# Improving Behavioral Health Integration and Coordination for Cal MediConnect (CMC) Members

Summary of Best Practices from a Survey of Cal MediConnect Plans

***January 17, 2020***

The Cal MediConnect (CMC) program was developed to better serve dual eligible beneficiaries – those enrolled in both Medicare and Medi-Cal. A primary focus of CMC is to better coordinate behavioral health care service delivery for individuals enrolled in CMC plans. Almost five years into the program, feedback from CMC plans shows that they are exploring a wide range of options to identify plan members' behavioral health service needs and better integrate these services with traditional physical health care. In an effort to improve behavioral health integration and coordination for CMC members, all CMC plans have examined and shared details of their internal processes, operations, and best practices.

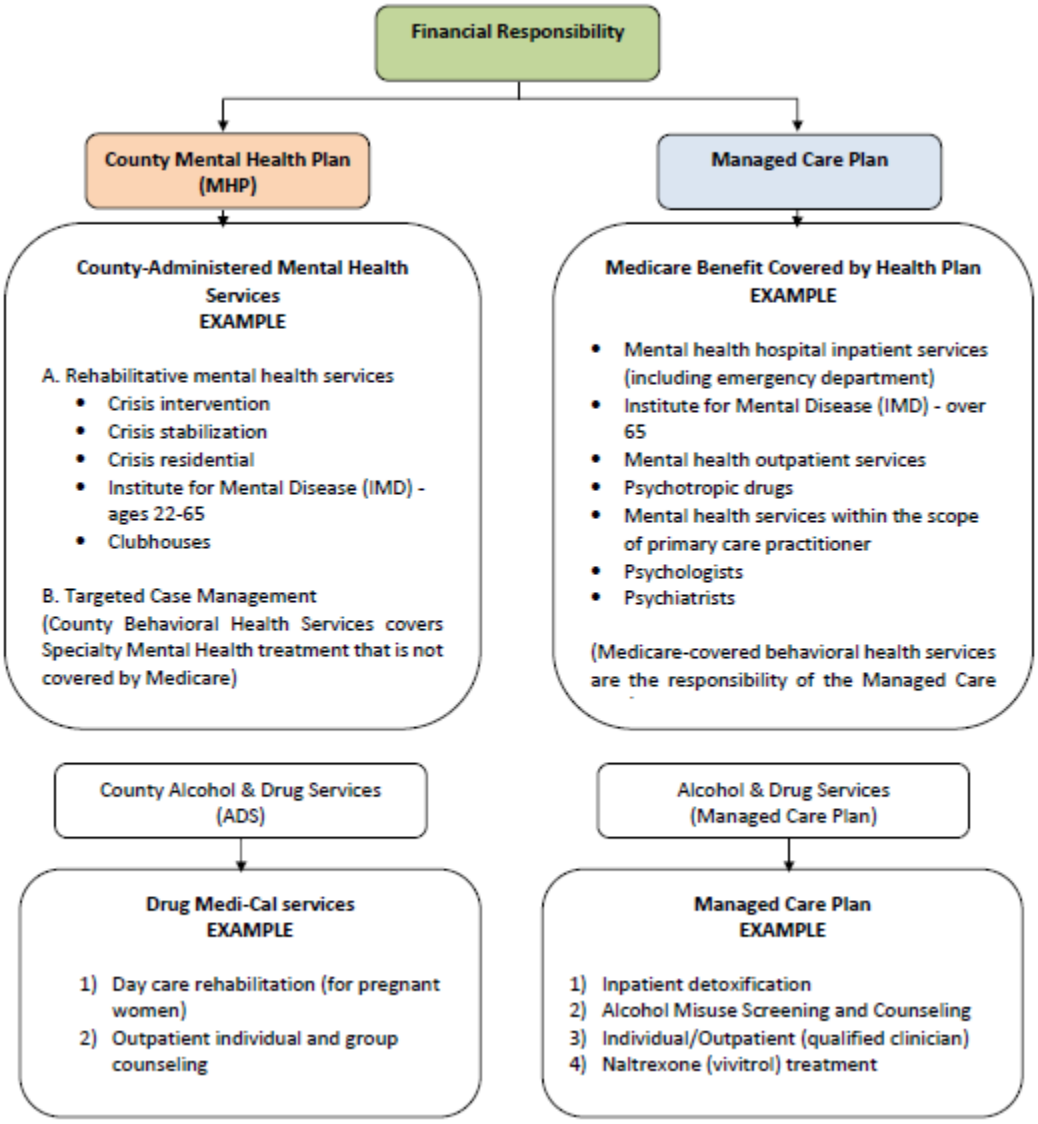
## Behavioral Health Care Coordination in the Cal MediConnect Program

One important service CMC plans provide is connecting members to behavioral health services, if needed. However, coordinating behavioral health care under the CMC program is challenging in part due to the complex system of providing and financing behavioral health care services for dual eligible beneficiaries. Harbage Consulting and the California Department of Health Care Services (DHCS) developed the CMC Behavioral Health Responsibility Coverage Matrix, which provides a list of the mental and behavioral health care services available under the CMC program, as well as the primary payer of these services (Appendix A). Figure 1 provides a summary of the financial responsibility for behavioral health services for CMC beneficiaries.

Plans are responsible for providing all Medicare-covered outpatient behavioral health care services for CMC members. Some plans use an integrative model to provide these services, in which they leverage internal CMC plan resources to provide services to members. Other plans delegate behavioral health care coordination to a third party. In Medi-Cal, specialty mental health (SMH) services are "carved out," with benefits provided by county behavioral health departments (counties) and county mental health plans and services delivered by the county or community providers. For dual eligible beneficiaries, some SMH services, primarily inpatient stays, are covered by Medicare and others are the responsibility of the county. Though SMH services are often either covered by the CMC plan or delivered by counties, CMC plans are responsible for coordinating behavioral health care for the members receiving them. This arrangement requires plans to work closely with counties to implement processes and procedures that help ensure a seamless and comprehensive system of coordinated care in

which members are able to access needed behavioral services. Plans and counties have implemented a wide range of approaches to work toward this aim.

**Figure 1. Financial Responsibility for Behavioral Health Services for CMC Beneficiaries**




The California Department of Health Care Services (DHCS) and its partner, the Centers for Medicare & Medicaid Services (CMS), selected behavioral health integration as a topic for in-depth exploration to better understand and disseminate the best practices in CMC plans' approaches to providing care coordination for members with behavioral health care needs. To this end, DHCS and Harbage Consulting developed a survey for CMC plans to better understand their approaches for improving the integration and coordination of behavioral health services

for CMC plan members (Appendix B). The survey addresses topics including, identifying member needs, care coordination approaches, data sharing, workforce, and education and training. Each plan sent detailed written responses to DHCS, and later directly discussed their responses with the Department in a series of one-on-one conference calls.
The combined lessons learned and best practices of CMC plans are reflected in this paper. In March 2019, DHCS hosted an in-person meeting where plans shared their learnings directly with one another.

## Developing Relationships and Strengthening Communication Channels

Plans reported that the ability to develop and sustain trusted relationships with counties was a key factor in their ability to successfully coordinate care for CMC members. Prior to implementation of the CMC program, many plans did not have strong relationships with county behavioral health departments. As county agencies provide SMH services for members, but CMC plans coordinate their care, plans have devoted substantial attention to building relationships with county partners to provide the full spectrum of care for their shared members.

Cal MediConnect plans reported several best practices to build relationships with counties:

- Liaisons: To help facilitate communication between partners with the aim of improving care coordination, some plans have dedicated staff to serve as a liaison between the plan and the county. In addition to serving as a plan point of contact and assisting with programmatic and operational issues, plan liaisons participate in regular meetings with the county staff and providers to discuss particular members and review data and measures. Both Santa Clara Family Health Plan and Health Plan of San Mateo (HPSM) have found that their plan liaison is essential to their ongoing relationship with counties. Some counties have also dedicated a liaison that works directly with the CMC plan, county providers, and community-based organizations (CBOs) to help the plan navigate the system and improve workflow.
- Memorandum of Understanding: Plans and counties were required to enter into memorandums of understanding (MOUs) to help confirm their roles and responsibilities in care coordination under Cal MediConnect. Anthem, for example, noted that they sometimes share the formal MOU with county providers to help familiarize providers with plan staff as well as the plan's authorization to communicate with county agencies for purposes of care coordination. Plans also noted they use MOUs to clarify accountability and detail the data sharing processes used to help support care coordination, though data sharing challenges sometimes still remain.

- Education & Training: The implementation of the CMC program changed or expanded the care coordination responsibilities of plans and counties, and in some cases necessitated new protocols and processes for coordinating care. Therefore, education about the program was noted as an important component of plan-county communication. Some plans stressed the importance of regular trainings and outreach to county providers about the program in order to solidify and reaffirm knowledge. Some plans also noted that due to staff turnover, having regular trainings help ensure that all county program staff – no matter how new to the program – understand the roles and responsibilities of all partners as well as the resources available to members. Trainings should be developed to speak to all parties involved in providing behavioral health services to CMC members, including county staff, providers, and the care coordination teams. Trainings should also be mindful of the complexity of the populations served under the CMC program, populations which may necessitate heightened communication among partners and greater resources from care teams. Community Health Group (CHG) reported strong collaboration with other CMC plans in San Diego County to train providers and CBOs about CMC services. The plans took a team approach to communicating clear and consistent information countywide.
- Regular Meetings: In addition to trainings, plans also noted the importance of meeting regularly with county staff and providers. These meetings can be used to discuss specific cases and emerging issues, as well as referrals and data. To the extent possible, plans noted that they try to bring together all providers from a member's care team at these meetings, including a member's physical and behavioral health providers, so there is full understanding of the services and treatment a member receives. Molina reported that care coordination is a standing item on the agenda for their meetings.

## Identifying Members' Behavioral Health Service Needs

Cal MediConnect plans use a variety of mechanisms to help identify members who may need behavioral health services, and ensure they are referred to the appropriate level of care. All plans are required to conduct a Health Risk Assessment (HRA) for every new member, and revisit the HRA annually to identify any changes in a member's status. The HRA is designed to assess a member's health risk and help identify further assessment needs, such as functional impairments, behavioral health conditions, and/or substance use disorders. CMC plans use the HRA to help identify members who may need behavioral health services, have unmet behavioral health service needs, need further assessment, or should be referred for services.

While the HRA provides useful information, it is not the only way to identify members in need of behavioral health services. CMC plans reported several ways they identify behavioral health

needs in addition to the HRA, often utilizing multiple mechanisms to constitute a "no wrong door" policy:

- Targeted Assessments: Some plans use more targeted assessment tools to screen members for behavioral health service needs. Members may be screened with these tools independent of the HRA, or based on their responses to the HRA. For example, L.A. Care uses a behavioral health screening form in addition to the HRA. The screening form is designed to identify and refer members to appropriate levels of care for behavioral health services.
- Internal Referrals: Plans noted that primary care providers (PCPs), physician practice groups (PPGs), case managers, and others who may interact with members, can refer members for behavioral health services, often without prior authorization. While this process serves as another mechanism to help connect members to needed services, Molina noted that these direct provider referrals can create data management challenges since they are not visible to the plan because they do not require prior authorization.
- Data Mining: Analyzing data provides CMC plans an opportunity to identify members and formulate interventions to ensure members' care is coordinated. L.A. Care and Molina reported regularly mining their inpatient admissions data for members with high utilization of the emergency department for behavioral health services or other utilization, which may suggest members have unmet behavioral health service needs. Similarly, IEHP monitors data to identify members with the highest risk, and those most likely to have a comorbid behavioral health diagnosis and potential unmet needs. Plans including Molina, for example, also monitor additional measures they are required to report as part of their participation in the CMC program, including Follow-Up After Hospitalization for Mental Illness and the Behavioral Health Shared Accountability Outcome Measure, and use the data to identify members who may need behavioral health services and care coordination.
- Self-Referrals: CMC members can also self-refer for behavioral health services through channels including telephone and email. For example, members of plans including Cal Optima and Santa Clara Family Health Plan can self-refer by calling the plan's behavioral health line and completing a phone screening.

Regardless of the mechanism used to identify members who may need behavioral health services, all plans have specific timeframes for how quickly the plan must outreach to a member, after the member has been identified as having potential behavioral health service needs.

## Referrals

Cal MediConnect members who are determined to need SMH services are referred to the county, though their care continues to be coordinated by the CMC plan. In making a referral, some plans, including L.A. Care and Molina, noted that they often have difficulty tracking that referral, and understanding whether a member referred to the county was ultimately able to get into care and receive services, or helping to ensure that this outcome was achieved. This disconnect occurs because plan and county data systems are separate, and there is no automated way to yield information about a completed referral. One of best practices implemented to address this challenge is to use a "warm hand-off" process, used by plans including Health Net and Blue Shield of California Promise Health Plan (Promise Health Plan). Under Health Net's process, the plan does not fully hand-off a referred patient to the county until they have determined that there is someone who can provide appropriate services to the member. This is preferred to alternative processes, in which the plan may only know whether a referred patient has connected to care when they receive a data file from the county and see the referred member in the county's data. The development of automated processes between plans and counties to share outcomes of referrals would help to improve the efficiency of coordination.

Cal MediConnect plans reported other best practices related to the referral process:

- Waiting Lists: Implementing and continuous monitoring of waiting lists is another noted best practice among CMC plans. If there is no one available to serve a member, members are put onto waiting lists until the needed level of care is available. Some plans, like Health Net, work with counties to put members into a lower level of care while on the waitlist, until the member can enter a program that can serve a higher level of need. Health Net also noted that working with the county under these circumstances is one way the plan learns about new programs and resources available to members.
- Bi-Directional Referrals: As the plans and county SMH serve members along a continuum of care, members sometimes transition between levels of service over time. Due to the differing responsibilities for the provision of behavioral health services in the CMC program, members may transition between having their care provided by the plan (or their delegate) and the county, or vice versa. To support a member's transition between these service levels, plans such as Health Net and Molina have implemented bi-directional referral processes, including use of specialized referral tools to help facilitate these transitions. Molina, for example, conducts ad-hoc care coordination and case management meetings with the county to resolve any questions or disputes about level of care that may arise from the bi-directional referral process, and ensure that all parties are in agreement regarding the member's treatment plan. CMC plans also rely on their liaisons to help ensure

members' smooth transitions between these systems, noting that patient education is an important aspect of the process.

A strong referral process is critical to ensuring that CMC members receive the right services from the right providers at the right time.

## Data Sharing

The ability to obtain timely and accurate data for members is a key aspect of coordinating behavioral health services for CMC beneficiaries. For members receiving services that are provided in the plan's network, there is a more direct mechanism for plans and providers to obtain data and monitor the services a member is receiving. However, for members receiving SMH services from the county, implementing a data sharing process is the primary mechanism by which plans are able to understand whether members have gotten into care and what services the member is receiving.

Most plans have set up data sharing agreements and platforms with counties to transmit data about members receiving SMH services. Plans often start by sharing their CMC enrollment list with counties, asking counties to share patient-level claims and utilization data for members who are receiving SMH services in return (often referred to as a "match" file). Plans leverage this information and data to outreach to members to determine whether they are interested in care coordination services and to coordinate their care, if they consent. Plans also share members' individualized care plans (ICPs) with counties. The ICP is a person-centered document that reflects a member's health goals and preferences, and is developed by members with their interdisciplinary care team (ICT).

In counties where there is no patient-level data sharing process, plans note substantial challenges in coordinating care for members. Both Molina and Promise Health Plan in San Diego county mentioned that plans must implement time-consuming workarounds to determine a member's interest in care coordination via county providers. Under this process, counties use the member enrollment list provided by the plan to reach out to county behavioral health providers letting these providers know they are working with a CMC member for whom the plan is attempting to coordinate care. The county provider is asked to follow-up directly with the plan about the member. This process leaves the plan highly dependent on the responsiveness of county providers, if providers respond at all. Some plans do their own direct follow-up with providers if they do not receive a timely response, but this is also a time-consuming, manual process that often does not yield optimal results.

Plans also encounter barriers to care coordination due to the need for member consent. Orange County stands out in comparison to other CMC counties in this respect due to the county's interpretation of the Health Insurance Portability and Accessibility Act of 1996 (HIPAA). Cal Optima providers are able to send mental health information to the county without member consent, because the county council views this issue under the HIPPA Privacy Rule, which permits covered entities to use or disclose protected health information for purposes of "treatment, payment or health care operations," with or without member consent.[i] Despite this, as in other counties, substance use disorder information cannot be shared in Orange County without authorization.

Several plans reported that counties often cite incorrect interpretations of federal data sharing rules, or concerns about violating them, as the reason for not sharing full information. In one county, for example, the county council does not consider CMC plans to be covered entities under HIPAA as the plans are not direct service providers. To overcome this obstacle, one plan in the county developed a workaround whereby a care coordination meeting is held between health plan case managers and county case managers and providers. During this meeting, data regarding shared members' conditions and treatment are exchanged verbally, for the purposes of care coordination. L.A. Care utilizes the intensive care division within the county to reach out to county clinics and educate providers that member consent is not required for purposes of care coordination.

## Care Coordination

The primary goal of care coordination is to understand and meet a patient's goals and preferences for their health care in the context of their overall health care needs. The care coordination process in the CMC program starts with the completion of the HRA, which is then used – often in concert with other tools – to determine what services and level of care coordination a member may need. Plans then develop care plans, create ICTs comprised of providers, CBOs, and caregivers, and assign members to a care manager. This process involves careful organization of patient care and active communication with partners to guide care delivery.

### *Care Coordination Infrastructure*

Regardless of whether a plan member receives behavioral health services provided by the plan, or Medi-Cal only SMH services provided by the county, the plan is responsible for care coordination. However, CMC plans have developed different models for care coordination of behavioral health services. Some plans delegate behavioral health care coordination to a third-

party organization, but retain coordination of physical health and other services. Other plans maintain both physical and behavioral health care coordination, often referred to as an integrative model. Table 1 shows which CMC plans use an integrated, delegated, or single entity model in their designated counties.

**Table 1. CMC Behavioral Health Services Model**

| Integrated | "Single Entity" | Delegated |
|---|---|---|
| • Anthem (in Santa Clara) | • Health Plan of San Mateo | • Cal Optima – Magellan |
| • Community Health Group | | • *Caremore – Beacon Health Options |
| • Health Net | | • L.A. Care – Beacon Health Options |
| • Inland Empire Health Plan | | • Promise Health Plan – Beacon Health |
| • Molina | | |
| • Santa Clara Family Health Plan | | |

*Caremore is the name of Anthem's health plan in Los Angeles County.

While no model seemed to constitute a single best practice, plans reported that each model has benefits and limitations in serving members:

- Integrated Model: Some plans maintain a specialized team of internal staff dedicated to serving members who have behavioral health needs. Plans note that this allows them to have more streamlined and integrated processes for communication and data sharing, ultimately facilitating better coordination of care. Familiarity – both from the provider and member perspectives – is also a benefit noted by plans that aids in the implementation of care coordination activities; providers are familiar with the other providers they are working with, and members have existing relationships with plans. Plans also note that care coordination activities are more real time in an integrative model, reducing delays in care integration, and enhancing the ability to monitor performance and make adjustments accordingly. Plans reported employing care coordination staff with behavioral health expertise for these purposes, but some did report challenges with retaining a skilled workforce in some areas. Anthem and Inland Empire Health Plan reported offering incentives such as tuition assistance to attract and retain care coordination staff. For Molina, each case manager is required to assist the member holistically with all behavioral

health and medical conditions, in addition to overcoming barriers related to social determinants of health.

- Delegated Model: Four plans currently use a delegated model to coordinate behavioral health care in which they contract with a third party with expertise in behavioral health. This model can help ensure that members with behavioral health needs have a highly-specialized care manager who understands the programs and services available to members and can help members navigate the system. However, as medical and other non-behavioral health services are being coordinated by the plan, plans reported that this can sometimes cause confusion among members as multiple entities are coordinating aspects of their care. Behavioral health data may also not flow as easily to plans when a third party is coordinating members' care, which may complicate care coordination activities. Caremore in Los Angeles County contracts with Beacon Health Options to coordinate and provide all behavioral health services for CMC members. Beacon staff are co-located with Caremore staff at Caremore's care centers in the county. This co-location allows behavioral health and physical health needs to be coordinated at one place with the member there in person or on the phone thereby limiting confusion among members and improving care coordination between multiple entities.
- "Single Entity Model": HPSM has a unique model where county specialty mental health clinics and their contracted private provider network (e.g., Federally Qualified Health Centers, independent providers and community-based clinics) provide HPSM CMC members access to a full spectrum of behavioral health and substance abuse services across the continuum of care needs. These providers screen, intake, serve, and/or refer members all as a part of the San Mateo County system of behavioral health care. This allows the member to access care seamlessly across the continuum without having to navigate across different billing entities or differentiate between the County network and other entities. The single entity model also enables the county and HPSM to collaboratively support care coordination in real-time. Through a Qualified Service Organization (QSO) agreement, HSPM has access to the county behavioral health system's electronic medical record (EMR), and during ICT meetings, HPSM provides care coordination information which results in member-centered, coordinated care planning.

*Shared Care Plans and Other Tools*

Cal MediConnect plans have been working to maintain a key aspect of care coordination— to break the silos between physical and behavioral health and take a more holistic view of each member.

As part of the data sharing processes, care plans are often shared among providers, and meetings of the ICT often include both the behavioral and physical health providers. This helps

to ensure that medical providers are aware of their patients' behavioral health services and treatment (including prescriptions), and vice versa. To ensure coordinated care, some plans have integrated their behavioral and physical health ICPs to foster a more holistic view of patients. Plans that do not have integrated care plans often ask providers for their signature to indicate their review of the care plan, to ensure they are reviewing the patient's other health goals and the other services the patient is receiving.

Cal MediConnect plans also use other forms and documents to share pertinent member information and keep providers up to date on members' care. For example, the Healthy San Diego collaborative developed a Coordination of Care Form that county behavioral health providers use to share members' behavioral health information with primary care providers. As county providers were already using it for Medi-Cal, the CMC plans in San Diego County agreed to use the form for their members as well.

*Patient Education*

In all counties, plan members must consent to behavioral health care coordination, and may be reluctant to participate due to factors including stigma of their behavioral health conditions or distrust of the medical system. As such, plans reported educating patients about the importance and benefits of care coordination as a best practice. Some plans reported that they have implemented proactive outreach processes to members who have newly entered care to see if they would like care coordination services, as well as check in with members over time to gauge satisfaction with services provided. Plans also noted the importance of ensuring that members continue to understand the services they are receiving, including when they may be transitioned to other behavioral health service levels.

## Ongoing Challenges and Next Steps

Despite CMC plans' targeted and comprehensive efforts and use of creative strategies to improve integration and coordination of behavioral health care services, there are several remaining challenges for which best practices were not easily identified:

- HIPAA and 42 CFR Part 2: HIPAA and the Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (42 CFR) Part 2, establishes a foundation of federal protection for personal health information by requiring safeguards to protect privacy and establishing conditions for the use and disclosure of this information without authorization. Some plans have faced challenges with data exchange due to county interpretations of HIPAA's federal data sharing laws as well as the strict requirements of 42 CFR, particularly regarding substance use treatments.[ii] Plans noted that many counties are reluctant to share

data due to often unfounded concerns about violating HIPAA rules. For plans working with more than one county, different interpretations of HIPAA by different county councils sometimes results in data sharing processes that are dissimilar between counties, creating inefficiencies and the need to develop time-consuming workarounds. Training county providers on privacy rules to prevent over-interpretation of the law could help to mitigate these challenges.

- Member Consent and Compliance: Plans reported some challenges in getting members to consent for behavioral health care coordination, despite the benefits. This may be due to the stigma around behavioral health diagnoses and the complexities of members' behavioral health and co-occurring conditions. For members who agree to care coordination, some plans have noted that some members who need to be stepped up or down to other levels of care or services are often reluctant to do so as it may result in unwanted changes to their care teams. Plans recognize that member education and ensuring the transparency of the consent process for the member are key to mitigating these challenges and are exploring options to fully overcome these issues.

**Appendix A: Behavioral Health Benefits in Cal MediConnect**

Coverage Responsibility Matrix

Updated January 2020

Health Plans will be responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medicaid.

While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration, Medi-Cal specialty mental health services that are not covered by Medicare and Drug Medi-Cal benefits will not be included in the capitated payment made to the participating health plans (i.e. they will be "carved out"). Demonstration plans will coordinate with county agencies to ensure enrollees have seamless access to these services.

Below are two tables (Coverage Matrix 1 and Coverage Matrix 2) that list the available mental health and substance use benefits and describe whether Medicare or Medi-Cal is the primary payer, and therefore whether the health plan or county will be primarily financially responsible for the services.

To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health services available per California's 1915(b) waiver and State Plan Amendments for targeted case management and rehabilitative mental health services.

Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use disorder treatment services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria specified in the 1115 waiver special terms and conditions and county Intergovernmental Agreement.

## Coverage Matrix 1: Mental Health Benefits

| Inpatient Services | | | |
|---|---|---|---|
| | **Type of Service** | **Benefit Coverage** | **Primary Financial Responsibility under the Demonstration** |
| **Psychiatric inpatient care in a general acute hospital** | Facility Charge | **Medicare** *Subject to coverage limitations* * | Health Plan |
| | Psychiatric professional services | | |
| | Medical, pharmacy, ancillary services | | |
| **Inpatient care in free-standing psychiatric hospitals** *(16 beds or fewer)* | Facility Charge | **Medicare** *Subject to coverage limitations and depends on facility and license type* * | Health Plan |
| | Psychiatric professional services | | |
| | Medical, pharmacy, ancillary services | | |
| **Psychiatric health facilities (PHFs)** *(16 beds or fewer)* | Facility Charge *(Most are not Medicare certified)* | **Medi-Cal** | County Mental Health Plan |
| | Psychiatric professional services | **Medicare** | Health Plan |
| | Medical, pharmacy, ancillary services | **Medicare** | Health Plan |
| **Emergency Department** | Facility Charges | **Medicare** | Health Plan |
| | Psychiatric professional services | | |
| | Medical, pharmacy, ancillary services | | |
| Long-Term Care | | | |
| **Skilled Nursing Facility** | Facility Charges | **Medicare/ Medi-Cal+** | Health Plan |
| | Psychiatric professional services | **Medicare** | Health Plan |
| | Medical, pharmacy, ancillary services | **Medicare** | Health Plan |
| **SNF-STP (fewer than 50% beds)** | Facility Charges | **Medicare/ Medi-Cal+** | Health Plan |
| | Psychiatric professional services | **Medicare** | Health Plan |
| | Medical, pharmacy, ancillary services | **Medicare** | Health Plan |

* County Mental Health Plans (MHPs) are responsible for the balance of inpatient psychiatric care that is not covered by Medicare for those beneficiaries who meet the medical necessity criteria for specialty mental health services. This includes any deductibles and copayments, and any services beyond the 190-day lifetime limit in a freestanding psychiatric hospital. Additionally, the County MHP is responsible for local hospital administrative days. These are days, as determined by the county, that a patient's stay in the hospital is beyond the need for acute care and there is a lack of beds available at an appropriate lower level of care.

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following an acute inpatient hospital stay of at least three days. For long-term care placement, Medi-Cal fee-for-service pays for these costs.

| Institutions for Mental Disease | | | |
|---|---|---|---|
| **Long-term care** | | **Benefit Coverage** | **Primary Financial Responsibility under the Demonstration** |
| **SNF-IMD, locked community-based facility for long-term care (more than 50% of beds are for psychiatric care)§** | Facility Charges ages 22-64 *Subject to IMD Exclusion**| **Not covered by Medicare or Medi-Cal+** | County Mental Health Plan |
| | Facility Charge ages 65 and older | **Medi-Cal** | Health Plan |
| | Psychiatric professional services | **Medicare** | Health Plan |
| | Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements) | **Medicare** | Health Plan |
| **Mental health rehabilitation centers (MHRCs) (IMD)** | Facility Charges | **Not covered by Medicare or Medi-Cal** | County Mental Health Plan |
| | Psychiatric professional services | **Medicare** | Health Plan |
| | Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements) | **Medicare** | Health Plan |
| **Psychiatric health facilities (PHFs) with more than 16 beds** | Facility Charges ages 22-64 *Subject to IMD Exclusion** | **County** | County Mental Health Plan |
| | Facility Charge ages 65 and older *(most are not Medicare certified)* | **Medi-Cal*** | County Mental Health Plan |
| | Psychiatric professional services | **Medicare** | Health Plan |
| | Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements) | **Medicare** | Health Plan |
| **Free-standing psychiatric hospital with 16 or more beds** | Facility Charges ages 22-64 *Subject to IMD Exclusion** | **Medicare*** | Health Plan |
| | Facility Charge ages 65 and older | **Medicare** | Health Plan |
| | Psychiatric professional services | **Medicare** | Health Plan |
| | Medical, pharmacy, ancillary services (some of these services may be included in the per diem reimbursements) | **Medicare** | Health Plan |

***** Medicare coverage for Institutions for Mental Diseases (IMDs) depends on the facility type, licensure and number of beds. IMDs include skilled nursing facilities (SNFs) with special treatment programs (STPs) with more than 50% of beds designated for primary psychiatric diagnosis, free standing acute psychiatric hospitals with more than 16 beds, psychiatric health facilities (PHFs) with more than 16 beds, mental health rehabilitation centers (MHRCs), and State hospitals. For those facilities that are Medicare reimbursable, once a beneficiary has exhausted his or her Medicare psychiatric hospital coverage, then Medi-Cal is the secondary payer. The Medi-Cal coverage would be subject to the IMD exclusion. Federal law prohibits Medicaid Federal Financial Participation (FFP) payment for beneficiaries age 22 to 64 placed in IMDs. This is known as the "IMD exclusion" and is described in DMH Letters 02-06 and 10-02.

+ A facility must be Medicare certified and the beneficiary must meet medical necessity criteria for Medicare coverage. Medicare pays up to 100 days after placement following an acute inpatient hospital stay of at least three days. For long-term care placement, Medi-Cal fee-for-service pays for these costs.

§ Patients placed in locked mental health treatment facilities must be conserved by the court under the grave disability provisions of the LPS Act.

| Outpatient Mental Health Services | | | |
|---|---|---|---|
| | | **Primary Financial Responsibility** | |
| **Type of Service** | **Benefit Coverage** | **Patient meets criteria for MHP specialty mental health services & is being treated by the county MHP^** | **Patient does NOT meet criteria for MHP specialty mental health services** |
| Pharmacy | **Medicare** | Health Plan | Health Plan |
| Partial hospitalization / Intensive Outpatient Programs | **Medicare** | Health Plan | Health Plan |
| Outpatient services within the scope of primary care | **Medicare** | Health Plan | Health Plan |
| Psychological testing/ assessment | **Medicare** | Health Plan | Health Plan |
| Mental health services§ *(Individual and group therapy, assessment, collateral)* | **Medicare** | Health Plan | Health Plan |
| Mental health services§ *(Rehabilitation and care plan development)* | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Medication management/Medication support services§ (*Prescribing, administering, and dispensing; evaluation of the need for medication; and evaluation of clinical effectiveness of side effects)* | **Medicare** | Health Plan | Health Plan |
| Medication support services§ *(instruction in the use, risks and benefits of and alternatives for medication; and plan development)* | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Day treatment intensive | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Day rehabilitation | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Crisis intervention | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Crisis stabilization | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Adult Residential treatment services | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Crisis residential treatment services | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |
| Targeted Case Management | **Medi-Cal** | County Mental Health Plan | Not a covered benefit for beneficiaries not meeting medical necessity criteria |

^1915b waiver and State Plan Amendments for targeted case management and expanded services under the rehabilitation option

§ Medicare and Medi-Cal coverage must be coordinated subject to federal and state reimbursement requirements. For further details on the services within these categories that are claimable to Medicare and Medi-Cal please see the following:

- DMH INFORMATION NOTICE NO: 10-11 May 6, 2010; DMH INFORMATION NOTICE NO: 10-23 Nov. 18, 2010; DMH INFORMATION NOTICE NO: 11-06 April 29, 2011

## Coverage Matrix 2: Substance Use Disorder Benefit -1115(a) Waiver Opt-In Counties

| | Type of Service | Benefit Coverage | Primary Financial Responsibility under the Demonstration |
|---|---|---|---|
| **Inpatient** | Inpatient Detoxification[1] | Medicare | Health Plan |
| **Inpatient/ Outpatient** | Professional Services[2] | Medicare | Health Plan |
| **Outpatient** | Structured Assessment Brief Intervention and Referral to Treatment (SBIRT)[3] | Medicare | Health Plan |
| | Drugs Used to Treat Opioid Dependence[4] | Medicare | Health Plan |
| | Partial Hospitalization Program | Medicare | Health Plan |
| | Outpatient Services | Drug Medi-Cal | DMC-ODS Pilot Program |
| | Intensive Outpatient Treatment Services | Drug Medi-Cal | DMC-ODS Pilot Program |
| | Narcotic (Opioid) Treatment Services[5] | Drug Medi-Cal | Health Plan (as of January 1, 2020) |
| | Additional Medication Assisted Treatment[6] | Drug Medi-Cal | DMC-ODS Pilot Program |
| | Withdrawal Management[7] | Drug Medi-Cal | DMC-ODS Pilot Program |
| | Residential Treatment Services[8] | Drug Medi-Cal | DMC-ODS Pilot Program |

[1] Any medication provided as part of inpatient treatment would be bundled into the inpatient payment and not paid separately. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1604.pdf

[2] Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf and https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf

[3] One alcohol misuse screening covered per year. Up to four counseling sessions may be covered if positive screening results. Must be delivered in a primary care setting. SBIRT may be provided via telehealth. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

[4] Medicare Part D does not cover methadone when used for treatment of opioid dependence. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1604.pdf

[5] Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries
Receiving Medicare Opioid Treatment Services Effective January 1, 2020 https://www.medicaid.gov/federal-policy-guidance/downloads/cib121719.pdf

[6] Counties contracting to participate in DMC-ODS may choose to offer additional MAT beyond the required NTP services. These additional services shall be described in the county intergovernmental agreement. Additional MAT includes the ordering, prescribing, administering, and monitoring of all medications for SUDs. These are medically necessary services that are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

[7] DMC-ODS counties are required to provide at least one level of withdrawal management services. DMC-ODS counties may offer additional levels.

[8] Counties must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.

# Appendix B: Cal MediConnect Plan Survey

**Identifying Behavioral Health Integration and Care Coordination Needs**

1. Describe the process in your county for referring beneficiaries to mild-to-moderate vs. specialty mental health services.
    a. Are there any challenges related to this process?
    b. How is the assignment communicated between the plan and county?

2. How do you as a plan identify members already receiving specialty mental health services?

3. How do you as a plan identify members in need of specialty mental health services?

4. Aside from the Health Risk Assessment (HRA) and referrals from PCPs, describe other ways in which you are identifying members who may be in need of behavioral health services or have unmet behavioral health service needs.
    a. Describe the process and timeline from identifying members to contacting them.

**Care Coordination and Care Integration for Members with Behavioral Health Service Needs**

5. What is your plan's approach to coordinating behavioral health care services delivered with in your plan (i.e. mild/moderate services)?
    a. Are you using an integrative model leveraging internal CMC plan resources or are you delegating care coordination and other services to a specialized third-party group (e.g. Beacon Health Options)?
    b. Explain the associated strengths and weaknesses, if any, of this approach.

6. What is the process of coordinating care for individuals who need specialty mental health services from the county? What are the key strategies utilized to coordinate care across agencies?
    a. Is the process unique to this population?
    b. What are the challenges and opportunities?

7. What is the plan's oversight process for ensuring that physical and behavioral health care is coordinated?
    a. How is this approach different for mild/moderate members compared to those receiving specialty mental health services from the county?
    b. How integrated are medical and behavioral health in your plan? Explain what this looks like, for example if behavioral health providers actively participate in care teams or if care plans are shared with behavioral health providers.

8. Some members' behavioral health conditions may improve or worsen over time, and they may transition from having mild-to-moderate to specialty mental health service needs, or vice versa.
    a. What does care coordination look like for these individuals, specifically?
    b. What are the key challenges in serving this population?

9. Are there any specific populations/sub-populations that are more challenging for you to coordinate services for, for example those with limited English proficiency or those with dementia?
    a. What are you doing to improve care delivery for these populations?
    b. Are there resources or policy changes that could help address some of these challenges?

**Plan/County Coordination**

10. Describe how the plan and county are working together under the CMC program to provide services to members with behavioral health needs?
    a. What does communication look like between the care coordinator and/or PCP (or ICT) and the county behavioral health provider?
    b. What does communication look like at the county administrative/plan level?
    c. What are the strategies used to facilitate communication between agencies?

11. What was your relationship with the county behavioral health department like prior to CMC and how has it changed since the program was implemented?
    a. Are there particular aspects that have improved or gotten worse?

12. For plans working with more than one county, do you feel that you have unique challenges or opportunities related to care coordination and integration?
    a. Have some strategies worked better in some counties than others?

13. Are you having difficulty understanding the plan's vs. the county's role in care coordination in any specific areas of the program? If so, what are these areas, and explain the challenges experienced.

14. Are there particular resources you need to do a better job coordinating behavioral health care both within and across agencies?

**Workforce, Training, and Education**

15. Describe the composition of your care team for members with behavioral health needs. Is it different for those with mild/moderate compared to Severe Mental Illness (SMI)?

16. Do you have dedicated staff with specific training to work with individuals with specialty mental health service needs?

17. Have you had to train staff to do care coordination?
    a. Are there specific resources that would be helpful to train additional care coordinators?

18. Describe what, if any, general workforce challenges you have?

19. Does your plan provide financial or other incentives to retain or attract staff?

20. For individuals in need of specialty mental health services, have you had any challenges working with members' behavioral health provider as a part of their care team? If so, please explain these challenges.

**Data Sharing**

21. The ability to have timely and accurate data for members is a key aspect of coordinating behavioral health services for CMC beneficiaries. What does data sharing look like between the plan and the county?
    a. How are you sharing data?
    b. What data is being shared – care plans, utilization, providers?
    c. What barriers/challenges, if any, exist to sharing data?

22. Are there certain processes or tools you have in place that you believe have contributed to improvements in data sharing across the county?

[i] 45 CFR 164.506. Uses and Disclosures for Treatment, Payment, and Health Care Operations. U.S. Department of Health and Human Services. Available at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html

[ii] 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records. U.S. Department of Health and Human Services. Available at: https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines.