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How California Can Build On CalAIM to Better Integrate Physical and Behavioral Health Care

A growing number of Medi-Cal members have serious behavioral health conditions, and many of them experience barriers in accessing care and poor health outcomes.[1] The pandemic has exacerbated these challenges, as Californians with low incomes have reported that their mental and emotional health has worsened during the pandemic, and drug overdose deaths have increased by 45%.[2]

People with serious mental illness (SMI) and substance use disorders (SUDs) often have co-occurring medical conditions and complex social needs that affect their health and well-being. They experience higher rates of chronic physical conditions, homelessness, and early mortality.[3] Across the country, people with behavioral health conditions receive less preventive care and more acute care.[4] Californians with behavioral health needs often struggle to access treatment, especially in lower income regions of the state.[5] While many residents have co-occurring mental health and SUD needs, only 1 in 13 with dual diagnoses receive treatment for both.[6]

In Medi-Cal, physical and behavioral health care services are managed and administered across several separate systems. Medi-Cal managed care plans (MCPs) manage physical health and nonspecialty mental health services, while county behavioral health departments manage both specialty mental health and SUD care, often through separate county programs.[7] County behavioral health agencies have deep expertise in managing and delivering care for populations with serious behavioral health needs, and in managing the broad array of behavioral health funding sources. However, when Medi-Cal members experience complex and interrelated physical and behavioral health conditions, they must navigate multiple systems to find the care they need. Physical and behavioral health providers often do not receive information about the co-occurring needs or treatment plans of their patients, and therefore are constrained in how they can deliver whole-person care. This fragmented care then leads to higher costs — people with serious behavioral health conditions incur greater spending on care, and these costs are largely attributable to increased physical health spending.[8]

Clinical integration of care has been shown to improve health outcomes for people with co-occurring physical and behavioral health conditions.[9] In California, many initiatives have been designed to advance clinical integration of care, including Whole Person Care pilots, the Health Homes Program, and the Coordinated Care Initiative, as well as many other initiatives led by counties and providers. CalAIM (California Advancing and Innovating Medi-Cal), which encompasses the CalAIM Section 1115 demonstration and the CalAIM Section 1915(b) waiver as well as related contractual and Medi-Cal State Plan Amendments, represents a significant opportunity to improve how care is delivered and experienced for people with serious behavioral health needs.[10] Some CalAIM behavioral health initiatives are explicitly designed to improve integration between mental health and substance use disorder care, and between physical and behavioral health. Although these initiatives do not change the carve-out of specialty behavioral health services in Medi-Cal, if implemented effectively they could help build a more integrated system of care over the long term.

"In order to meet the physical, behavioral, developmental, and oral health needs of all members in an integrated, patient-centered, whole person fashion, DHCS [the California Department of Health Care Services] is seeking to — over time — integrate delivery systems and align funding, data reporting, quality, and infrastructure to mobilize, incentivize, and support care delivery toward common goals."

— CalAIM Section 1115 Renewal Application

California policymakers have meaningful opportunities to build on the strengths of the specialty behavioral health system while leveraging the promise of CalAIM reforms to address the fragmentation in physical and behavioral systems and ensure that all members can experience the benefits of integrated care. This brief analyzes how relevant CalAIM reforms can build toward greater physical-behavioral health integration. It profiles local innovations and select national examples that can inform areas of opportunity for Medi-Cal to advance integration at the interface of MCPs and county behavioral health agencies.

Framework for Physical-Behavioral Health Integration

Efforts to improve physical-behavioral health integration must occur across various system functions, including financing, administration, and clinical care delivery. These efforts are closely interrelated and mutually reinforcing.

- **Financial integration** initiatives integrate purchasing of physical and behavioral health care, which creates aligned incentives for managing total cost of care and a holistic array of outcomes. Financial integration also supports value-based payment (VBP) approaches.
- **Administrative integration** initiatives support the delivery of integrated care through traditional managed care functions such as network management, provider payment, and data collection and reporting.
- **Clinical integration** initiatives advance integrated care at the point of service delivery.

Initiatives to achieve clinical integration often encounter barriers related to financial and administrative fragmentation, such as misalignments in funding and data reporting requirements. This brief focuses on financial and administrative integration opportunities to address these barriers at the intersection of MCPs and county behavioral health systems.

Integration efforts can be understood as existing along a continuum. The north star of integration efforts is achieving a "single point of accountability" for physical and behavioral health. However, effective integration efforts take into account where systems are starting from and build from there. Accordingly, it is often critical to address "building blocks for integration" as key steps in system evolution toward the goal of a single point of accountability. Some examples of these building blocks include these:

- Infrastructure such as data sharing and health information exchange
- A licensing and regulatory environment related to integrated care delivery
- Quality measurement that assesses outcomes across the full continuum of services
- Provider readiness supports for integrated care delivery
- Payment methods and financial incentives for integrated practices, including the development of VBP models across physical and behavioral health

A number of CalAIM initiatives can serve as important building blocks for more integrated physical and behavioral health care in Medi-Cal, but their impact will depend on how they are implemented. There are numerous opportunities to continue building toward this single point of accountability by supporting greater financial and administrative integration within the current system.

The Potential Impact of CalAIM on Physical-Behavioral Health Integration

CalAIM behavioral health initiatives address a range of important issues for the delivery and sustainable financing of behavioral health, including expanding access to care, reducing administrative burden, moving toward integration of mental health and SUD, and more closely aligning payment for behavioral health with physical health. Whereas the most ambitious of these is the proposed Full Integration Plan pilot, which reflects the north star of a single point of accountability, many other initiatives also create or strengthen key building blocks for integration. Some of these initiatives may not focus explicitly on integration as a near-term goal. However, by centering a vision for integration, stakeholders may be able to leverage opportunities over the long term toward greater integration across all levels of the system. These initiatives are briefly described below along with a brief analysis of the potential impact on integration.

Behavioral Health Policy Reform (components implemented beginning in January 2022). This initiative changes and modernizes several behavioral health policies in Medi-Cal, including revising criteria for accessing specialty mental health services; allowing reimbursement for treatment services during the assessment period (before diagnosis); clarifying reimbursement for treatment of services for co-occurring SUD diagnoses; implementing a standardized, statewide screening and transition tool; and updating clinical documentation requirements.[11] Documentation redesign reforms (currently planned for implementation in July 2022) will standardize assessments and requirements for clinical documentation of specialty mental health and SUD services.

The "no-wrong-door" policy (also to be implemented in July 2022) will enable providers to be reimbursed for initial assessment and treatment before diagnosis even if the individual is later transferred to a different delivery system. As a result, people seeking care who may or may not yet have a behavioral health diagnosis will be more able to get medically necessary treatment in the settings where they present. These initiatives are supported through the Behavioral Health Quality Improvement Program, which provides incentives for counties to implement activities related to these policy changes as well as payment reform and data exchange with managed care plans.[12]

- **Impact on integration.** Revising criteria for specialty mental health services may reduce fragmented care by standardizing definitions and system responsibilities. Establishment of standard statewide criteria is critical for clarifying the roles and responsibilities for MCPs and counties, which can lay the groundwork for the delivery of more coordinated care. Additionally, simplifying and streamlining clinical documentation and removing burdensome requirements will make it easier for providers to offer treatment of co-occurring physical and behavioral health conditions.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal and Policy Improvements (implemented January 2022). DMC-ODS became the first SUD treatment demonstration project in the country approved under a Section 1115 waiver when it was initiated in 2015. Under DMC-ODS, participating counties opting into the program serve as managed care plans with increased responsibilities for ensuring access to evidence-based SUD services and coordination with other systems. Under CalAIM, DHCS is reforming some DMC-ODS policies and supporting broader county participation.[13] In certain DMC-ODS

counties, DHCS will also pilot contingency management, an evidence-based behavioral health treatment for psychostimulant use disorders.

- **Impact on integration.** By promoting DMC-ODS participation among the remaining counties, this initiative could improve member access to evidence-based treatment practices and a continuum of SUD services as well as create administrative efficiencies that will increase the capacity of county behavioral health agencies. These policy improvements can also support counties' flexibility to use funding to design new approaches and potentially participate in new arrangements with other partners. Additionally, since counties participating in DMC-ODS have requirements to coordinate care across physical and behavioral health systems, greater overall DMC-ODS participation could lead to improvements in member experience.

Enhanced Care Management (ECM) (implemented beginning in January 2022). ECM is designed to address clinical and nonclinical needs of enrollees with complex needs through systematic coordination of services and care management, including across the physical and behavioral health delivery systems.[14] The ECM benefit will be delivered by ECM providers that contract with MCPs. High-touch care coordinators support six populations of focus, including adults with SMI or SUD or both. ECM providers can be medical and behavioral health care providers and community-based organizations; the largest group is expected to be Federally Qualified Health Centers. MCPs are encouraged but not required to contract with county behavioral health departments as ECM providers, and they must describe how they will prioritize engagement of county behavioral health systems in their ECM Model of Care.

- **Impact on integration.** ECM providers must coordinate care across physical and behavioral health services, which can support better overall coordination of care for those with co-occurring physical and behavioral health conditions. While this initiative will identify a single entity responsible for care management for many people with co-occurring conditions, the opportunities to advance more integrated care through ECM will depend on which providers are contracted as ECM providers, and on those providers' capacities and infrastructure to coordinate across physical and behavioral health (for example, through data exchange with MCPs). As MCPs build their ECM provider networks, contracting with county behavioral health agencies and county provider networks represents a key opportunity to support more integrated care for people with serious behavioral health conditions.

Community Supports (implemented beginning in January 2022). MCPs have the option to offer Community Supports as medically appropriate, cost-effective alternatives to services covered under the Medicaid State Plan.[15] The 14 approved Community Supports are designed to support those with complex needs, and include housing-related services, medical respite, and meals, among others. Community Supports have been designed to support Medi-Cal members experiencing challenges such as homelessness and food insecurity, and among these populations is a high prevalence of people with serious behavioral health conditions eligible to receive care from specialty behavioral health systems.

- **Impact on integration.** MCPs and Community Supports providers should align efforts related to people served by specialty mental health or DMC-ODS or both with county behavioral health agencies, as applicable. Additionally, if people receiving Community Supports are also eligible for ECM, the ECM provider is required to coordinate across the Community Supports providers as well as physical and behavioral health providers. County behavioral health agencies can be providers of three Community Supports — housing transition and navigation services, housing tenancy and sustaining services, and day habilitation programs.[16] Additionally, counties have important roles to coordinate with providers of other Community Supports,

such as sobering center services, short-term post-hospitalization housing, and recuperative care. For example, when Medi-Cal members use sobering center services, providers would need to directly coordinate with county behavioral health agencies for warm handoffs and to support linkages for follow-up treatment. Additionally, after discharge from an inpatient psychiatric stay managed by a county mental health plan, people experiencing homelessness or unstable housing could receive short-term posthospitalization housing or recuperative care. These scenarios demonstrate the importance of alignment across physical and behavioral health entities to support coordinated care for those with complex needs.

Behavioral Health Payment Reform (to be implemented in July 2023). Under the current system, counties providing behavioral health services are reimbursed for costs incurred using Medicaid Certified Public Expenditure (CPE) methodologies. Through CalAIM, behavioral health payment reform will shift away from CPE to intergovernmental transfer (IGT) methodologies and reimburse counties on a fee-for-service basis. To establish the new payment rates for services, specialty behavioral health systems will mostly transition away from Healthcare Common Procedure Coding System Level II coding to instead use Current Procedural Terminology (CPT) coding. CPT coding is more specific, which will better support accurate reimbursement to counties and more effectively track quality outcomes.

- **Impact on integration.** Payment reform could more closely align reimbursement and documentation for behavioral health with methodologies used for physical health, which would serve as an initial building block for greater integration and risk-based contracting. While physical and behavioral health systems use CPT coding in different ways, more standard use of CPT may lay the groundwork for integrated utilization management and data systems in the future.

SMI/SED IMD Waiver (to be implemented July 2023). States generally cannot receive federal Medicaid matching funds for services provided to Medicaid enrollees in institutions for mental disease (IMDs), defined as hospitals, nursing homes, or other institutions with more than 16 beds that are primarily engaged in treating people with mental illness.[17] DHCS anticipates developing and submitting a Section 1115 demonstration waiver request in October 2022 to receive federal matching funds for short-term residential treatment services in IMDs for people with an SMI or serious emotional disturbance (SED). As a condition of federal approval, this waiver would require increased investment in the full continuum of care beyond residential treatment, with a focus on community-based services, to increase access to treatment. To inform the upcoming waiver request, DHCS produced an assessment of California's behavioral health system capacity that defined a core continuum of behavioral health services across eight major service categories.[18]

- **Impact on integration.** While this waiver request has not yet been developed, many of the required elements will likely relate to key building blocks for integration. Some of the goals of this demonstration are improved access to community-based services for people with SMI and SED, including through increased integration of primary and behavioral health care, as well as improved care coordination and transitions.[19] Additionally, the demonstration requires development of a health information technology plan that would address data integration across physical and behavioral health. Achieving these goals may require infrastructure investments as well as provide supports for integrated care delivery.

Behavioral Health Regional Contracting (implementation date to be determined). This initiative encourages counties to pursue regional contracting arrangements to manage behavioral health. Regional contracting is currently allowed, but few counties have developed these arrangements. Regionalization will potentially reduce administrative burden and improve

access to care, especially for smaller counties, as well as support greater participation in DMC-ODS.

- **Impact on integration.** This initiative could support smaller counties in developing the capacity and readiness to achieve greater integration of mental health and SUD. Additionally, by regionalizing, counties could focus on joint infrastructure investments (such as information technology) that are the building blocks to physical-behavioral health integration.

Administrative Integration of Mental Health and SUD (to be implemented January 2027). Specialty mental health and SUD services are administered through separate plans and structures within counties, which create significant burdens for people in navigating care, as well as administrative burdens and barriers to integration for providers and plans. This initiative will integrate county specialty mental health and SUD services into a single county behavioral health managed care program. Administrative integration will move toward a single behavioral health contract between the county and state, as well as changes to data sharing with providers and to electronic health records (EHRs). While many counties currently have separate EHRs for specialty mental health and SUD services, administrative integration will require counties to develop approaches for sharing EHRs across specialty mental health and SUD providers.

- **Impact on integration.** Administrative integration can support greater clinical integration of care for specialty mental health and SUD needs. Providers may be more likely to offer both mental health and SUD care when they contract with a single county plan for behavioral health, versus separately with MHPs and DMC-ODS. If providers contract with a single plan, they will not have to navigate different policies and practices related to credentialing, auditing and oversight, and billing for mental health and SUD care, as they do now. Administrative integration will also support more clinical integration for Medi-Cal members across their behavioral health needs through such mechanisms as integrated 24-hour access lines and coordinated treatment planning.[20] Administrative integration of mental health and SUD care is also necessary to advance physical-behavioral health integration. Enabling operational efficiencies within county behavioral health systems may increase their capacity to integrate with physical health systems. To the extent that county behavioral health departments develop integrated EHRs for mental health and SUD, these could help streamline development of an EHR inclusive of physical and behavioral health data, a pivotal building block for integration.

Full Integration Plans (no sooner than January 2027). Under this proposal, DHCS will support a pilot of Full Integration Plans that integrate physical, behavioral, and oral health under a single entity and contract. Future stakeholder input will inform the design of this model, which would address what types of entities will be eligible to serve as these entities and any requirements for partnerships, as well as management of non-Medicaid funding streams.

- **Impact on integration.** Full Integration Plans will achieve a single point of accountability for payment, administration, and oversight for physical, behavioral, and oral health for designated enrollees. This model has the potential to improve enrollee experience and health outcomes by streamlining the very complex systems for physical and behavioral health care and supporting the delivery of coordinated, whole-person care.

Select County-MCP Integration Initiatives

A number of California counties and MCPs have been exploring innovative approaches to advancing more integrated administration and financing of physical and behavioral health. These approaches, often developed to address the barriers to delivering more integrated care within the current system,

offer valuable lessons for stakeholders. Notably, both examples below are County Organized Health System MCPs, in which only one MCP serves a county. Scaling these integrated approaches to other managed care models throughout the state would likely entail additional complexities.

Wellness and Recovery Program: Regional DMC-ODS Program

In 2020, Partnership HealthPlan of California contracted with seven counties to launch a regional DMC-ODS program known as the Wellness and Recovery Program.[21] Under this program, Partnership administers the SUD benefit on the counties' behalf, managing functions such as provider contracting and payment, a 24-hour access line, and data reporting requirements. Counties pay Partnership for each Medi-Cal enrollee who uses SUD services in a given month (a "per-user per-month" payment). Partnership then pays its contracted SUD providers.

In the Wellness and Recovery Program, financial integration of medical and SUD care within the MCP supports clinical integration of SUD care across the continuum of need, with a no-wrong-door approach. Across the state, Medi-Cal physical health and SUD services have been historically managed separately, resulting in a lack of systematic coordination across members' medical and SUD care. While 37 of California's 58 counties (as of February 2022) participate in DMC-ODS, many of California's smaller and more rural counties do not have the administrative or financial capacity to participate in the program. By supporting county participation in DMC-ODS, the program allows Medi-Cal members in these counties to access expanded SUD services across the region from a larger pool of available providers.

Partnership and the participating counties needed to navigate many programmatic and contractual issues to develop this program and encountered significant challenges in developing and receiving state and federal approvals for the financial arrangement. The per-user per-month arrangement addressed many of these issues, and was designed to ensure that counties do not pay for services not delivered, rates vary across counties, and Drug Medi-Cal funds do not mix with funding for other services.[22] The Wellness and Recovery Program supports greater clinical integration, though it does not fully integrate all financing — each respective partner is at risk for and can achieve savings from either medical or SUD care alone, and it excludes mental health. Regardless, it does offer an approach for greater integration that could be used by other counties or regions. By integrating the administration of a subset of behavioral health benefits and all physical health benefits, this program supports administrative efficiencies for the MCP and counties, more integrated data reporting and analysis of quality outcomes, and greater coordination of care across physical health and SUD care.

Administrative Integration in San Mateo County

Health Plan of San Mateo (HPSM) has been working with San Mateo County Health (SMC Health) to integrate administrative functions across the MCP and county behavioral health agencies. These organizations have a long history of working together to support greater integration of physical and behavioral health. In prior collaborations, when HPSM and SMC Health sought to further integrate primary care in specialty behavioral health settings, they encountered substantial barriers due to the separate administrative requirements and financing for physical and behavioral health care that led to fragmented care delivery. The limitations these system constraints imposed on clinical integration initiatives supported their decision to focus on administrative and financial integration.

The two organizations have investigated opportunities to consolidate administrative functions, with the goals of improving members' physical and behavioral health outcomes through better leverage of HPSM's and SMC Health's organizational strengths and reducing complexity for providers and enrollees. The

operational functions deemed most ripe for consolidation based on feasibility and value for providers and members included:[23]

- Call center and intake activities
- Credentialing and certification
- Provider network for some specialty behavioral health providers who also contract with HPSM for members with mild-to-moderate behavioral health needs
- Targeted data quality and financial reporting
- Utilization management for inpatient care

Notably, HPSM and SMC Health found that integration of care management activities was too complex to pursue under the current system, given the extent of variation across Medi-Cal program requirements for physical and behavioral health. As the next step, HPSM and SMC Health will plan potential integration activities among all or a subset of the five functions identified as promising.

Relevant National Examples to Inform California Initiatives

Integration efforts from other states — such as Arizona, Washington State, and North Carolina — offer insights on how Medi-Cal can most effectively expand the number of enrollees who experience integrated care. These initiatives also offer case studies on how CalAIM priorities have been implemented statewide in other states and may help to illuminate how existing innovative local initiatives in California could be supported statewide. Common lessons from these examples include:

- State leadership around integrated care can foster partnerships between MCPs and county behavioral health entities.
- Integration models can preserve a strong role for public behavioral health entities within a shift to a more integrated benefit.

Projects to Enable Single Accountable Entities

As stakeholders across the state, including DHCS, identify and apply lessons from local and national relevant initiatives, they may consider pursuing other projects that would advance integration, such as those proposed below. These projects, especially when considered as preparation for the Full Integration Plans, can help to identify opportunities for progress toward identifying single accountable entities for physical and behavioral health.

- **Explore a limited integrated quality measurement and data sharing pilot**, with incentives for multiple stakeholders (MCPs, county behavioral health agencies, and providers) to participate in targeted data sharing related to a specific measure set for people with serious behavioral health conditions. For example, if the state could comprehensively measure the percentage of people served by county behavioral health systems who have had a primary care provider visit in the past year, valuable insights could be provided about the baseline needs for integrated care. These data could also inform appropriate quality measures for entities accountable for physical and behavioral health care.
- **Support initiatives for counties and MCPs to advance voluntary integration.** Under current law, there are multiple pathways to financial integration, including these: (1) the MCP may choose to subcontract to a county to serve as a specialty integrated plan, an option available in each managed care model, (2) a county may delegate all or some mental health plan (MHP) obligations to a qualified MCP via a subcontract, or (3) the county may work with DHCS and an MCP for the MCP to be designated as the MHP and DMC contractor. These models are described in *Voluntary Behavioral Health Integration in Medi-Cal: What Can Be Achieved Under Current Law*.[24] Stakeholders may pursue these approaches in advance of the launch of the Full Integration Plans.

- Provider incentives to achieve integrated quality measures can help to support the delivery of whole-person care.

Arizona Targeted Investments Program

The Targeted Investment (TI) program was originally designed to provide up to $300 million over five years for MCPs to incentivize providers (primary care, mental health, and hospital) to develop systems that integrate and coordinate physical and behavioral health care.[25] The state incorporates TI payments into managed care capitation rates, and MCPs provide incentive payments to providers that meet defined targets. The state has reported that the TI program has spurred growth in the number of integrated care clinical providers and increased use of trauma-informed care protocols, among other impacts. In 2021 the TI program was extended for one year, and the state has submitted a proposal to renew this program beginning in 2022. MCPs can employ VBP strategies to support continued integration initiatives.

- **Relevance for CalAIM and Medi-Cal.** While behavioral health payment reform will support counties to incentivize quality goals, and ECM will support integrated care management for target populations, the TI program takes a statewide approach and focuses explicitly on physical-behavioral health integration by identifying integrated quality measures and incentivizing providers across the continuum of need to deliver whole-person care.

King County Integrated Care Network

Washington State moved to a fully integrated managed care model with the passage of legislation to focus on whole-person care. Whereas in most regions MCPs integrated behavioral health services, King County chose to continue to manage behavioral health services as the King County Integrated Care Network (KCICN).[26] Multiple MCPs contract with KCICN to manage behavioral health services, and KCICN contracts with providers (similar to the role of an independent practice association network manager). Cited benefits include reduced administrative burden for MCPs and providers, enabling the county to braid Medicaid and county behavioral health funding, and support for integrated care coordination, data, and administration.

- **Relevance for CalAIM and Medi-Cal.** The state began with administrative integration of mental health and SUD as a key building block, which CalAIM also lays the groundwork to do. The contractual arrangement between MCPs and KCICN may be a compelling model for voluntary integration efforts between counties and MCPs, or as an approach for the Full Integration Plans.

North Carolina Tailored Plans

North Carolina Behavioral Health/IDD Tailored Plans (TPs) are launching in 2022 as part of a statewide shift to managed care, and are an example of integrated MCPs that solely serve a specific population — people with serious behavioral health conditions, intellectual or developmental disabilities, or traumatic brain injuries.[27] Public behavioral health plans were the only entities eligible to apply to become TPs, though they can subcontract to other entities. All selected TPs are partnering with MCPs for functions such as network management, claims processing, and utilization management. Additional benefits will be available only to TP enrollees, such as residential treatment, multisystemic therapy, and assertive community treatment. Tailored care management will designate a single care manager for all TP enrollees to provide comprehensive whole-person care management and will be primarily based in provider settings.

Relevance for CalAIM and Medi-Cal. Under current California law, there is a pathway for creation of specialty integrated plans, which may be of interest for county-MCP partnerships. Tailored care management requirements are similar to ECM, and there may be lessons to inform ECM design and implementation.

Additionally, the specialty plan model may be an approach for the Full Integration Plans.

Further Opportunities to Support the Building Blocks for Integration

California stakeholders have many opportunities to foster greater integration of physical and behavioral health by building out essential components to integration: quality measures, data sharing, payment reform, and provider capacity and readiness. CalAIM offers opportunities to apply lessons from the local and national initiatives described above, but other initiatives will also be important to these efforts to advance physical-behavioral health integration. These include:

- The CalAIM Behavioral Health Quality Improvement Program, which provides incentive payments for county behavioral health agencies to develop the necessary infrastructure for CalAIM and related initiatives, related to payment reform, policy changes, and bidirectional data exchange.[28]
- The upcoming MCP procurement contract, which will establish new and more robust requirements for MCPs to coordinate and integrate care.[29]
- DHCS's 2022 Comprehensive Quality Strategy, which outlines behavioral health integration as a clinical focus area and aligns with DHCS's health equity strategy to address key health disparities. The quality strategy prioritizes cross-system measures such as follow-up for mental health and SUD treatment services after an emergency department visit.[30]

In the context of these initiatives, some further opportunities to strengthen the building blocks of integration include:

- **Support development of a set of integrated access, quality, and outcome measures across physical and behavioral health systems.** These measures can be used to quantify and monitor outcomes for people with co-occurring conditions. County behavioral health agencies and MCPs can collaborate to jointly select measures and track performance over time to improve integration efforts, and DHCS can develop a set of feasible measures, including those that address disparities, and share this information with stakeholders statewide.[31] These measures could potentially be incorporated into future state contracts with MCPs and specialty behavioral health plans.

- **Strengthen health information exchange.** There are multiple opportunities to support information-sharing infrastructure, which can foster clinical practice changes and establish a strong foundation for future efforts to create a single point of accountability. Some examples include supporting county behavioral health participation in regional health information exchanges and establishing a statewide consent agreement across physical and behavioral health care organizations to share data, testing a universal consent form / release of information, and developing a consent management registry accessible by enrollees, providers, MCPs, county behavioral health agencies, and DHCS. The landscape in this area will be further shaped by the upcoming Data Sharing Guidance package (released for public comment in December 2021) as informed by the California Office of Health Information Integrity's State Health Information Guidance, as well as the requirements in Assembly Bill 133 for health care entities to sign the California Health and Human Services Data Exchange Framework in 2023.[32]

- **Support provider readiness and capacity to deliver integrated care.** A state-administered incentive program to foster clinical practice changes, improve communication between physical and behavioral health providers, and support provider infrastructure development including for data sharing. Provider infrastructure development will be particularly critical for county behavioral health departments to serve as ECM providers. This program could scale the Behavioral Health Integration Incentive Program[33] by creating broader standards

across more providers, or follow Arizona's approach in which MCPs pay providers who meet benchmarks for delivering clinically integrated care. Future incentive payment initiatives could also build on lessons from incentives for MCPs and providers related to ECM and Community Supports.

- **Incentivize development of VBP models that recognize the true costs of both physical and behavioral health.** While these models are not part of the significant transformations in CalAIM's behavioral health payment reform initiative, planning efforts around VBP opportunities can inform future initiatives. High-value behavioral health care services may more meaningfully reduce medical spending rather than behavioral health spending. Thus, as financially integrated models may best position behavioral health providers to lead total cost of care, stakeholders should consider developing robust VBP components for the Full Integration Plans. In the near term, incentivizing data exchange capabilities and infrastructure will support provider readiness for VBP models. Future guidance on VBP models should (1) incentivize the delivery of the full continuum of services in the most appropriate settings, (2) identify opportunities for models that integrate physical and behavioral health care, and (3) support investment in integrated delivery of physical and behavioral health care, which will require new infrastructure such as information technology to support data sharing.

Conclusion

As CalAIM transforms how many aspects of care are delivered and administered, behavioral and physical health stakeholders across the state are engaging in the challenging work of administering new services, establishing new payment structures, and coordinating care for new populations of focus. To realize CalAIM's vision for integration, stakeholders will need further direction on how to navigate the fragmented systems of care at the county-MCP interface. Many CalAIM initiatives can help strengthen the "building blocks for integration," while the Full Integration Plans reflect the north star of a single point of accountability. By leveraging the opportunities within CalAIM initiatives and applying lessons from relevant local and national integration initiatives, California policymakers can deliver on the promise of a more integrated system of care.

About the Author

This paper was prepared by Logan Kelly, MPH, senior program officer at the Center for Health Care Strategies. The **Center for Health Care Strategies** is a national nonprofit policy center dedicated to improving the health of Americans with low incomes.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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