health needs, as managed by a single accountable entity.

## Guiding Principles

The work group developed a core set of guiding principles for an integrated system of physical and behavioral health care that would lead to better outcomes for enrollees.

- ▶ Provide an accessible and well-coordinated continuum of care, from prevention to recovery services.
- ▶ Deliver person- and family-centered care that is culturally responsive and advances health equity.
- ▶ Promote hope and wellness while building on individual, family, and community strengths.
- ▶ Deliver high-quality services across care settings while ensuring choice in the care provided.

With these principles in mind, and with consideration of experience in California and in other states' Medicaid programs, the work group established a clear goal to guide system redesign, as well as nine recommendations to achieve this goal.

## Goal

By 2025, all Medi-Cal enrollees will experience high-quality, integrated care for physical health, mental health, and substance use needs, with all of an individual's care managed by a single entity accountable for payment, administration, and oversight.

## Recommendations

1. Assign responsibility for physical and behavioral health services to Medi-Cal managed care plans, while allowing delegation to interested counties and/or regions to the extent that such partnerships meet a single statewide standard for integration, quality of care, and accountability.
2. Implement statewide integrated care for Medi-Cal enrollees through a phased process beginning in 2020 and completed by 2025, in order to foster a transition that ensures continuity of care and promotes long-term sustainability.
3. Ensure that accountable entities develop the internal capacity, expertise, and infrastructure required to effectively manage integrated physical and behavioral health care.
4. Identify immediate and long-term opportunities to reform existing state and local behavioral health funding mechanisms, statutes, regulations, and/or other policies to promote the delivery of integrated care.
5. Incorporate principles of risk and value-based payment into the financing of behavioral health services in order to align incentives with desired outcomes.
6. Engage stakeholders to ensure that accountable entities are responsive to individual and community needs, and that the new system of integrated care delivers on the promise of improved consumer and family outcomes.
7. Foster integrated physical and behavioral health care for dual eligible enrollees by promoting the alignment of Medicare and Medi-Cal benefits in accountable entities.
8. Establish standard process and outcome measures and accountable, transparent systems to monitor and evaluate the ongoing impact of integration across the state.
9. Strengthen the behavioral health workforce to ensure access to high-quality care during and after the transition to integrated care.

These ambitious recommendations aim to ensure that Medi-Cal enrollees and families receive the prevention, treatment, and recovery services needed to achieve their health and quality-of-life goals. As informed by the approaches of other states in tackling the challenges of poor health outcomes and high costs for individuals with complex physical and behavioral health needs, this paper describes an achievable statewide pathway toward integrated care delivery by 2025. California now has the opportunity to take bold action to become a national leader in improving the health and well-being of Medi-Cal enrollees. Grounded in principles of recovery, equity, choice, and transparency, these recommendations point to a system that is far more capable of producing desired outcomes for Medi-Cal enrollees with behavioral health needs, and for California as a whole.

The recommendations in this paper were universally endorsed by the members of the work group, who represent a broad array of stakeholders and regions across the state:

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# Introduction

A recent poll released by the California Health Care Foundation and Kaiser Family Foundation showed that approximately half of all Californians think that people with mental health or alcohol or drug problems do not receive the services that they need.<sup>1</sup> Notably, these percentages are higher among respondents who have themselves sought behavioral health services. Medi-Cal enrollees with physical and behavioral health needs must navigate multiple separate systems to receive needed care — often leading to confusion that may hinder access to care, stress, and increased health care costs.

This paper puts forth recommendations to build an integrated system of care in Medi-Cal — one that brings together physical health, mental health, and substance use services to treat the whole person. Currently, Medi-Cal enrollees with complex behavioral and physical health needs often fail to receive needed care because they must seek it across multiple disconnected service delivery systems. The framework proposed in this paper builds on areas of strength within the current structures, while addressing the systemic barriers to improving care due to the current organization, financing, and administration of physical health care, mental health care, and substance use disorder (SUD) care in Medi-Cal.

The disparate funding streams and decentralized structures of behavioral health care in Medi-Cal have evolved over decades through a series of legal, political, and financial arrangements. As a result, most enrollees who need care for chronic physical, mental health, and SUD issues confront three separate systems. Navigation across these systems is typically left to the consumer to figure out.

Looking from the systems level, the disconnected responsibilities for health services in Medi-Cal limit each entity's incentives to invest in whole-person care, preventive care, and early intervention across the continuum of needs. Fragmentation in the current system often results in critical disruptions in care and a lack of care coordination, which lead to poor health and social outcomes, as well as increased health care costs.

It is an axiom in health care that every system is perfectly designed to get the results it achieves. In Medi-Cal, if California aims to meaningfully improve outcomes for people with behavioral health needs, the systems that serve them must be redesigned accordingly.

# Background

**People with behavioral health conditions experience worse health and social outcomes.** People with behavioral health conditions are more likely to experience chronic physical conditions, poor social outcomes, and early mortality. They have higher rates of major chronic diseases, such as diabetes, cancer, asthma, and hypertension — and an elevated risk for modifiable health risk behaviors, such as tobacco use and poor nutrition, which further increases their likelihood of developing chronic physical illnesses.<sup>2</sup> Individuals with behavioral health conditions are less likely to receive preventive health care than people without these conditions, and often receive lower-quality physical health care.<sup>3</sup> Behavioral health conditions are also associated with increased rates of homelessness, unemployment, poor educational performance, and involvement with the criminal justice system.<sup>4</sup> People with serious mental illness<sup>5</sup> (SMI) die on average 25 years earlier than those without SMI, and people with a drug dependence diagnosis die on average 22.5 years earlier than individuals without such a diagnosis — often from preventable physical illnesses.<sup>6</sup>

People living in low-income households are more likely to have serious behavioral health needs. Recent data showed that 4% of California adults have an SMI, whereas 9% of those living at or below the federal poverty level (FPL) and 6% of those with incomes between 100% and 200% FPL have an SMI diagnosis.<sup>7</sup> While 7% of all California children had a serious emotional disturbance (SED), the prevalence was 10% among children living in households at or below the poverty line.<sup>8</sup> And, while 8% of California residents met criteria for substance use disorder (SUD), people with a serious mental health diagnosis are more at risk to experience an SUD — over 34% of adults with SMI and over 9% of children with an SED have a co-occurring SUD.<sup>9</sup>

**High health care costs associated with behavioral health diagnoses.** These poor health and social outcomes often lead to high health care costs. Nationally, people with behavioral health diagnoses comprise 20% of the Medicaid population but incur 48% of all spending, with spending per enrollee that is four times greater than those without a behavioral health diagnosis.<sup>10</sup> These costs are largely attributable to increased physical health care spending. For example, one study found over 80% of the increased costs for people with comorbid mental and physical health conditions were associated with physical health expenditures.<sup>11</sup>

Under the current systems of care, Medi-Cal enrollees who incur the highest costs disproportionately have behavioral health conditions. Among the most costly 5% of Medi-Cal enrollees — who account for over half of all Medi-Cal spending — 45% have a diagnosis of SMI, more than double the percentage with diabetes. The total monthly cost of care for Medi-Cal enrollees with diabetes who receive SUD treatment is 60% higher than for enrollees who do not receive this treatment, and that total monthly cost is 250% higher for individuals receiving treatment for both SMI and SUD.<sup>12</sup>

**Fragmentation of physical and behavioral health services.** In California and across the country, many Medicaid enrollees with complex behavioral and physical health needs are served by multiple systems — one that manages their physical health care, and separate systems that manage mental health and SUD services — resulting in a lack of care coordination across systems and poor health outcomes.

Fragmentation of physical and behavioral health services has been shown to result in poor health status and increased health care costs.<sup>13</sup> Co-occurring physical and behavioral health conditions may interact and lead to a worsening of symptoms and health outcomes.<sup>14</sup> People with physical and behavioral health needs have often experienced a lack of understanding among their providers of the relationship between their physical and behavioral health disorders, and may be prescribed multiple and potentially conflicting medications that result in side effects or adherence challenges.

**Integrating clinical delivery through systems integration of physical and behavioral health care.** Integrating the clinical delivery of physical and behavioral health services — often through expanding access to behavioral health care in primary care settings — has been demonstrated to improve health outcomes, significantly reduce health care costs, and promote patient-centered care.<sup>15</sup> Despite these positive outcomes and cost savings, states encounter many barriers to promoting integrated care at the clinical level because of siloed systems of financing physical, mental health, and substance use care. Therefore, many states are pursuing system integration approaches designed to support clinical integration and enable statewide transformation to improve health outcomes for Medicaid enrollees with behavioral health needs.

Increasingly, states are advancing system integration in Medicaid by pursuing initiatives to “carve in”<sup>16</sup> behavioral health benefits to be managed as part of comprehensive managed care contracts.<sup>17</sup> Variations in state approaches offer useful lessons to inform California’s Medi-Cal behavioral health integration strategy, and three state case studies are detailed further in Appendix A.

# California's Care System

California was the first state in the country to pilot managed care in its Medicaid program, beginning in the 1970s, and over time has moved the large majority (over 80%) of enrollees, including children, adults, seniors, and people with disabilities, into managed care plans. The management of mental health and SUD care in Medi-Cal also has evolved over decades through changes to the administration, delivery, and funding of behavioral health services. The current system includes disparate funding streams and a decentralized structure to manage and deliver services across multiple entities, often resulting in a fragmented experience of care for Medi-Cal enrollees with physical and behavioral health needs.

Medi-Cal enrollees receive health services managed by multiple entities, depending on their behavioral health needs. These include the following:

- ▶ Managed care plans (MCPs), which contract with the state to manage all physical health services as well as mental health services for individuals with mild to moderate mental health needs.
- ▶ County mental health plans, which contract with the state to manage specialty mental health services for adults and children who have a covered diagnosis and meet criteria for impairment and intervention, which include less stringent criteria for children consistent with the Early and Periodic Screening, Diagnostic, and Treatment benefit.
- ▶ County alcohol and drug programs, including counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS)<sup>18</sup> pilot program as well as counties providing standard Drug Medi-Cal state plan services. While Drug Medi-Cal services were administered and paid for by counties through state contracts, under DMC-ODS counties serve as managed care plans with increased responsibilities for access to care and coordination with other systems of care.<sup>19</sup>

Integration of care for Medi-Cal enrollees must therefore take place on three levels: (1) integrating physical and behavioral health care for people with SMI and/or SUD, particularly for those with co-occurring chronic physical diseases; (2) integrating mental health care across the continuum of need from mild to severe; and (3) integrating mental health and substance use disorder services for people needing both types of services.

Implementing integration at each of these levels is complicated by the complex landscape of funding, administration, and delivery of physical and behavioral health services across California's 58 counties. The models of MCPs vary by county, and in their provision of specialty behavioral health services, the counties also vary in their utilization of county-operated services versus contracted external providers, interpretation of eligibility requirements, screening and assessment practices, service availability, populations served, and average spending per person.<sup>20</sup> Health plans and counties use varied screening tools to determine whether an enrollee meets criteria to be served by a county mental health plan, resulting in widely disparate access to services across counties for an enrollee presenting with the same symptoms.<sup>21</sup>

**System history and authorities.** Originally established by the Short-Doyle Act in 1957, California's county-based mental health system has evolved over time — as has coverage for mental health conditions across the continuum of need. The first Section 1915(b) Medi-Cal Specialty Mental Health Services Waiver was approved in 1995 and modified in 1997, enabling the state to develop county mental health plans to manage and deliver specialty mental health services.<sup>22</sup> This type of waiver allows the state to waive freedom of choice and provide services through managed care, and covers all Medi-Cal enrollees that meet criteria for eligibility for specialty mental health services. The Section 1915(b) waiver was most recently reappraised for a five-year period extending through June 30, 2020. Additionally, federal and state legislation and regulations have expanded covered benefits and eligibility for mental health services, including the 2014 expansion of Medi-Cal MCP benefits to include treatment for mild to moderate mental health conditions.

Substance use disorder services in Medi-Cal have been delivered through county alcohol and drug programs as part of the standard Drug Medi-Cal state plan services. The Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program, approved in 2015, was the first in the country to leverage new federal Section 1115 waiver authority to pay for residential treatment as part of a broader continuum of SUD treatment. DMC-ODS authority was ultimately absorbed into California's broader Medi-Cal 2020 waiver, which was also approved in 2015 and includes the Whole Person Care Pilots to coordinate physical health, behavioral health, and social services for specific target populations.

As both the Section 1915(b) and Section 1115 waivers expire in 2020, California now has a unique opportunity to develop a comprehensive, statewide approach to implementing an integrated system of care that helps all Medi-Cal enrollees and families to achieve their health and quality-of-life goals. The pathway to implementation outlined in the recommendations in this paper leverages the strengths of the existing system and lessons from previous pilot programs as well as other states' experiences.

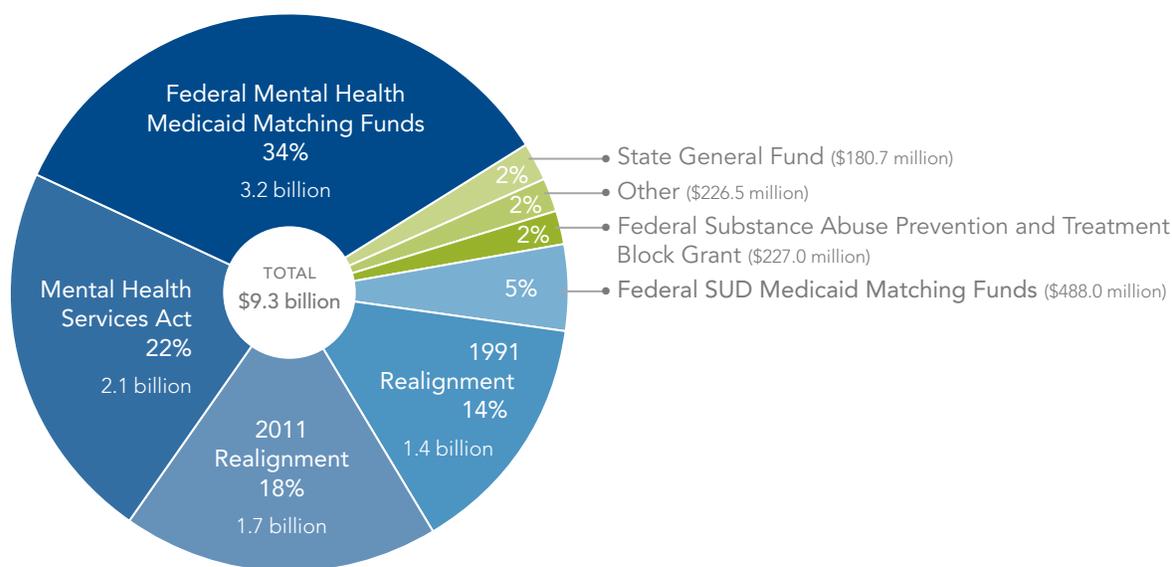
## Funding

Funding to deliver behavioral health services to Medi-Cal enrollees consists of federal mental health Medicaid matching funds as well as state-dedicated revenue sources that are not contingent on state appropriations, including personal income taxes and sales taxes as well as vehicle license fees. Counties also contribute general funds for the delivery of behavioral health services. Counties are anticipated to receive \$9 billion in FY 2019–20 for the delivery of behavioral health services across multiple funding sources, as identified in Figure 1.

Before 1991, counties received funding for specialty mental health services through the state budget appropriations process, which led to unpredictable annual revenue.<sup>23</sup> The 1991 and 2011 realignments transferred administrative and financial control for multiple programs, including specialty mental health and substance use disorder services, from the state to counties.<sup>24</sup> Subsequently, the passage of Proposition 30 in 2012 added constitutional provisions that require state and county cost sharing for unfunded mandates that may increase costs for 2011 realignment programs. The 2004 passage of Proposition 63, the Mental Health Services Act, also significantly reshaped — and augmented — county mental health funding.<sup>25</sup>

Per capita revenues and expenditures are widely acknowledged to vary between counties.<sup>26</sup> The categorical funding sources for behavioral health services, as included in the MCP benefit, are financed: through state general funds matched by federal Medicaid dollars. This fragmented funding and administration result in services and programs that are not aligned with the overall whole health needs of Medi-Cal enrollees.

Figure 1. California County Behavioral Health Funding, by Source, FY 2019–20 Estimates



Note: Other includes mental health block grants, Medicare, county general fund, and other grants.

Source: California County Behavioral Health Funding (infographic), Mike Geiss, Geiss Consulting, prepared for CHCF, February 13, 2019.

### Implications for enrollee outcomes and costs.

Fragmentation in the current system can result in gaps in care and lack of care coordination that lead to poor health and social outcomes, as well as increased health care costs. MCPs and county mental health plans do not typically systematically share data; therefore, these plans as well as the providers that care for Medi-Cal enrollees often lack comprehensive information about an individual's physical and behavioral health conditions, referrals, and treatment plans. Additionally, Medi-Cal enrollees can experience critical gaps in care when their mental health needs fluctuate between moderate and severe, as they may lose access to trusted providers and be required to navigate referrals to transition between systems.

The disconnected responsibilities for mild to moderate, specialty mental health, and substance use services limit the incentives to invest in prevention and early intervention services. MCPs may experience financial savings when, for example, an enrollee with a mild to moderate condition deteriorates and transitions to the carved-out county system.<sup>27</sup> On the other side, while county behavioral health departments do provide some prevention and early intervention services as part of their broad functions, county mental health plans have limited ability to target early intervention services to Medi-Cal enrollees with mild to moderate conditions. Similarly, while there are potential cost savings to MCPs through early and effective substance use interventions, the MCPs have historically not focused on this population because the downstream treatment services are outside of their benefit obligations.

## Other States' Approaches

Across the country, states have sought to improve health outcomes and control costs for Medicaid enrollees with behavioral health needs by integrating physical and behavioral health care. Historically, physical and behavioral health systems have evolved separately, and many states developed separate structures for managing these systems by carving out behavioral health benefits to be covered by prepaid inpatient health plans or the fee-for-service system, and separated from managed care contracts. States that carve out behavioral health benefits have sometimes undertaken efforts to improve care coordination and promote the clinical integration of physical and behavioral health care through colocation of these services. However, a growing number of states and policy experts have acknowledged that these carve-out arrangements present significant barriers to establishing accountability, coordinating enrollee care, and improving enrollee outcomes.<sup>28</sup>

Accordingly, states are increasingly carving behavioral health benefits into their Medicaid managed care organization (MCO) benefit package.<sup>29</sup> Among the 39 states that use comprehensive risk-based MCOs, six reported carving out all behavioral health service types from MCO contracts.<sup>30</sup> In state fiscal year 2019, six states reported actions to carve behavioral health services into MCO contracts, and two additional states reported plans to implement additional integrated MCO contracts.<sup>31</sup>

Many states that have promoted integrated care models in Medicaid have used one of three approaches:<sup>32</sup>

- ▶ **Comprehensive managed care carve-in.** Behavioral health services are included in comprehensive MCOs, which may or may not subcontract with behavioral health organizations (BHOs) to manage these services.
- ▶ **Specialty plan.** A specialty plan manages all physical and behavioral health services for enrollees with serious behavioral health needs.
- ▶ **Hybrid approach.** A combination of the comprehensive managed care carve-in and specialty plan approaches.

Within each of these approaches, states use different implementation strategies. Many states phase in integration by population or by region. States may transition from a specialty plan to a hybrid approach or a comprehensive

managed care carve-in. The work group examined multiple state models, including those of Arizona, New York, and Washington. These three states' approaches are summarized in Table 1 and detailed in Appendix A.

**Table 1. Summary Matrix of State Approaches to Integrating Physical and Behavioral Health Services\***

|  | ARIZONA   | NEW YORK   | WASHINGTON   |
|--|---|--|--|
| <b>Medicaid enrollment</b>                 | 1.9 million   | 6.5 million  | 1.8 million  |
| <b>Prior system</b>                        | Specialty behavioral health services carved out from MCOs and managed by Regional Behavioral Health Authorities.  | Specialty behavioral health services carved out from MCOs and provided via fee-for-service.  | Specialty behavioral health services carved out from MCOs. Regional Support Networks managed specialty mental health services and SUD services administered via fee-for-service.   |
| <b>Overview of approach</b>                | Initiated integrated specialty plans for individuals with SMI, then transitioned to hybrid approach that maintained specialty plans while introducing integrated services for the general population managed by MCOs. | Hybrid approach: Integrated MCOs serve the general population; these MCOs also manage separate specialty plans for individuals with SMI or severe SUD needs. | Comprehensive carve-in approach by implementing fully integrated managed care for all populations, including the interim step of implementing regional Behavioral Health Organizations to manage mental health and SUD services in most regions. |
| <b>Timeline</b>                            | Most populations transitioned to integrated care between 2014 and 2018.   | Most populations transitioned or are transitioning to integrated care between 2015 and 2019.   | Regions transitioned or are transitioning to integrated care between 2016 and 2020.  |
| <b>Phasing</b>                             | Phased implementation by geography and population, with early focus on individuals with SMI.  | Phased implementation by geography and population, including later phasing in of children.   | Phased implementation by region, with regions opting in to implementation phase.   |
| <b>Number of plans</b>                     | One integrated plan per region for individuals with SMI; multiple integrated plans for general population.  | Multiple integrated plans per region.  | Multiple integrated plans per region.  |
| <b>Procurement of new integrated plans</b> | Yes   | No; existing MCOs applied for qualification to establish specialty plans.  | No; existing MCOs responded to a request for proposals to add behavioral health services.  |

\*The case studies in Appendix A provide additional information on each state approach, including details on implementation phases and state outcomes.

# Guiding Principles, Goal, and Recommendations

The recommendations in this paper were developed through a series of three meetings initiated by the California Health Care Foundation and the Well Being Trust and held between June and October of 2018. These meetings brought together leaders with deep experience in county behavioral health departments, behavioral health provider organizations, state agencies, Medi-Cal managed care plans, consumer advocacy, policy research, and philanthropy (the “work group”). The vision for the work group was to develop a blueprint for greater integration of physical and behavioral health care in Medi-Cal, to address the poor health outcomes and high costs for enrollees with behavioral health conditions.

Each meeting included in-depth discussion on topics such as visions for an integrated system, desired outcomes of an integrated system, analysis of alternate approaches to integration, and considerations for implementation. The meetings were informed by presentations from leaders from other states on different approaches to behavioral health integration, as well as synthesized interview findings from a broad group of California stakeholders. During July and August, the authors of this paper conducted interviews with 12 stakeholders, including county behavioral health directors and behavioral health providers, with the goal of broadening the work group’s understanding of opportunities and challenges in pursuing different pathways to integration. The work group provided ongoing feedback on recommendation development, and the work group members listed at the beginning of this paper endorsed all included recommendations.

## Guiding Principles

These recommendations build on other research and initiatives to examine and improve the delivery of behavioral health care for high-need Medi-Cal enrollees, and are grounded in a core set of guiding principles.<sup>33</sup> These four guiding principles developed by work group members describe a vision for an integrated system of physical and behavioral health in Medi-Cal that would transform the delivery of care to achieve better outcomes for enrollees.

- ▶ Provide an accessible and well-coordinated continuum of care, from prevention to recovery services.

- ▶ Deliver person- and family-centered care that is culturally responsive and advances health equity.
- ▶ Promote hope and wellness while building on individual, family, and community strengths.
- ▶ Deliver high-quality services across care settings while ensuring choice in the care provided.

With these principles in mind, and with consideration of experience in California and in other states’ Medicaid programs, the work group identified an overarching goal for improved care for Medi-Cal enrollees as well as nine recommendations to achieve this goal.

## Goal

**By 2025, all Medi-Cal enrollees will experience high-quality, integrated care for physical health, mental health, and substance use needs, with all of an individual’s care managed by a single entity accountable for payment, administration, and oversight.**

**Rationale.** People with complex needs benefit from well-coordinated physical health and mental health and substance use care. However, very few Medi-Cal enrollees currently experience this coordination. When consumers and families are required to navigate fragmented systems of physical and behavioral health care, they face barriers to accessing high-quality services and are more likely to experience poor health outcomes. A clear and decisive timeline to implement broad system changes for all Medi-Cal enrollees will ensure that integrated care becomes the norm rather than the exception, while at the same time recognizing that it will take time to build toward this vision.

**Accountable entity.** A single entity accountable for the payment, administration, and oversight of physical and behavioral health services for a population of enrollees.

**Integrated care.** The delivery, coordination, and payment for care related to the full continuum of an individual’s physical and behavioral health needs, as managed by a single accountable entity.

Integrated care can help to ensure that consumers and families receive the prevention, treatment, and recovery services needed to achieve their health and quality-of-life goals, rather than having their access to services limited by geography, available categorical funding sources, or specific diagnoses. Integrating payment, administration, and oversight for all services can reduce barriers to information sharing, assure provider network continuity when consumer and family needs change, and align incentives to invest in prevention, care coordination, and ongoing recovery supports to foster hope and wellness. An integrated model may also yield cost savings through the more efficient use of resources, increased focus on prevention, and reductions in avoidable acute care utilization.

Integrated care models should be thoughtfully implemented within an overall state approach that addresses the holistic physical, behavioral, and social needs of complex and vulnerable Medi-Cal enrollees. The transition framework should include readiness standards and apply lessons learned from previous initiatives, including Whole Person Care Pilots, the Coordinated Care Initiative, the Health Homes Program, the Drug Medi-Cal Organized Delivery System, the California Children’s Services Whole Child Model, innovations and best practices funded through the Mental Health Services Act, the expansion of mental health benefits in MCPs to treat mild to moderate mental health conditions, and other county- and provider-based efforts to integrate physical and behavioral health services. By building on areas of strength within the current system, and systematically addressing the barriers to delivering high-quality integrated care, California can advance statewide transformation and improved outcomes for Medi-Cal enrollees with behavioral health needs.

## Recommendations

**1. Assign responsibility for all physical and behavioral health services to Medi-Cal managed care plans, while allowing delegation to interested counties and/or regions to the extent that such partnerships meet a single statewide standard for integration, quality of care, and accountability.**

**Rationale.** Based on careful consideration of other states’ approaches to integrating care, as well as Medi-Cal’s existing building blocks, bringing responsibility for all physical and behavioral health services into Medi-Cal MCPs is the most reasonable starting point for integration. Including all behavioral health benefits in MCPs would align incentives for managing the full continuum of physical and behavioral health services, while leveraging the capabilities of MCPs to manage financial risk for the full continuum of physical and behavioral health needs. However, delegation arrangements between MCPs and counties could preserve county roles in managing all or some portion of services for certain populations, as long as each accountable entity demonstrates the ability to achieve and be accountable for maintaining designated standards and outcomes for integrated care. To promote greater efficiencies, delegation arrangements should enable multi-county partnerships to manage services on regional bases. All integrated entities, regardless of delegation arrangements, must be uniformly accountable for ensuring that their assigned populations have access to high-quality care across a full continuum of needs, and that members experience the benefits of integrated care at the clinical level across care settings.

### Behavioral Health Integration in Washington

Washington state has recently moved from a county/regionally managed behavioral health system to integrated managed care led by health plans. Here, the state is enabling regions to develop varying arrangements based on regional interest and capacity. For example, in Southwest Washington, the plans uniformly contract with a single administrative service organization (ASO) to manage all crisis services. In King County (which includes the city of Seattle), the county intends to subcontract with the integrated health plans to manage all specialty behavioral health services for the first year of implementation, with a long-term plan to follow.

Note: See Appendix A for more information.

Just as California's 58 counties utilize six models for Medi-Cal managed care, MCPs, counties, and regions will need to tailor their approaches locally while maintaining a single statewide standard for integration, quality of care, and accountability. Effective approaches will integrate system cultures to build on existing strengths and historical knowledge in county systems to serve consumers and families with behavioral health needs. Stakeholders in each county will need to consider and plan how to deliver integrated care that incorporates the full array of publicly financed behavioral health services (including those that supplement Medi-Cal services, such as the prevention or support services funded through the Mental Health Services Act, as well as the Substance Abuse Prevention and Treatment Block Grant and county general funds) and how to most effectively serve individuals with behavioral health conditions who are not enrolled in Medi-Cal, by employing the full range of existing financing streams. Also, stakeholders will need to consider how to manage counties' responsibility and risk for systems that intersect with clinical behavioral health services and will be affected by a transition to integrated financing of care, including but not limited to child welfare, county corrections, and homeless services.

## **2. Implement statewide integrated care for Medi-Cal enrollees through a phased process beginning in 2020 and completed by 2025, in order to foster a transition that ensures continuity of care and promotes long-term sustainability.**

**Rationale.** An ambitious timeline will create the impetus for change to improve care across California. While Medi-Cal enrollees should begin benefiting from more integrated models of care as soon as possible, the state should develop a rollout plan that reflects county/regional preferences and the ability to meet readiness standards. As the state learns from the different approaches and experience of early implementers and examines the outcomes achieved, these findings should inform ongoing statewide implementation. Additionally, the state should consider phasing in different populations to address the complexities of transitioning behavioral health services for specific populations, such as children and youth. An implementation strategy that phases in counties or regions as well as specific vulnerable populations will help to ensure the necessary investments and

commitment among all key stakeholders. This approach will foster a mindful transition that minimizes risk to vulnerable consumers and communities, ensures continuity of care, and avoids destabilizing the infrastructure of care delivery.

To promote timely transitions to integrated care by 2025, the state should support counties in mitigating any substantial issues — including financial challenges — that may impede this transition. For example, the state may need to address county concerns with liability for risk, infrastructure development, and/or existing funding allocations. Managing these issues will likely be critical for counties to begin the transition as early as possible after 2020.

## **3. Ensure that accountable entities develop the internal capacity, expertise, and infrastructure required to effectively manage integrated physical and behavioral health care.**

**Rationale.** Implementation of effective models will require significant investments to ensure plan-provider contractual relationships and develop the capacity of accountable entities to transform the administration of physical and behavioral health services. MCPs will likely need to develop increased capacity and expertise to manage the landscape of mental health and SUD services, including a deeper understanding of the rehabilitation and recovery-based models of care. Likewise, counties may need to develop increased capacity and infrastructure to participate in delegation arrangements with accountable entities that meet the requisite criteria for integration. To ensure network adequacy and continuity of care during this system transition, the state should initially require the managed care plans to work with existing county behavioral health administrative entities to maintain contracts with all existing providers that are certified in Medi-Cal and deliver specialty mental health, SUD, and mild to moderate mental health services. The state should also ensure that accountable entities have established the required expertise and infrastructure by using contract requirements or readiness reviews that assess areas such as staffing, integration of information technology and claims processing, and integrated utilization management.

#### 4. Identify immediate and long-term opportunities to reform existing state and local behavioral health funding mechanisms, statutes, regulations, and/or other policies to promote the delivery of integrated care.

**Rationale.** Current funding and policy structures hinder investments in long-term prevention, treatment, and recovery capacity, as they reinforce silos, incentivize the development and usage of discrete programs, and cause significant budgeting challenges due to a multi-year process to reconcile expenditures in arrears. The current cost-based reimbursement system creates incentives to increase service utilization and incur greater costs, rather than to deliver high-value care that improves health outcomes. Resources from all available funding sources should be optimized for the benefit of consumers and families, and financing should follow consumers to support the delivery of integrated care. Relevant statutes, regulations, and other related policies should be aligned with these principles and should ensure accountability, resource optimization, and coordination of high-quality services. Implementation of such changes could ease the pathway to implementation.

The transition to integrated care will require changes to these financing and policy structures. Restructuring may require action at the federal, state, and county levels, with some actions easier to implement than others. Critical changes will likely include modifications to (1) the Section 1915(b) Medi-Cal Specialty Mental Health Services waiver, (2) statutory law to allow for voluntary contracting and risk-based payment, and (3) regulations and policies connected to certified public expenditures. In addition to Medi-Cal funds, other funding sources used for behavioral health services include but are not limited to county Mental Health Services Act funds, the 1991 Mental Health and the 2011 public safety realignment funds, the federal Substance Abuse Prevention and Treatment Block Grant, and additional county funds (overmatch). Accountable entities should, to the extent possible, manage all these funding sources for Medi-Cal enrollees' behavioral health services (in addition to funding for physical health services) in order to avoid creation of new silos that might impede delivery of high-quality integrated care.

While some of these financing and policy changes will be complex to address, early adopting counties and regions can begin to pursue integration before all issues have been resolved. For example, the state could take action to enable counties and regions to voluntarily contract with managed care plans and could consider structures to incentivize early adoption. Early adopters could also look for opportunities to utilize non-Medi-Cal funding sources to support integrated care.

#### 5. Incorporate principles of risk and value-based payment into the financing of behavioral health services in order to align incentives with desired outcomes.

**Rationale.** The state and counties should facilitate the transition to integrated care by immediately aligning the budgeting and rate-setting process for behavioral health services with that for physical health services. Moving to risk-based contracting for oversight and management of behavioral health services will help to spur the formation of accountable entities by harmonizing incentives across physical and behavioral health responsibilities.

California should also develop payment methodologies for behavioral health care that will promote clinical integration at the delivery system level. By incentivizing accountable entities to develop value-based payment (VBP) models, California can create financial incentives for high-quality and high-value care across the full continuum of services. VBP models that recognize the true cost of behavioral and physical health care and are sensitive to consumer acuity will help ensure the long-term sustainability of a comprehensive, high-quality system of care. These models can also reduce administrative burden and induce providers and organizations to deliver the full continuum of services in the most appropriate settings to support health, wellness, and recovery.

Additionally, VBP models may help to spur investment in elements of critical infrastructure for the delivery of integrated care. These elements could include information technology to foster data sharing between providers, such as integrated electronic health records; supports for community-based organizations; and services that address the social determinants of health, which may offer significant benefits for people with complex health and social needs.

## 6. Engage stakeholders to ensure that accountable entities are responsive to individual and community needs, and that the new system of integrated care delivers on the promise of improved consumer and family outcomes.

**Rationale.** Stakeholder guidance should inform the planning and implementation of integrated care models. The state, regions, and counties should begin to engage stakeholders early and throughout the implementation of the integration. The timeline and phases for the transition should be designed to be responsive to local needs, with ongoing stakeholder engagement to address emerging challenges. Stakeholder engagement should be structured to create meaningful opportunities for stakeholders, especially consumers and families, to provide input that informs the development of accountability mechanisms. Additionally, stakeholders should participate in the design and implementation of consumer and family outreach and education strategies to minimize any disruptions during the transition.

## 7. Foster integrated physical and behavioral health care for dual eligible enrollees by promoting the alignment of Medicare and Medi-Cal benefits in accountable entities.

**Rationale.** Dual eligible enrollees constitute almost one-quarter of adult Medi-Cal enrollees receiving specialty mental health services.<sup>34</sup> Many additional Medicaid-only enrollees with serious mental illness will become dual eligible within two years by nature of their qualifying disabilities. For dual eligible individuals, Medicare becomes the primary payer for physical health services and some limited behavioral health services, while Medicaid remains the primary payer for most specialty mental health services and substance use services. Therefore, policy initiatives that aim to integrate all physical and behavioral health services need to consider Medicare-covered benefits.

Current integrated care options for dual eligible beneficiaries in California include Medicare-Medicaid Plans created under the Cal MediConnect Program, Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), and the Program of All-Inclusive Care for the Elderly. Each of these models exists in a select number of counties. As California develops a statewide approach to Medicare-Medicaid integration that incorporates an evaluation of

the Cal MediConnect Program and other opportunities at the federal level, the state should identify pathways to promote aligned enrollment in accountable entities for dual eligible beneficiaries with behavioral health needs.

## 8. Establish standard process and outcome measures and accountable, transparent systems to monitor and evaluate the ongoing impact of integration across the state.

**Rationale.** All stakeholders will have an interest in evaluating the impact that a transition to accountable entities has on access, costs, and quality of care, and in ensuring that no harm is done in the process and that individuals and families receive the services and supports they need. In addition to managing the administration, financing, and oversight of all physical and behavioral health services, the accountable entities should be responsible for improving the experience of care, ensuring timely access to a full continuum of services and recovery supports, enabling consumer and family choice in the care provided, and delivering better health outcomes at the individual and community level. State regulatory agencies should provide monitoring and oversight of accountable entities. Reporting systems should be publicly available and built on existing oversight and quality measurement tools, and should incorporate data reflecting relevant outcomes from criminal justice, education, and other sectors. The work group identified key principles for selecting outcome measures that: (1) accountable entities should be held uniformly responsible for achieving; and (2) should be used to evaluate statewide integration efforts. These principles are outlined in Appendix B.

## 9. Strengthen the behavioral health workforce to ensure access to high-quality care during and after the transition to integrated care.

**Rationale.** Delivering high-quality integrated care — including evidence-based screening, treatment, and recovery service delivery as well as best and promising community practices — will require more providers and staff to serve Medi-Cal enrollees in specialty mental health and addiction treatment settings, in primary care, and in community-based services. Access to care in California is limited by the overall shortage and geographic maldistribution of behavioral health providers, particularly linguistically and culturally diverse providers that reflect the population served. Primary care and other

physical health practitioners may lack the training and experience to provide high-quality care without stigmatization of serious behavioral health conditions, which may prevent individuals with SMI and SUD from seeking and experiencing the benefits of integrated care.

The transition to integration will require special attention to the behavioral health workforce. During the transition process, California should attempt to retain all existing providers, and should develop supports to improve providers' administrative and clinical capacity to participate in integrated care, including primary care providers. In addition to licensed clinicians, the behavioral health workforce includes other allied occupations and staff, such as peer support specialists, parent partners, and therapeutic aides, who may be less familiar to traditional MCP provider network development efforts. As many services delivered by such allied staff have been demonstrated to be a best practice in helping individuals achieve recovery, integrated entities should be supported in and held accountable for their efforts to retain these staff. Finally, county-employed providers and staff may be affected by this transition, and integrated care models will need to address key concerns related to the county workforce.

The work of the California Future Health Workforce Commission should inform long-term efforts to expand access to care and ensure that consumers and families receive needed services that foster wellness. Addressing current and projected workforce shortages in rural areas will be critically important to improve outcomes for individuals with behavioral health needs.

## Conclusion

These ambitious recommendations aim to ensure that California Medi-Cal enrollees and families receive the prevention, treatment, and recovery services needed to achieve their health and quality-of-life goals. As informed by the approaches of other states in tackling the challenges of poor health outcomes and high costs for individuals with complex physical and behavioral health needs, this paper describes an achievable state-wide pathway toward integrated care delivery by 2025. Grounded in principles of recovery, equity, choice, and transparency, these recommendations point to a system that is far more capable of producing desired outcomes for Medi-Cal enrollees with behavioral health needs, and for California as a whole.

California policymakers and stakeholders have a unique opportunity to address the systemic underperformance of the current system and develop a system that is instead designed to deliver on the promise of whole-person care. As both the Section 1915(b) and Section 1115 waivers expire in 2020, and as the new gubernatorial administration develops an agenda for the next era of behavioral health care, California can now take bold action to become a national leader in improving the health and well-being of Medi-Cal enrollees with behavioral health needs, their families, and communities across the state.

## Appendix A. State Case Studies

### Arizona Case Study

**Pre-integration system structure.** The Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid agency, was historically responsible for physical health services for most populations, and the Department of Health Services' Division of Behavioral Health Services (DBHS) was responsible for behavioral health services under a contract with AHCCCS. DBHS oversaw Regional Behavioral Health Authorities (RBHAs) that managed mental health and substance use services. AHCCCS enrollees with serious behavioral health needs thus enrolled in two health plans — one plan that managed physical health care, and an RBHA plan that managed specialty behavioral health services. The system included different payment methodologies with diverging incentives, as RBHAs used block purchasing to contract with providers of behavioral health services, while physical health plans paid providers through fee-for-service.

**Impetus for integration.** The early mortality of individuals with serious mental illness (SMI) was a strong motivating factor for Arizona in advancing integration. A 2006 national report found that Arizona had the greatest average disparity in the life span of residents with SMI as compared to the general population — over 31 years.<sup>35</sup> Given that early mortality was largely driven by physical health conditions, Arizona leaders developed a plan that aimed to improve integration for enrollees with SMI to improve these poor health outcomes.

**Phases of integration.** AHCCCS developed a phased approach to integrate care by population and region, and integrated the state-level administration of physical and behavioral health services early in this process. AHCCCS also invested in extensive ongoing stakeholder outreach throughout the transition phases, including the creation of a dedicated office for this purpose, to engage key stakeholders and ensure ample avenues for information sharing and feedback.

- ▶ **2013.** Children with a qualifying condition under the Children's Rehabilitative Services program transitioned to integrated care managed by one contracted plan for physical and behavioral health and long-term care.

- ▶ **2014.** In Maricopa County (Phoenix), enrollees with SMI transitioned to a single integrated RBHA that was charged with managing both behavioral and physical health services.
- ▶ **2015.** The integrated RBHA model was extended statewide to all enrollees with SMI, with a single plan selected to manage care in each of three regions.
- ▶ **2015.** AHCCCS became responsible for overseeing physical and behavioral health services. This merger with DBHS was proposed in the fiscal year (FY) 2016 budget of Governor Doug Ducey, and then endorsed by the legislature. Through this merger, many staff with behavioral health expertise joined AHCCCS and incorporated wellness and recovery models into the oversight of integrated care delivery.<sup>36</sup>
- ▶ **2016.** Dual eligible enrollees and all Tribal Regional Behavioral Health Authority and American Indian Health Program populations transitioned to integrated care.
- ▶ **2018.** The majority of adults and children enrolled in Medicaid have transitioned to integrated care through the AHCCCS Complete Care (ACC) program, with a managed care plan coordinating all physical and behavioral health services. ACC includes adults with mild to moderate mental health or substance use needs. Each of the three existing RBHAs has an affiliated ACC plan. RBHAs continue to provide integrated physical and behavioral health care for individuals with SMI, as well as behavioral health services for children in foster care and individuals with developmental disabilities.
- ▶ **2019.** AHCCCS anticipates integrating care for individuals with developmental disabilities.
- ▶ **2020.** AHCCCS anticipates integrating care for all children in foster care.

Currently, enrollees with SMI as well as the general adult and child populations receive all physical and behavioral health care managed by one entity with one provider network, enabling more streamlined care coordination to improve health outcomes. Enrollees with SMI receive integrated care managed through an integrated RBHA, while the general adult and child population receives care from an ACC integrated managed care organization (MCO), with multiple MCOs available in each region.

### Components of State Approach

**Waiver authority.** Arizona's Section 1115 waiver to expand integrated care was most recently renewed in 2016 and amended in 2017.

**Dual eligible beneficiaries.** AHCCCS requires all Medicaid plans to offer a companion Medicare Dual Eligible Special Needs Plan (D-SNP) to promote aligned enrollment in the same health plan for all services.

**Management of non-Medicaid services and services for non-Medicaid populations.** RBHAs continue to provide crisis services to non-Medicaid populations and cover non-Medicaid behavioral health services for Medicaid enrollees.

**Delegation of responsibilities.** AHCCCS prohibits integrated plans from delegating certain functions key to integration.

**Procurement process.** Newly integrated RBHAs were selected through a competitive bidding process led by DBHS, with the selected entities across the regions including two partnerships between existing RBHAs and Medicaid MCOs, and a partnership between Medicaid MCOs and a county behavioral health provider network.

### State Outcomes

#### Spending in value-based payment (VBP) arrangements.

Integrated health plans and RBHAs have increased spending in VBP arrangements each year as a result of contractual requirements set forth by AHCCCS. A percentage of VBP arrangements is specifically targeted to services for individuals with SMI and to providers of integrated care.

**Clinical integration.** AHCCCS implemented a payment model in which clinics delivering integrated physical and behavioral health care may receive a 10% rate increase for evaluation and management codes based on the clinic meeting a defined threshold for integrated delivery of physical and behavioral health services. The state also launched the Targeted Investments Program to advance clinical integration, investing \$300 million over five years to support provider-level efforts to develop the systems required to deliver integrated care. Selected providers receive payments for completing core components and milestones through year three, and then become eligible to receive performance-based payment through year five based on quality measures for specific populations.

**Participation in state health information exchange.** The state has also reported significant increases in behavioral health provider participation in the state health information exchange, enabling greater coordination and information sharing across different providers.<sup>37</sup>

**Investments in supportive housing for enrollees with SMI.** When the Maricopa County RBHA began managing physical health services in 2014, it also launched a supportive housing services. A study reported that consumers in this program experienced a 20% reduction in psychiatric hospitalizations after enrollment, with a 24% decrease in total cost of care, with savings driven by reductions in behavioral health costs.<sup>38</sup>

**Improved outcomes for dual eligible enrollees.** Arizona reports increases in preventive care and reductions in hospitalizations due to better-coordinated care for dual eligible individuals.<sup>39</sup>

## New York Case Study

**Pre-integration system structure.** Most specialty behavioral health services for adults and children were provided via fee-for-service, carved out from managed care plans that covered physical health services as well as limited behavioral health services, depending on Medicaid eligibility type. Specialty behavioral health services were licensed by the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, while the Department of Health was responsible for physical health services delivered by MCOs.

**Impetus for integration.** New York pursued behavioral health integration as part of a statewide restructuring of the Medicaid program to achieve improvements in health outcomes, sustainable cost control, and a more efficient administrative structure.<sup>40</sup> A multi-stakeholder Behavioral Health Reform Work Group of the Medicaid Redesign Team guided design and implementation. In its recommendations, the work group noted that the lack of coordination of behavioral and physical health at the clinical, regulatory, and financial levels contributes to fragmentation with little accountability for improving the poor health and social outcomes experienced by enrollees with behavioral health needs.<sup>41</sup> A children's behavioral health subgroup found that the current system to serve children and families was underfunded and provided disjointed, noncomprehensive services to families.<sup>42</sup>

**Phases of integration.** New York pursued a phased approach to enrolling Medicaid clients into integrated plans, starting with a regional rollout for all adults eligible for Medicaid managed care. Beginning in 2015 in New York City and 2016 statewide, MCOs began managing expanded behavioral health services for adults in addition to all physical health services. These expanded behavioral health services included services previously covered through fee-for-service, such as partial hospitalization and SUD inpatient and outpatient services, as well as new services that were not previously covered under Medicaid, such as licensed behavioral health practitioner and behavioral health crisis intervention services. Newly covered services for children and families include family peer support services, psychosocial rehabilitation, and youth peer advocacy and training.

Concurrently, individuals with SMI or SUD diagnoses became eligible to enroll in Health and Recovery Plans (HARPs), a new type of health plan. HARPs were newly

created within existing MCOs as products to function as separate lines of business with distinct rate structures and staff with enhanced behavioral health expertise. HARPs emphasize care management and must contract with health homes to provide care management and develop person-centered care plans. HARPs also cover new benefits for home and community-based services, such as family support and training, peer support services, and supported employment. These services are designed to help individuals meet recovery and wellness goals. Individuals eligible to enroll in a HARP may instead decide to enroll in a mainstream MCO if they prefer. Multiple HARPs and existing MCOs in each region manage integrated physical and behavioral health benefits.

New York plans to phase in children to enroll in integrated MCOs and HARPs in 2019.

## Components of State Approach

**Waiver authority.** The state submitted an amendment to its Section 1115 waiver demonstration in 2015 to enable MCOs to provide integrated physical and behavioral health care, as a part of the Medicaid Redesign Team reforms. Phasing in children will require transitioning six Section 1915(c) waivers to an integrated Section 1915(c) waiver and then a Section 1115 waiver authority.

**Dual-eligible beneficiaries.** HARPs and traditional MCOs do not provide integrated Medicare benefits.

**Management of non-Medicaid services and services for non-Medicaid populations.** Non-Medicaid-funded services for Medicaid enrollees are not managed by HARPs or MCOs, but are encouraged to be included and addressed in enrollee care plans as needed. Uninsured populations receive behavioral health services through local or state-operated services.

**Delegation of responsibilities.** Subcontracting is allowed and frequently employed, but all policies and procedures between health plans and subcontracting behavioral health organizations (BHOs) are extensively assessed. Relevant policies and procedures included staffing requirements, network adequacy, information sharing, and integrated performance indicators.<sup>43</sup>

**Procurement process.** New York modified the Medicaid managed care model contract to include behavioral health requirements, and did not procure new contracts. Existing MCOs absorbed all Medicaid behavioral health services for the general population, and could apply to become a HARP to serve individuals with more severe needs.

## State Outcomes

**Development of value-based payment (VBP) pilots and quality measures.** The VBP Pilot Program, which supports broader VBP activities in the Section 1115 waiver, was designed to support the transition to VBP and test new outcome measures. Some of these pilot programs will focus on provider groups serving HARP enrollees or involved in integrated care.<sup>44</sup> Pilots will also test HARP quality measures, which were designed to encourage care coordination and high-quality, patient-centered care.<sup>45</sup>

**Development of an evaluation tool.** New York has developed an evaluation tool to measure the impact of HARP enrollment.<sup>46</sup>

## Washington Case Study

**Pre-integration system structure.** MCOs contracting with the Washington State Health Care Authority (HCA) managed all physical health care as well as mild to moderate behavioral health care. Until 2016, Regional Support Networks (RSNs) managed specialty mental health services for enrollees with SMI and were at risk for providing all necessary mental health care for Medicaid enrollees who met Access to Care standards. RSNs subcontracted with community mental health agencies to deliver care. RSNs also managed federal grants and provided crisis and involuntary treatment services to safety-net populations under a separate, state-only contract. Meanwhile, SUD services were administered separately by county governments on a grant-funded and fee-for-service basis.

**Impetus for integration.** With legislative support, Governor Jay Inslee advanced an agenda of whole-person care through integrating physical and behavioral health, citing the poor health outcomes, high cost of care, and risks to public safety caused by mental health and substance use disorders.<sup>47</sup> In 2014, new legislation created financial incentives for local governments to opt into integrated care, mandated integrated delivery of care in both physical and behavioral health settings, reformed licensing regulations, and required access to recovery support services. Additionally, this legislation required a task force to create recommendations to achieve full integration by 2020.

**Phases of integration.** First, the state created new regional service areas (RSAs) for physical and behavioral health care, and RSNs transitioned to become managed BHOs responsible for both mental health and SUD services. BHOs also manage non-Medicaid-covered community behavioral health services provided to both Medicaid and non-Medicaid enrollees, including crisis services.

While requiring all regions to transition to integrated managed care by 2020, the state allowed RSAs to implement in waves. One region opted to become an early adopter in 2016, a second followed in 2018, five regions will begin in 2019, and the remaining three regions are planning to integrate by the 2020 deadline.

In this integrated managed care system, MCOs coordinate care across the full continuum of physical and behavioral health services, with between three and five MCOs contracted to provide care in each region.

## Components of State Approach

**Waiver authority.** The Section 1915(b) behavioral health waiver first approved in 1993 has been renewed through 2022 and amended to facilitate movement of regions into the fully integrated model. Washington's Section 1115 waiver demonstration, the Medicaid Transformation Project, was approved in 2017 and includes goals and an evaluation approach for integrated managed care. The Section 1115 waiver also includes an initiative for Accountable Communities of Health to advance bidirectional integration of physical and behavioral health, including support for providers to transition to fully integrated managed care.

**Dual-eligible beneficiaries.** Dual eligible beneficiaries are not included in fully integrated managed care, and instead receive Medicaid behavioral health benefits by enrolling in Behavioral Health Services Only coverage as part of the MCO contracts.

**Management of non-Medicaid services and services for non-Medicaid populations.** Washington has allowed flexibility in how RSAs manage behavioral health services for non-Medicaid populations. For example, BHOs have the right of first refusal to continue functioning as Behavioral Health Administrative Service Organizations (BH-ASOs), receiving non-Medicaid funding and managing the crisis system and involuntary treatment, as well as other services for non-Medicaid populations. Under this scenario, integrated managed care plans are required to contract with the BH-ASO for crisis services. Some non-Medicaid services that wrap around Medicaid services are managed by MCOs, while most non-Medicaid services are managed by BH-ASOs.

**Delegation of responsibilities.** While services and functions may be delegated during the transition, HCA has stated it does not intend to allow subcontracting of key functions over the long term. HCA noted a willingness to discuss delegation agreements on certain elements of provided services.<sup>48</sup> In King County (including the city of Seattle), all selected plans are contracting with the county to deliver behavioral health services during 2019, as a long-term plan is developed for implementation in 2020.

**Procurement process.** Washington selected fully integrated managed care plans from a competitive bidding process open to the existing Medicaid managed care plans across the state.

## State Outcomes

**Improved outcomes in first region adopting fully integrated managed care.** An evaluation of 19 enrollee outcome measures in the Southwest Washington region implementing fully integrated managed care found that ten enrollee outcomes showed statistically significant improvement in calendar year (CY) 2016, and 11 enrollee outcomes showed statistically significant improvement in CY 2017.<sup>49</sup> Outcomes that showed improvement in CY 2017 include:

- ▶ Adults' Access to Preventive/Ambulatory Health Services
- ▶ Substance Use Disorder Treatment Penetration
- ▶ Mental Health Treatment Penetration - Broad Definition
- ▶ Percent Employed
- ▶ Follow-up after Emergency Department (ED) Visit for Alcohol or Other Drug (AOD) Dependence - Within 7 Days
- ▶ Follow-up after ED Visit for AOD Dependence - Within 30 Days
- ▶ Follow-up after ED Visit for Mental Illness - Within 7 Days
- ▶ Follow-up after ED Visit for Mental Illness - Within 30 Days
- ▶ Inpatient Utilization per 1000 Coverage Months - Combined Medical and Psychiatric
- ▶ Cervical Cancer Screening
- ▶ Chlamydia Screening in Women

## Appendix B. Key Principles for Measuring Enrollee Outcomes

The primary goal for an integrated system of physical and behavioral health care in Medi-Cal is to achieve improved physical, behavioral, and social outcomes for enrollees. Accountable entities must be uniformly responsible for ensuring that the individuals they serve have access to high-quality care across a full continuum of needs, and for delivering a defined set of outcomes.

The work group identified key principles for selecting the outcome measures used to assess accountable entities and evaluate statewide integration efforts.

- ▶ To track and evaluate the physical, behavioral, and social outcomes of adult and child enrollees, utilize standardized measures that address the following domains: (1) quality of life and other patient-defined outcomes to assess wellness, (2) functional changes and indicators of progress toward recovery and wellness, and (3) integrated management of physical and behavioral health conditions.
- ▶ To assess the quality and capacity of accountable entities to impact enrollees' outcomes, utilize standardized measures that address the following domains: (1) screening and prevention; (2) referral tracking, care coordination, and medication management across physical and behavioral health services; (3) access to the full continuum of services and recovery supports; and (4) administrative data sharing, grievances, and dispute resolution.
- ▶ Based on the established domains, deploy a measurement set that includes existing measures when available, in order to account for the complexity of delivering integrated care while not unduly adding to measurement burden.
- ▶ When tracking health and social outcomes as well as health care costs and utilization, use a multi-year time frame to capture meaningful changes that emerge over a longer period of exposure to integrated entities.

These principles can help to develop a measure set that rigorously assesses the impact of integration on enrollees, informs continuous quality improvement efforts, and enables the California Department of Health Care Services (DHCS) to hold integrated entities accountable for ensuring that their members experience improved outcomes. As described in recommendation #8, the reporting systems should build on existing oversight and quality measurement tools and must be transparent with publicly available data reporting for stakeholders to evaluate the impact of this transition to integrated care.

## Endnotes

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