Research Brief

The Coordination of Behavioral Health Care Through Cal MediConnect

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

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

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

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

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

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

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

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

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

Streamlining Communication Between CMC Plans and Behavioral Health Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Study 2: Overcoming Data-Sharing Challenges

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

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

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

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

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

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

Increasing Access to Behavioral Health Care

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

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

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

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

Case Study 3: New Platforms for Data Sharing

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

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

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

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

Other Challenges to Coordinating Behavioral Health Care

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

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

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

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

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

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