BUILDING SUCCESSFUL PARTNERSHIPS WITH MANAGED CARE PLANS

Briefing Paper from the DMC-ODS Waiver Forum held on December 9, 2016
Elizabeth Stanley-Salazar, M.P.H.

With the support of the Blue Shield of California Foundation, the CIBHS DMC-ODS WAIVER FORUM creates a collaborative think tank to support county behavioral health and substance use disorder leaders in the planning and implementation of the Drug Medi-Cal Organized Delivery System. Working with the California Behavioral Health Directors Association (CBHDA) Substance Abuse, Prevention and Treatment (SAPT) Committee, the second FORUM was held in December of 2016, to explore Building Successful Partnerships with Managed Care Plans. A prevailing challenge for individuals served by the public-sector safety net is their lack of access to physical and behavioral health services. With the expansion of Medi-Cal eligibility, health care is available to them for the first time; however, treatment for substance use disorders remains a carve out and requires planned coordination. We will now need to build the on ramps and bridges between providers for these individuals to access coordinated care.

Historically, the physical health system has been one of the most distant partners of the Alcohol and Drug (AOD) service network. First, the funding for substance use disorder (SUD) services has been grossly inadequate and the public-sector infrastructure underdeveloped. Second, the indigent and individuals at highest risk for SUD have not been eligible for health benefits other than emergency services until the Person Centered Affordable Care Act (PCACA) expansion of Medi-Cal eligibility. The drug Medi-Cal (DMC) continuum of services has been so limited that even after the approval for billing Screening, Brief Intervention, Referral and Treatment by physicians, referrals and access did not significantly change. There are many reasons for this; however, in many counties the funding for these services and the continuum of care simply does not exist.

For those counties that decide to participate in the DMC-ODS Waiver there are several terms and conditions which speak to the coordination of alcohol and drug services and physical health services based on standards prescribed by Medicaid 42 CFR 438.208(3)(b)(2). Each county must enter into a Memorandum of Understanding (MOU) with any Medi-Cal Managed Care Plan (MCP) serving Medi-Cal beneficiaries and monitor the effectiveness of its MOU. This requirement can be met through an amendment to the Specialty Mental Health Managed Care Plan MOU for mental health services that has been implemented in all counties as of 2016.

The Waiver requires that the county ensure that each beneficiary has an ongoing source of primary care, including access to specialists, as appropriate, for the beneficiary’s condition and identified needs. To achieve this coordination, the Waiver requires that client information must be shared with health plans serving the beneficiary including the results of any assessments. To this end, the counties have been actively working with county counsel, stakeholders and providers to work out the consent for release of information between entities while protecting beneficiary privacy pursuant to 42 CFR Section 2. Importantly, the Waiver requires a plan that provides for care coordination and seamless transitions of care within the DMC organized delivery system, as well as between the DMC certified providers and primary care and mental health partners.

This Forum examined the current landscape in managed care in California and the implications of the DMC-ODS Waiver for Health Plans. Terrie Stanley, Vice-President of Medical Services for Care 1st Health Plan and previously with CalOptima, provided a primer on managed care. She highlighted the challenges faced by the Health Plans in coordinating mental health and substance use disorders treatment, and the
opportunities and barriers ahead. Rhyan Miller, of the Riverside University Health System Behavioral Health and Substance Use Disorder Services (RUHS-BH-SUD) was joined by Arlene Ferrer and Laurence Gonzaga, Behavioral Health Managers, of the Inland Empire Health Plan (IEHP), to describe the evolution of and the current partnership between the Riverside County and the Inland Empire Health Plan.

**Managed Care in California**

Enrollment in Medi-Cal has significantly increased over the past decade. The Medi-Cal program now covers 1 in 3 Californians and the spending has grown nearly threefold. The Medi-Cal program overwhelmingly relies on the managed care delivery system, with over 80% of all beneficiaries enrolled in managed care health plans. Services for the seriously mentally ill and those with substance use disorders remain carved out of managed care health plans. Both of these carve outs have moved to managed care delivery described below.

Based on 2015 Medi-Cal enrollment data, every county uses one of four main models of managed care that operate throughout the state. To complicate matters, the county or plans subcontract with other plans and these plans in turn delegate risk to independent physician associations (IPAs), medical groups, and/or hospitals.

**Managed Care Program Models, by County**

![Map showing managed care program models in California](image)

<table>
<thead>
<tr>
<th>Model</th>
<th>Enrollment (Dec. 2015)</th>
</tr>
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<tbody>
<tr>
<td>San Benito</td>
<td>7,400</td>
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<tr>
<td>Imperial</td>
<td>72,513</td>
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<tr>
<td>Regional</td>
<td>294,341</td>
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<tr>
<td>GMC</td>
<td>1,102,804</td>
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<tr>
<td>COHS</td>
<td>2,190,182</td>
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<tr>
<td>Two-Plan</td>
<td>6,540,360</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10,207,600</strong></td>
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</tbody>
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* Total does not include 849 individuals enrolled in Primary Care Management (PCM) models in San Francisco and Los Angeles county.

**Note:** All striped counties were included in the rural expansion of managed care that began in late 2013.

Medi-Cal managed care plans vary in the degree to which they choose to delegate the delivery of care. For plan managers the myriad delegation agreements create administrative challenges. The movement of beneficiaries between plans and subcontractors creates its own set of administrative and financial issues.
One of the main complexities in the managed care business is a problem known as “delegation confusion,” that accompanies the movement of beneficiaries. While 80% of beneficiaries do not switch plans frequently, 20% will move between multiple plans, as frequently as monthly, making payments to the plans difficult to manage both at the state level and the plan level. Services can be delayed or denied and losses are accrued at the plan level.

### Managed Care Program Models, By Type and Enrollment

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Enrollment (Dec. 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-Plan</td>
<td>The Department of Health Care Services (DHCS) contracts with one county-developed plan called a Local Initiative (LI) and one commercial plan.</td>
<td>6,540,360</td>
</tr>
<tr>
<td>County Organized Health System (COHS)</td>
<td>The county operates a single managed care plan, with which DHCS contracts directly.</td>
<td>2,190,182</td>
</tr>
<tr>
<td>Geographic Managed Care (GMC)</td>
<td>DHCS contracts with several commercial plans. Only Sacramento and San Diego counties are designated GMC counties.</td>
<td>1,102,804</td>
</tr>
<tr>
<td>Regional Model</td>
<td>The Regional Model is a slightly modified version of the Two-Plan approach created for the rural expansion, in which the state contracts with two commercial plans over a geographic region.</td>
<td>294,341</td>
</tr>
<tr>
<td>Imperial Model</td>
<td>Two commercial plans contract with DHCS.</td>
<td>72,513</td>
</tr>
<tr>
<td>San Benito Model</td>
<td>One commercial plan contracts with the state. In this model, beneficiaries can opt out of managed care.</td>
<td>7,400</td>
</tr>
</tbody>
</table>

*Sources: Medi-Cal Managed Care Program Fact Sheet, DHCS; On the Frontier: Medi-Cal Brings Managed Care to California’s Rural Counties, CHCF, March 2015; Medi-Cal Managed Care, CHCF, March 2000; Medi-Cal Managed Care Enrollment*

### Managed Care Delegation Continuum
Ms. Stanley’s presentation of plan delegation led to a discussion of multiple issues raised by the county administrators in attendance. Overall, these comments can be distilled to the impact on access to services and payment responsibilities. While health plans currently provide limited SUD treatment through primary care, the AOD administration of each county provides the SUD treatment services as a carve out utilizing the Substance Abuse Prevention and Treatment Block Grant, Medi-Cal, or other grants and local funds. One of the examples given by the administrators was the lack of access to medical detoxification and prescriptions for medication assisted treatment. The situation was described by one county administrator as an ongoing push-pull over responsibilities and payment.

Carve outs are confusing to beneficiaries who may have preferred providers and may not want to participate in the new county organized delivery system. None of this is surprising as the partnerships and responsibilities by and large have not existed nor have they been defined until now. Ms. Stanley echoed the administrators concern regarding a health care workforce that lacks the training and understanding of a common approach to substance abuse diagnosis and treatment.

The DMC-ODS is in its infancy and in many counties a full continuum of care is not in operation. This has led to a lack of interest in the DMC-ODS by many managed care plans. One can speculate that the anticipated changes to the PCACA and the uncertainly of the coverage for the expansion population are creating a “wait and see” approach to new practices. For many AOD administrators, the fear of returning to gaps in services and waiting lists under a possible Medicaid block grant is generating uncertainty that produces understandable risk avoidance and inaction.

Over the past decade, health plans have been challenged not only by the sheer numbers of new beneficiaries; but also, with sweeping changes in the composition of the populations served. In November 2010, in preparation for the expected surge in Medi-Cal enrollment for adults, California was granted a waiver by the Center for Medicare and Medicaid Services (CMS) called “The Bridge to Reform Demonstration.” Counties were offered the option to develop Low-Income Health Programs (LIHPs) to provide health care coverage to nonelderly adults who were not yet, but would likely be in 2014, eligible for Medi-Cal. LIHPs became active in July 2011 and provided coverage until their statutory sunset date of December 31, 2013.
Among California’s 58 counties, 53 opted to establish LIHPs and roughly half of the 1.1 million optional adults added to the Medi-Cal program in January 2014 were transitioned from LIHPs. Between January 2014, the first month of Medi-Cal eligibility, and December 2014 enrollment grew to 2.5 million, altering the demographic composition of Medi-Cal’s overall population.

Prior to these expansions, Medi-Cal provided coverage to persons with disabilities; low-income children and their parents/caretaker relatives; pregnant women; the aged; Individuals with particularly complex medical conditions. Growth between December 2012 and December 2014 was brought about largely by newly eligible adults ages 19-64 without dependent children and the transition of children from the former Healthy Families Program. This rapid and enormous growth had a significant impact on plans throughout the state.

Enrollment in the Fee For Service (FFS) system was at 55% in 2010. By the end of 2015 Managed Care Plan (MCP) enrollment grew to 77% of all beneficiaries. Prior to 2013, females accounted for 55% of Medi-Cal’s overall population. Today the distribution is 49% female and 51% male. Children constituted roughly 50% of the overall Medi-Cal enrollment prior to 2013 and now account for 42% of Medi-Cal’s overall population. Forty nine percent are ages 40-64 and 540,000 or 20% are ages 55-64. The CA Medi-Cal Population is now 60% self-reported Latino, and 50% of the beneficiaries report not speaking English well or at all. These changes in demographics have significantly altered service delivery and created shortfalls in workforce numbers and provider capacity.

Overall, the massive expansion in enrollment has generated a threefold increase in the total Medi-Cal costs with an increase from $5,056 to $6,856 per enrollee over the past decade. This spending increase per enrollee over the last 10 years equates to a 3.1% compound annual growth rate (CAGR). In 2005-06, fee for service spending represented 58% of the total budget and 2015-16, managed care spending was 58% of the total.
As we look to the future of possible care coordination, we need to consider several challenges facing the MCPs. Ms. Stanley pointed out that in addition to managing significant growth, there have been competing mandated priorities for Managed Care Plans during the 2014-2017 timeframe without much regulatory relief on the horizon. These state and federal priorities include Cal Medi-Connect – Medi-Cal/Medicare for Dual Eligible beneficiaries; the Medi-Cal 2020 Whole Person Care Pilots; and new CMS Health Home mandates in addition to the Medicaid Final Rule implementation. Two state agencies oversee California’s Medi-Cal program, the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) providing oversight and quality assurance. While the regulations are challenging as they stand, a June 2015 State Auditor’s report concluded that DHCS did not perform adequate oversight of Medi-Cal managed care plans. While managed care organization (MCO) members are generally satisfied with their personal doctor, their overall rating of their health plan and their ability to get care quickly was below national benchmarks. California requires full-scope managed care plans to publicly report on a number of different quality measures and performance varies greatly. Quality reports show that MCOs have highly variable performance on quality of care indicators, with many performing below the minimum performance benchmark and national averages. Ms. Stanley pointed out that regulations and requirements are overlapping, out dated in some cases, and incentivizing performance has been underutilized.

Specialty Managed Care Behavioral Health Services Carve-Out

In California, certain populations and services are carved out of the managed care model and remain in the fee for service system. These include mental health services for individuals with serious mental health conditions and the treatment of substance use disorders. Behavioral health services for individuals with mild to moderate mental health needs are provided services through the Medi-Cal Managed Care Plans. As noted earlier these plans may choose to subcontract with behavioral health services plan to provide these services.

This carve out approach is not new. Historically, the nation’s health care safety net has separated or carved out treatment of physical and behavioral disorders. Funding streams and system regulations that support these carve outs have been in place for many years, usually taking the form of discretionary or block grants. However, with the growing interest in reducing the cost of the health care, there has been significant recognition that a siloed approach exacerbates poor outcomes for patients and ultimately higher costs for
all public systems. Over the past ten years, integration of services and/or care coordination has promised and in some cases has delivered improved results.

Mental health and substance use disorders in California are some of the most commonly treated conditions among the entire Medi-Cal population, particularly for the most costly segments. For this reason, there is a financial case for the coordination of behavioral health services for health plans.

![Prevalence of Diseases Treated Among Most and Least Costly Enrollees* (CY 2011)](chart)

*Source: Understanding Medi-Cal's High-Cost Populations, DHCS, March 2015.*

By design, Medi-Cal beneficiaries with mental health needs must navigate two separate health care delivery systems: the county Specialty Mental Health Plan and the Medi-Cal Managed Care Plan. In 2012, passage of Senate Bill X1-1, codified the managed care plans and the county mental health departments’ role in the delivery of mental health services. Each of the counties maintains a memorandum of understanding with managed care plans serving beneficiaries residing in the county.
While this MOU is specifically regulated by the DHCS, there is no one statewide definition of mild to moderate vs. serious mental health disorders, resulting in billing disputes between partners and in some complex cases barriers to access. Conflicts also occur between plans and counties related to the exchange of client information. The myriad approaches to client data collection and storage are not interoperable, and complicate and impede the coordination of care and service transitions. With all of the challenges, these regulations for mental health services have been in place since 2013 and have greatly changed the landscape for service delivery statewide.

**Drug-Medi-Cal Organized Delivery System Carve Out for SUD Treatment**

Approved in August 2015, the Drug Medi-Cal Organized Delivery System (DMC ODS) 1115 Waiver has the potential of significantly expanding SUD services reimbursable under the Drug Medi-Cal program for counties that decide to participate. The waiver is designed to test a new paradigm for the organized delivery of health care services for Medi-Cal enrollees with a substance abuse disorder and improve outcomes while decreasing other system health care costs. Once in operation, the waiver will support coordination and integration across systems, strengthen county oversight of the provider network capacity, and improve consumer access to services. In counties that do not opt in, beneficiaries will continue to receive only those substance use disorder treatment services outlined in the approved State Medicaid Plan.

Unlike the specialty mental health system, there is no separation of treatment service responsibilities for mild to moderate vs. serious substance use disorders. The DMC-ODS Waiver designates the County Behavioral Health Authority as a specialty managed care plan for all substance use disorder treatment. The Counties must design and implement a full continuum of services, modeled after uniform levels of care identified by the American Society of Addiction Medicine criteria, and coordinate care with MCP and MHP to address the immediate and long term physical, mental, and care needs of beneficiaries. The counties must implement selective provider contracting and credentialing processes that will meet standards outlined in the waiver. These include beneficiary access hotline; authorization for residential services; care coordination with managed care plans serving beneficiaries in the county; quality improvement activities; and utilization management.

With the DMC-ODS, the opportunity for coordinated care is on the horizon; however, there are many barriers to streamlining communication, consultation and coordination with the managed care plans.
These barriers start with the early Identification of the need for SUD treatment. Not only is there a shortage of professionals trained in the identification and treatment of SUD, many health care providers feel hindered by how and where to make referrals. There are many complexities when navigating the SUD system including linkage to a centrally managed network with the needed levels of care. Additionally, there is an inadequate number of professionals who speak more than one language which magnifies barriers to access as well as treatment. Finally, social stigma surrounding identification and treatment is real. Ms. Stanley pointed out the “biggest elephant in the room” is the critical need to establish uniform data and information sharing policies, guidelines, and mechanisms consistent with applicable state and federal data privacy and security laws, to provide for timely sharing of beneficiary data, assessment, and treatment information.

Ms. Stanley presented several innovative ideas that health plans could initiate now working with counties who are opting into the waiver. MCPs can collaborate with the county AOD administrator to prioritize training, structural and procedural support to primary care practitioners for identification and referrals to the DMC-ODS. MCPs can start to engage and educate all providers and beneficiaries about the services and resources available in the DMC-ODS and the pathways to access services. MCPs can reach out to community organizations who would serve the beneficiaries. There are currently no cross system state level meetings; however, all agreed that there are opportunities for this dialogue to begin.

The immediate benefits to managed care plans are the coordination of substance use disorder treatment and health services through the linkage to DMC-ODS case management services; beneficiary support for medication compliance; physician consultation for medication assisted treatment (MAT); transportation services; linkage to housing; and long term recovery support. These interventions can all support the health plans efforts to reduce hospital utilization and readmissions. Additionally, Ms. Stanley outlined several innovations that could have significant impact on client outcomes. These include the:

- Access for primary care practitioners to same day referrals for SUD treatment through the Beneficiary Access Line or preferred provider relationships through no wrong door policies
- Early identification and targeted interventions such as Screening, Brief Intervention and Referral to Treatment (SBIRT), ASAM assessment, transportation to programs for high utilizers of emergency department services
- Utilizing coordinated and/or interoperable electronic health records between SUD, physical health and mental health providers and plans both health and specialty plans
- Agree on the outcome data to be collected and how it will be utilized. Utilize the Healthcare Effectiveness Data and Information Set (HEDIS) measures when available across systems
- Create financial provider incentives for collaboration and partnership
- Employ alternative reimbursement strategies for providers, such as member-centered case rates and/or performance-based payments

**Moving from Ideas to Action: Riverside University Health Services and Inland Empire Health Plan Partnership**

In 2001, the Inland Empire Health Plan (IEHP) identified the need for coordination of services with the county health and behavioral health systems. Rhyan Miller, Arlene Ferrer, & Laurence Gonzaga presented an overview of the plan, its history of collaboration and innovation, its accomplishments and the challenges ahead. It is worth noting that Arlene Ferrer and Laurence Gonzaga serve in dedicated county liaison positions as Behavioral Health Care Managers.
Inland Empire Health Plan (IEHP) is a rapidly growing Medi-Cal and Medicare, not-for-profit health plan serving Medi-Cal eligible clients in Riverside and San Bernardino counties. With a provider network of over 5,000 providers and more than 1,800 employees, IEHP serves over 1.2 million residents of the Riverside and San Bernardino counties who are enrolled in Medi-Cal, Cal MediConnect (Medicare), or the Healthy Kids Program. Since its inception in 1996 as the region’s first Medi-Cal managed care plan, IEHP’s mission has been to improve the delivery of quality and wellness-based healthcare services. IEHP is a Knox-Keene licensed health plan and organized as a Joint Powers Agency. The first collaborative partnership with RUHS BH for Medi-Cal went into effect 2001. IEHP and RUHS BH achieved a new level of collaboration under the SB X1-1 mandates.

Historically, all behavioral health services (BHS) had been delivered by the County Department of Behavioral Health Services. These include the Access Unit, CARES Line, county clinics, FFS providers, and county contracted agencies. Healthy Kids (Riverside) Members were seen by Riverside County Department of Mental Health. Healthy Families, Healthy Kids (San Bernardino), and DualChoice members were managed by PacifiCare Behavioral Health (PBH). Mr. Gonzaga explained that this resulted in services that were disconnected and isolated from medical services. There was a lack of coordination of care between PCPs and BHS providers and no direct relationship between IEHP and BHS providers. There was inadequate standardized BHS treatment. Outpatient mental health services were underutilized and substance use disorder treatment services were not available to members. The primary care physicians described referring into the “Black Hole”

It was clear to all providers and stakeholders that members needed access to both BHS and SUD services. In January 2014, IEHP implemented the mandate to deliver mild to moderate services to beneficiaries and coordinate with the county Specialty Mental Health Plan who would deliver services for serious mental illness services through an MOU. The MOU developed between the partners focused on the reduction of overall morbidity and mortality of the behavioral health population. With the DMC-ODS Waiver, the MOU can now be expanded to include pathways and services for a continuum of services for substance use disorder treatment. The MOU clearly describes the responsibilities and pathways for streamlining access to services and monitoring outcomes across systems.

**Medi-Cal MHSUD Delivery System: MHP(County), AOD, MCP (IEHP)**

**County Mental Health Plan (MHP)**
- Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services
- Outpatient Services
  - Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
  - Medication Support
  - Day Treatment Services and Day Rehabilitation
  - Crisis Intervention and Crisis Stabilization
  - Targeted Case Management
  - Therapeutic Behavior Services
- Residential Services
  - Adult Residential Treatment Services
  - Crisis Residential Treatment Services
- Inpatient Services
  - Acute Psychiatric Inpatient Hospital Services
  - Psychiatric Inpatient Hospital Professional Services
  - Psychiatric Health Facility Services

**County Alcohol and Other Drug Programs (AOD)**
- Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services
- Outpatient Services
  - Outpatient Drug Free
  - Intensive Outpatient (newly expanded to additional populations)
  - Residential Services (newly expanded to additional populations)
  - Narcotic Treatment Program
  - Nutritions
- New Services
  - Inpatient Detoxification Services
  - (Administrative linkage to County AOD still being discussed)

**Medi-Cal Managed Care Plans (MCP)**
- Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services
- MCP services to be carved-in effective 1/1/14
  - Individual/group mental health evaluation and treatment (psychotherapy)
  - Psychological testing when clinically indicated to evaluate a mental health condition
  - Outpatient services for the purposes of monitoring medication treatment
  - Psychiatric consultation
  - Outpatient laboratory, medications, supplies and supplements
The first step to this innovative partnership was revamping the screening and referral process and pathways to services. IEHP worked closely with the county MHP to develop screening criteria for specialty mental health services for beneficiaries with severe functional impairments. An existing RUHS-BHS web portal was redesigned for bi-directional referrals including urgent care visits, authorizations, and prescription and medication management. The same web portal has been modified to include referrals for SUD treatment which are submitted electronically and directed to specific RUHS SUD staff. All staff have been trained in managing mental health and substance abuse disorders and the importance for warm transfers. There is now an average of 50 calls a month and 15 referrals a week from primary care physicians and clinic staff. These initial collaborative efforts have lead to several patient centered innovations based on the presenting needs of the beneficiaries. There has been an Integration Initiative with co-located multi-disciplinary teams; Health Home Clinic with intensive care coordination for complex cases; and a Pain Management Program.

The panel members expressed pride and excitement in the development of the Pain Management Program that includes the following components:

- Multidisciplinary team approach provided under the care of a medical doctor
- Collaboration between pain management specialist, clinical psychologist, chiropractor, acupuncturist, nutrition specialist and addiction counseling
- Optimize pain management and patient outcomes through psychotherapy, biofeedback, behavioral medicine, narcotic/medication use evaluation and counseling and multidisciplinary educational group component/support
- Provide close monitoring, urine drug screens and up to weekly consultation for high risk patients
- Reinforce evidence-based clinical guidelines

Detoxification is not currently provided for the Pain Management Program participants. The team is working diligently to remove the barriers that currently exist to voluntary inpatient detoxification services (VID). DMC-ODS itself does not include voluntary inpatient detoxification services. Notices outlining the diagnostic criteria, fee for service approval process, and claims preparation have been distributed to all network providers and hospitals. The major sticking point in the system development has been the inability for hospitals to successfully bill fee for service claims to DHCS for voluntary inpatient detoxification under the fee for service payment system. The administrators report and IEHP agrees that the VID is inaccessible at this time due to the inability to bill. Action is being taken by stakeholders is being done to correct this situation working with DHCS.

IEHP and County Substance Abuse and Prevention Treatment Program (RUHS-BH SUD) panel members shared the work done to date on the MOU to meet DMC-ODC Waiver Requirements. Meetings have been held with the RUHS-BH SUD team to outline care coordination, care management, and sharing of information between each system. While not required, RUHS-BHS SUD included provisions for prevention services which they are currently providing and that would enhance the services to the beneficiaries. The PCPs will be trained to use SBIRT in all settings. Referrals will be managed through modifications to the existing electronic portal. Case managers will have access to the diagnosis immediately through the electronic health record. RUHS-BH SUD also included transitional housing and recovery support centers in the continuum of care as encouraged in the DMC-ODC Waiver. Referral information and preliminary assessment and diagnosis are immediately available for case management purposes. The panel expressed
their excitement as the DMC-ODS is slated to go live on February 1, 2017. The presentation of a well-developed and mature partnership between the county and the managed care plan resonated with the administrators. There is a consensus that collaborative partnerships with the health care system is the key to improved client outcomes. It takes time and effort and financing for these ever evolving partnership to start and to mature.

**County to County Collaboration**

The Administrators broke into small groups discussions to identify lessons learned from individual counties and opportunities that can be leveraged based on the presentations. Because San Francisco has a strong and mature collaborative partnerships between its health and behavioral health systems, it offers many clinical innovations based on the experimentation and evaluation of medical protocols over time. For example, primary care physicians in the county health system have developed a protocol for using Buprenorphine in pain management with beneficiaries with substance use disorders. Additionally, San Francisco has found that because Phenobarbital has low street value, it is an effective intervention for use in outpatient detoxification. Prescribing Naloxone for individuals using opioids has proven very effective in reducing overdose. Medication assisted treatment has proven results as studied in San Francisco where there is a reduction in repeated emergency room alcohol withdrawal cases when Naltrexone is routinely given upon discharge for any alcohol related hospitalization. Each of these therapies have had medical review and standardized training and protocols in place.

Alameda and San Mateo initiated similar cross-system health and medical protocols. Administrators noted the buy in by the health care system staff requires medical endorsement; clarity of protocols, education, and training. Investment for these critical activities is needed and administrators hope will come from the MHP. There are no funds available for system investment in the DMC-ODS. San Mateo reports that communication and clinical feedback to the PCP on the patient progress generates significant buy-in. San Mateo reports the biggest difference in cross system partnership has been co-location and multi-disciplinary case planning. San Mateo embeds staff in the county emergency departments and these staff participates in case management of hospital admissions and discharge planning. Mr. Miller noted that RUHS-BH-SUD would like to see care coordination with participation of the PCPs in the care of patients needing chronic pain management and/or detoxing from certain drugs. Mr. Gonzaga reported several new initiatives between RUHS-BH-SUD and IEHP to engaged PCPs, including a pilot with PCPs to monitor high levels of addictive medications and move these to multi-disciplinary team review.

Clearly innovations in care coordination are occurring throughout the state. One of the barriers integration of these into to standard practices is the fact that information is not flowing openly to the medical and health care community. The MCPs can choose to provide a critical role in the dissemination of best practices. The engine of care coordination and improved outcomes in complex cases is the multidisciplinary case conferencing. The specificity of the carve out MOUs is critically important. As important is the communication pathways and development of cross system referral and clinical functional pathways. One idea presented by the panel was to involve practitioners in the MOU drafting process to ensure that it is relevant and addresses actual needs of the population served.

As these new partnerships evolve and communication occurs, there is opportunity to change many of the duplicative and costly roles of embedded in each of the silos. For example, beneficiaries have multiple mandated case managers collecting the same information in each system. The state agencies can do much to coordinate and streamline these requirements. DHCS regulations now require abstinence from alcohol and/or drug use for 24 hours prior to treatment admission, creating barriers to access and adverse
beneficiary engagement experiences. The fact that regulated silos have created procedures that are duplicated in each system is a given and provides the greatest opportunity to streamline and reduce costs.

**Conclusions**

Historically, the nation’s health care safety net has separated treatment of physical and behavioral issues, treating body and mind independently and not providing “whole-person” care. State and federal policymakers are increasingly focusing on the need to better coordinate care for this population, not only to improve health and generate potential cost savings, but also to help reduce homelessness, end the cycle of repeat jail visits, and improve this vulnerable population’s overall quality of life.

The Drug Medi-Cal Organized Delivery System offers the greatest opportunity to date to coordinate whole person care to individuals suffering from substance abuse disorders with the health care system. Providing and referring for substance use disorder treatment has been daunting to health care providers and to clients not only because of multiple carve outs, funding silos, and structural administrative and regulatory barriers but also a simple lack of capacity in many counties. Every county has a unique alcohol and drug service delivery network and every Managed Care Plan has a unique provider network. There are counties that have developed partnerships despite barriers and others that are just starting the dialogue. Perhaps the most challenging hurdle ahead is workforce development. The most important change for improved client outcomes is the value placed on integration and coordination across systems and silos. We can only hope that this is sustained throughout all models of change.