

**BEHAVIORAL HEALTH TECHNICAL WORK GROUP**  
**FINAL REPORT AND RECOMMENDATIONS**  
*Department of Health Care Services*  
*Medi-Cal 1115 Waiver*  
May 2010

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On March 9, 2010, the California State Department of Health Care Services (DHCS) convened the first of four meetings of the Behavioral Health Technical Work Group (BHTWG). The BHTWG was one of five technical work groups that the DHCS established to advise them on various issues related to the renewal of the Medi-Cal Section 1115 Waiver. In particular, the BHTWG was charged with identifying potential models and approaches of for integrating behavioral health. This report summarizes the recommendations of the BWHTWG.

**BACKGROUND**

The integration of care for Medi-Cal beneficiaries with physical and behavioral health conditions, including substance use, has long been recognized as critical to improving the health outcomes of beneficiaries as well as reducing costs. A recent study found that nearly 50% of Medicaid beneficiaries with a disability suffer from a mental health condition. Although the proportion of beneficiaries who have a substance use problem is less well documented, it is also expected to be significant.

In addition to poorer outcomes for individuals with such co-morbidities, health expenditures to treat the chronic conditions are greater when a mental health condition is present. There is increasing evidence that integrating behavioral health with the treatment of the chronic condition reduces overall health care costs<sup>1</sup>.

For purposes of this discussion, we will use the following definition of integration developed by the Hogg Foundation – a leader in mental health:

*“...integrated healthcare is the systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served... The question is not whether to integrate, but how. Neither primary care nor behavioral health providers are trained to address both issues.”*

Efforts have been underway for many years in California to figure out how to better integrate primary care, mental health and substance use services. The discussions of the BHTWG and this paper build on the significant work already in progress and draws from the experiences and “lessons learned” of those local communities.

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<sup>1</sup> Unutzer, J. et al. Am J. of Managed Care 2008

- Counties such as Shasta, San Mateo, Santa Clara, and San Diego have all been engaged in integration activities that include the participation of community based FQHC's, the county mental health departments and in some cases local health departments working collaboratively on integration models;
- The County Medical Services Program (CMSP) has integrated care pilots underway in 12 clinics and 14 counties;
- Integration and stepped care initiatives are being designed and implemented by county mental health departments – including early pilots of mental (behavioral) health care homes which provide primary care services within mental health clinics;
- A significant number of counties with approved Mental Health Services Act-Prevention/Early Intervention Plans have identified mental health services in primary care as one of the primary activities for support; and
- The Integrated Behavioral Health Project (IBHP) has supported nine pilots over the last four years to model integrated behavioral health in community clinic FQHCs. A four-year foundation funded initiative, IBHP's goals are to accelerate integration and enhance access to behavioral treatment services within primary care settings, improve treatment outcomes for underserved populations, and reduce the stigma associated with seeking such services.

At the state level, the California Primary Care, Mental Health and Substance Use Services Integration Policy Initiative (IPI), brought together stakeholders across the different disciplines to craft a vision, set of principles and a roadmap for integration focusing, in particular, on the safety net. That report has informed the work of the BHTWG, which affirmed the vision and principles contained within the report as the starting point for their conceptual work (see Appendix 1)

In particular, the IPI recommends that efforts to integrate behavioral health, substance use and primary care recognize that people experience a spectrum of physical health, mental health, and substance use conditions, which can be categorized in four quadrants, as described in figure below. Individuals in Quadrants I and III, for example, may require a different mix or intensity of services than individuals in Quadrants II. It is important to note that individuals move between the Quadrants and the value of the Four-Quadrant Model is its use as a tool to help conceptualize systems of care, not in deciding individual treatment plans or outcomes.



	Cost Without Mental Health Condition	Cost With Mental Health Condition
All Adults (with and without chronic cond')	\$1913	\$3454
Heart Condition	\$4697	\$6919
High Blood Pressure	\$3481	\$5492
Asthma	\$2908	\$4028
Diabetes	\$4172	\$5559

From Carter Center Nov 2009 Presentation citing Robert Graham Center for source of data. Larry Green author.

The new 1115 Waiver proposes to test different integrated behavioral health models, approaches, and ideas as they relate to various population groups (i.e., Four Quadrants), managed care structures, and local delivery system relationships. As discussed by the BHTWG, the field is in relatively early development and no single approach has emerged. In fact, one lesson that is becoming clear from these models is that there is no one-size-fits-all model, and that the system must be designed to fit the local health care environment and the target population.

Therefore, the Waiver will provide opportunities to integrate behavioral health and/or substance use core components in the development of Organized Delivery Systems (ODS) for the "Seniors and Persons with Disabilities" (SPD) population as well as in the continuation and potential expansion of the Health Care Coverage Initiative (HCCI).

The goals of piloting different approaches for the integration of behavioral health and substance use in select ODS and HCCIs are:

- To inform the development of standards for managed care, including network and access standards, for mental health and substance use services for the SPD population and, potentially, to test those standards
- To inform the development of a mental health and substance use benefit that will be incorporated in the Benchmark benefit package, required by federal Health Care Reform for the new Medicaid expansion population.
- To apply and evaluate best practices for integrating behavioral health and substance use services into a Person Centered Health Care Home in order to serve the spectrum of behavioral health and physical health conditions and needs. This approach could focus on the Frequent Users population within an HCCI or other ODS.

It should be noted that the federal health care reform law creates a new state option, as a State Plan Amendment, effective January 1, 2011, to allow Medicaid beneficiaries with chronic conditions, including serious and persistent mental health conditions, to designate a provider or a team of providers, as a health home. The State should explore the implications of this option for implementing the various ideas, especially as they relate to the SPDs or HCCI.

### Pilot Elements

The BHTWG recommends that pilots clearly address the following elements:

1. Core components. The state-convened Behavioral Health Technical Workgroup (BHTWG) developed a matrix (see Appendix 2) that identifies the key core components of integrated behavioral health care along four dimensions—clinical, operational, financial, and oversight—as well as a range of best practices for each of them. The five core components are:

- Care Management:
- Data Management and Information Exchange
- Engagement of Consumers
- Clear Designation of Person Centered Health Care Home
- Performance Measures

Models should incorporate most, if not all, of the core components, although they will need to be tailored to the particular circumstances of the county and the configuration of the service delivery system. In addition, since the pilots will not be stand-alone, the governance will need to be clearly delineated within the overall governance of the HCCI or ODS.

The BHTWG recognizes that it is not feasible—certainly, initially—to implement all core elements for all populations, so the ODS or HCCI will determine which core elements and best practices are best-suited and most critical for different populations. For example, people with chronic disease and mild mental health issues may benefit from a certain level of care management, while individuals with multiple chronic diseases and severe mental illness will likely require more intensive care coordination and spectrum of services.

2. Target populations. As described above, people with both physical and behavioral health conditions, can be categorized in four quadrants, depending on the number and severity of those conditions. However, to be clear, the four-quadrant model is a population designation and individuals may move between and across those quadrants. A fully integrated system would enable individuals to access the system through different service “doors” and receive a level of services commensurate with the need.

The approach outlined in this paper intentionally allows for the decision making around defining which specific target populations (within the conceptual four-quadrant model)

will be the focus of the pilot approaches to be determined at the local level. And, since specialty mental health services provided under the 1915 (b) Waiver will continue to remain outside of this 1115 Waiver, local counties may choose to address certain issues regarding the behavioral health integration needs of the SMI in their pilot approaches, such as “braiding” financing, with an overall goal of improving access to medical care for people with SMI who also have disabilities or chronic physical conditions.

It is anticipated that one or more of the pilots will address the so-called “Frequent User” population, defined as individuals with a complex set of chronic conditions, including mental health. Because they generally receive uncoordinated care, they utilize hospital ERs at a very high frequency. The Frequent Users pilot could be incorporated into either an HCCI or an ODS for SPDs, depending on where the population is identified.

3. Financial incentives and other financing issue. Lessons learned from other states and pilots, especially the Pennsylvania model that utilizes the principle of shared risks and shared financial incentives, would be used to align financing with the practice changes being sought. Because various elements of the health care system are involved – and potentially benefit from – integrated behavioral health care, financing arrangements should be developed that align the incentives to produce improved health outcomes and lowered costs over the long term. Models will identify and incorporate different structures and mechanisms for developing a financing system that will be sustainable and that promotes system integration and transformation.

There are, additionally, several financing barriers, which pilots could address, that prevent FQHC clinics and other providers from integrating behavioral health that must be addressed for integration to become an adopted and accepted standard of practice. Such barriers include:

- Not reimbursing health centers for both a mental health visit and a primary care visit on the same day;
- Not reimbursing for the services of Marriage and Family Therapists (MFTs), when they make up the largest proportion of mental health providers in the state;
- Denying coverage for the cost of case management services for FQHC’s most complex patients; and
- Limiting primary care providers’ ability to reach patients beyond clinic walls, for example for outreach purposes or to work collaboratively and co-locate within County Mental Health settings.

There must be financial incentives included in the waiver that encourage care coordination and case management that can be delivered by a variety of appropriate staff to promote team-based care. Some of the best practices in primary care based chronic care are not currently reimbursable at FQHC’s. For example, in the clinic setting, disease management and care coordination activities utilize a range of providers, from physicians and nurses, to health educators and medical social workers. Many of the tasks needed to appropriately care for some aspects of chronic care conditions -- particularly monitoring and education—may be better performed by other team members, including well trained consumer and peer advocates, if they have special skills or experience, such

as language proficiency or other cultural sensitivity, or personal experience of the disease. However, provider organizations are generally not paid for non-physician caregivers, preventing clinics from being able to properly support the critical work performed by other members of these multidisciplinary teams.

Local communities interested in implementing BH pilot approaches should consider financing that would pay for components of the Chronic Care Model that have been shown by the research literature to be effective not only in improving health outcomes, but also in reducing non-ambulatory costs, such as hospitalization, but that are currently not eligible for Medi-Cal reimbursement within clinics. Examples include: group visits, time spent entering data into and using disease registries for population management, and reimbursement for patient self-management training which is especially critical for chronic conditions, where management is under direct control of the patient (such as diet and medication use)<sup>2</sup>.

4. Oversight. Because an HCCI or ODS will assume responsibility for improving outcomes for persons with behavioral health issues, these behavioral health integration efforts will be conducted through those organizations, which will have overall governance of the pilot approaches. Nevertheless, many of these pilots will involve specialty mental health services and substance use services, which are provided by different systems of care, administered by counties. Therefore, these pilot approaches will require the managed care plan, ODS or HCCI to develop partnerships with county mental health, behavioral health plans and specialty mental health care providers, as well as substance use programs and providers. Similarly, to the extent that community clinics and FQHCs are included, or seek to be included, in the network participating in a county HCCI or ODS serving the SPD population, partnership arrangements will need to be developed. The inclusion of consumers and well-trained advocates will also enhance the oversight of the pilot approaches. It will be particularly important that all such arrangements provide clear accountability that promotes integration and ensure there are opportunities for behavioral health clinics, as well as primary clinics, to serve as a Person Centered Health Care Home.

**B. Pilot Approaches for Integrating behavior health care, including substance use services, in the 1115 Waiver:** Because of the changes required by the federal health care reform and parity laws, it is recommended that Pilots prioritize issues and approaches that best lay the groundwork for and can inform the implementation of those laws. The recommendations regarding the specific elements in each pilot are intended to provide guidance about best practices, based on the literature and the experience of BHTWG participants. However, as mentioned above, the BHTWG recognizes that each pilot will need to be designed to accommodate the local health care environment and the target population.

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<sup>2</sup> CPCA Behavioral Health Integration Waiver Comments/Paper, April, 2010

1. *Integrate Behavioral Health in the Person Centered Health Care Home in an Organized Delivery System for SPDs.* Integrate behavioral health and primary care and enable both the behavioral health and primary care settings to serve as a Person Centered Health Care Home for SPDs. This pilot would inform the development of contract requirements being developed for organized delivery systems/managed care for SPDs, with specific regard to mental health and substance use services.

For people with a Serious Mental Illness (SMI), who receive mental health treatment under the separate 1915(b) Waiver, integrated behavioral health efforts may focus on how best to coordinate and integrate services provided by the two systems of care—the ODS and the specialty mental health plan. However, data indicate that there are substantial numbers of SPDs who suffer from some type of mental health condition that does not qualify as a SMI (Faces III). For those individuals, the ODS will have responsibility for ensuring that behavioral health care is accessible, integrated and coordinated.

Based on the work of the BHITWG, it is recommended that the pilot include:

- Care Coordination (see previous worksheet)
  - Team Based Care
  - Psychiatric consultation
  - Engage medical specialty care in the discussion
  - Explore options to facilitate consultation process, i.e., telemedicine, e-Referral process
- Data Management/Information Exchanges:
  - Reporting and feedback loops to inform work
  - Population based care and registries
- Engagement of Consumers:
  - Use of Motivational interviewing approaches
  - Brief interventions
  - Self-management goal setting
  - Problem solving skills to teach patients how to live with their illness
  - Healthy Living Classes, Tobacco cessation programs, etc
  - Use of trained consumer advocates/persons with life experience as potential workforce in these area
- Clear Designation of PCHCH:
  - Bidirectionality – each home takes primary responsibility for the care and coordination of services, both PC and BH, and adequately resourced to carry out these services.
  - At minimum, virtual home with an emphasis on communication and coordination, ease of shared record, active outreach to bring in people
  - Physical co-location (with warm hand-offs) would be optimal but this does not always translate into integrated care and is not always practical given space restraints, etc.
  - Defined process for designating where the primary home is so clear responsibility for care coordination.

- Oversight: A partnership between county BH/PC/SU and local health plan or organized delivery system serving the SPD population would need to be developed to manage the financing and incentives. To the extent that primary care is delivered by community clinics and FQHCs, it is expected that clinics could contract with ODS and have opportunities to be the health home.
- Evaluation and measurement:
  - Cascades model
  - Measures should be phased in. While early pilot implementation efforts may be necessarily focused on incentivizing systems to work on the structural and process measures, pilots should concurrently identify client outcome measures that are also appropriate to be launched simultaneously or nearly simultaneously and that, over time, can be developed to scale:
    1. Structural measures, such as establishing and implementing staged financial incentives
    2. Process measures
    3. Screening measures need to have accompanying resources to address positive screens
    4. Outcome measures

2. *Integrate behavioral health core components and/or substance use treatment in a HCCI county.* Similar to the pilot above, this pilot approach would integrate behavioral health and primary care and enable both the behavioral health and primary care settings to serve as a Person Centered Health Care Home for enrollees of a county HCCI. Elements would include bi-directionality, care coordination, stepped care and universal screening.

- People with conditions in all of four quadrants would be served through an HCCI expansion that includes behavioral health. However, given that counties' CPEs are not distributed across all four quadrants, it is important to look at where counties have match able dollars, and design a proposal that follows the dollars and uses that match.
- Oversight would reside at the county level, with the HCCI bringing all parties together. To the extent that primary care is delivered by community clinics and FQHCs as they do in many current HCCI, it is expected that clinics could contract with counties as the primary care site for providing integrated behavioral health services.
- For HCCI pilots that focus specifically on integrating substance use screening and treatment:
  - Core elements: Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs that have demonstrated success in allowing for substance use screening and brief treatment in primary care settings; provider training; triage to ensure that referral works, treatment happens, and information comes back; appropriate linkage and referral to mental health.

- All partners would share in the financial risk and savings, especially hospitals if they see a reduction in avoidable ED and inpatient usage.
- Health outcomes include self-perception of health status, harm reduction, compliance with care plan, increased PCP use, reduced incidence of avoidable hospitalization and ED use.
- Financing: Medi-Cal can pay for the screening portion of SBIRT in order to obtain FFP. Drug Medi-Cal can now pay for some treatment services so that financing could be incorporated into the Waiver. Similarly, mechanisms for local investments in BH can be used as a match in the context of HCCI.

3. *Integrate behavioral health and substance use services in a HCCI county with a focus on Frequent Users population.* Incorporate intensive case management, with connections to a range of social supports, within a person-centered health care home, in order to address the unique needs of the so-called “frequent users” population.

- Target population would primarily focus on Quadrants 2 and 4, with high mental health needs.
- Health care home would be located with either the primary care or the behavioral health provider.
- Oversight would rest with the county, and a partnership with the county behavioral health managed care would need to be developed.
- Case rating and risk adjustments to the managed care plan would be developed
- Process, health and financial outcomes include:
  - Relationship building with the various partners and stakeholders, including hospitals, law enforcement, PCP, MH and SU service providers
  - Reduced hospitalization and ER visits; improvements in chronic conditions
  - All partners share in financial risk and incentives to promote sustainability

4. *Develop a mental health and/or substance use benefit for inclusion in the benefits package offered through a HCCI.*

- California will need to establish a “benchmark” benefits package for individuals that will become Medicaid eligible in 2014 as a result of federal health care reform. Because of the federal parity law, it will need to include some level of mental health and substance use services. This pilot would enable California to obtain experience with developing a benefits package and setting rates for these services in advance of the deadline for implementation in 2014.
- In designing the mental health benefit, direct mental health services as well as care coordination activities and other core elements should be considered. County or contracting clinics could be reimbursed for providing primary and mental health services on the same day, if the services are co-located.
- HCCIs could focus on incorporating a comprehensive substance abuse benefit so that SU services become integrated into the overall health care coordination and

management of the beneficiary. County drug treatment funding or Drug Medical could be integrated and used as match.

## Appendix 1

### The Integration Policy Initiative

Launched in 2008, the Integration Policy Initiative (IPI) is a collaborative project, led by the California Institute for Mental Health (CiMH), the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP). The IPI is a project of CiMH and funded by The California Endowment with additional financial support provided by IBHP.

### IPI Vision

*Overall health and wellness is embraced as a shared community responsibility.*

### IPI Principles

To achieve individual and population health and wellness (physical, mental, social/emotional/ developmental and spiritual health), healthcare services for the whole person (physical, mental and substance use healthcare) must be seamlessly integrated, planned for and provided through collaboration at every level of the healthcare system, as well as coordinated with the supportive capacities within each community. The IPI Principles are the foundation for that collaborative activity.

1. The Institute of Medicine report, *Improving The Quality Of Health Care For Mental And Substance-Use Conditions*,<sup>1</sup> made two overarching recommendations:
  - “Health care for general, mental, and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.
  - The aims, rules, and strategies for redesign set forth in *Crossing the Quality Chasm* should be applied throughout mental/substance use health care on a day-to-day operational basis but tailored to reflect the characteristics that distinguish care for these problems and illnesses from general health care.”
2. Person-centered healthcare and recovery/resiliency are central to achieving overall health and wellness, as described in the Quality Chasm aims/rules and the MH/SU Recovery statements in the Report.
3. Individuals need timely access to healthcare for the whole person, based on each person’s preferences, beliefs, needs, culture, family and support systems, views about wellness and individual strengths and resources.
4. When a child/youth is being served, healthcare services apply not only for the individual, but for the family. Services that are child-and-family-centered involve family members’ participation in educational and other services and attention to the healthcare needs of the family members
5. Addressing population disparities in physical, mental and substance use healthcare means ensuring parity of access (e.g., notwithstanding race, ethnicity, gender, sexual orientation, age, cognitive ability, insurance/economic status, geography) and

- providing culturally competent services without stigma in the context of the individual's primary language and cultural, spiritual and value systems.
6. Positive relationships, communication, acknowledgement of interdependence and collaborative learning among physical, mental and substance use healthcare providers are critical.
  7. Providers in primary care and MH/SU settings will demonstrate core competencies in physical, mental and substance use healthcare screening/identification of need, referral protocols and collaborative care models.
  8. Services are delivered through person-centered, team-based care with consistent use of proven collaborative care models.
  9. Prevention and early intervention, evidence-based practices and promising practices are used wherever possible to optimize health and well-being as well as effective clinical outcomes and cost effectiveness.
  10. Planning and implementation ensures that integration is achieved at both the person-level and the community/population-level:
    - Each individual has a person-centered healthcare home, which provides MH/SU services in the primary care setting or primary care services in the MH/SU setting.
    - Each community has established a Collaborative Care Mental Health/Substance Use Continuum (the IPI Continuum). The IPI Continuum is a framework for service development that identifies population need across MH/SU levels of risk/complexity/acuity and assigns provider responsibilities within any given community for delivering those services. The community dialogue to establish the Continuum should result in mechanisms for stepped MH/SU healthcare back and forth across the Continuum, mechanisms to address the range of physical health risk/complexity/acuity needs of the population, and collaborative links between the integrated healthcare system and other systems, community services and resources
    - Measurement is aligned to support the IPI Continuum, Quality Improvement and fidelity implementation of proven models as well as evaluation of emerging models, with accountability, transparency and measures matched to the levels of the Continuum.

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<sup>i</sup> *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, Institute of Medicine, 2005