CalAIM Behavioral Health Administrative Integration

DHCS Concept Paper

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Executive Summary

California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal by reducing complexity across the Medi-Cal delivery systems for behavioral health services, among other reforms. Consistent with that goal, CalAIM proposed the Behavioral Health Administrative Integration initiative to consolidate specialty mental health services (SMHS) and substance use disorder (SUD) services—covered either by county Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) programs—into a single county-based behavioral health program. This program will be operated under a single, integrated contract between counties and the state. The Department of Health Care Services (DHCS) and counties will partner on a phased implementation approach that achieves statewide administrative integration of SMHS and SUD by State Fiscal Year (SFY) 2027–2028, as described in this concept paper.[1] DHCS looks forward to stakeholder comments on this approach.

The Goals of Behavioral Health Administrative Integration

The primary goals of Behavioral Health Administrative Integration are to improve health care outcomes and the experience of care for Medi-Cal beneficiaries—particularly those living with co-occurring mental health and SUD issues—and to reduce administrative burden for beneficiaries, counties, providers, and the state, as described in Part I of this concept paper.

Historically, counties have administered two separate programs for the delivery of Medi-Cal SMHS and SUD services, each with its own state contract and funding streams. Individuals with serious mental health needs access inpatient and outpatient SMHS through their county's Mental Health Plan (MHP). For SUD treatment, counties operate either a DMC program or, at county election, the DMC-ODS managed care SUD program. The state-county contracts for these programs include certain similar or identical requirements, as well as program-specific requirements for clinical documentation, health plan and provider compliance reviews, billing and claiming, licensing and certification, and more.

This administrative complexity has created unintended barriers for clients that seek care for co-occurring mental health and substance use conditions, in addition to adding to the administrative burdens faced by behavioral health providers and officials at the state and county levels. The Behavioral Health Administrative Integration initiative seeks to reduce those barriers and burdens by aligning and integrating SMHS and DMC/DMC-ODS program requirements to the greatest extent possible. This may, in turn, facilitate behavioral health providers offering more seamless and integrated treatment to beneficiaries who need both mental health and SUD services.[2]

This initiative will not mandate changes in care models at the provider level. There will continue to be value in highly specialized programs that focus on addressing more specific mental health or SUD needs. With the policy changes outlined in this concept

[1] California's State Fiscal Year runs from July 1 to June 30.

[2] California law specifies how existing funding streams for specialty behavioral health may be used to support mental health and/or substance use disorder services. These restrictions will not be addressed as part of CalAIM Behavioral Health Administrative Integration.

paper, DHCS aims to support and encourage development of a behavioral health workforce—including licensed and unlicensed providers—that can competently identify and address co-occurring mental health and SUD needs across all settings and delivery systems. Behavioral Health Administrative Integration provides an opportunity to facilitate access, improve quality, and provide a more integrated care experience for beneficiaries, potentially including adjustments to policies that currently hinder the expansion of integrated care models.

Through this initiative, DHCS and counties will collaborate to streamline and strengthen three domains:

- **Beneficiary experience** with county and provider interactions when seeking behavioral health services
- **Internal county structures and processes** regarding program administration and data management
- **DHCS oversight** of county and provider operations

Whereas counties currently execute two separate contracts with DHCS for the provision of SMHS and SUD services, this CalAIM initiative will result in counties adopting a single integrated contract for the delivery of Medi-Cal behavioral health services.[3] Counties that participate in DMC-ODS will consolidate their behavioral health programming into a single prepaid inpatient health plan (PIHP) managed care structure rather than operating separate managed care programs for SMHS and SUD services. Counties that have not opted into DMC-ODS may continue offering DMC services outside of managed care while participating in all other applicable aspects of this initiative, including by adopting updated MHP and DMC contracts with DHCS that promote integration goals.

The Behavioral Health Administrative Integration initiative will proceed in three phases, described below, thereby allowing DHCS and counties to spread their efforts across multiple years ahead of the full statewide implementation in 2027. Certain aspects of this proposed timeline and other elements described in this concept paper may be contingent on receiving all necessary federal approvals from the Centers for Medicare & Medicaid Services (CMS) and/or revisions to current DHCS regulations or state legislation.

The Components of Behavioral Health Administrative Integration

Because Behavioral Health Administrative Integration touches on multiple distinct aspects of state and county operations, this concept paper breaks the initiative down into 11 components, which are organized into the three domains listed above

[3] Although this concept paper will generally refer to behavioral health programs operated by "counties," DHCS can also work with groups of counties that seek to establish regional behavioral health programs. In addition, although counties (or groups of counties) will operate one integrated Medi-Cal behavioral health program from the perspective of state and federal law, counties remain at liberty to structure their internal operations as they see fit. For example, some counties have already opted to consolidate their behavioral health personnel under a single county department, while other counties maintain separate departments (or divisions within a department) for SMHS and SUD operations.

(beneficiary experience, internal county operations, and DHCS oversight).[4] These domains are described briefly below and more fully in Part II of this concept paper, which reviews applicable legal requirements for each component at the federal and state levels, the status of state and county integration efforts, the vision for integrating each component in the short and long terms, and the concrete steps needed at the state and county levels to achieve integration.

This document reflects the CalAIM principles that have been codified in state law—notably including Welfare & Institutions Code Section 14184.404, which was enacted in 2021 under AB 133—and is informed by input from county behavioral health officials (as described in Appendix 2), as well as the CalAIM Behavioral Health Workgroup, which consists of consumer advocates, providers, and county and state representatives.

Figure 1. The 11 Components of Behavioral Health Administrative Integration

Streamlining the Beneficiary Experience	Integrating County Structures and Processes	Integrating DHCS Oversight Functions
1. County-Operated 24/7 Access Line **2.** Screening, Assessment & Treatment Planning **3.** Beneficiary Materials, Appeals & Grievances	**4.** DHCS-County Contracts **5.** Data Sharing & Privacy **6.** Cultural Competence Plans **7.** Quality Improvement	**8.** External Quality Reviews **9.** DHCS Compliance Reviews **10.** Network Adequacy **11.** Provider Oversight

A. Streamlining the Beneficiary Experience

This domain of Behavioral Health Administrative Integration captures DHCS and county efforts to streamline how Medi-Cal beneficiaries experience care as they learn about, request, and engage with the Medi-Cal behavioral health system. Existing state policies allow counties to integrate each of these components to some degree, and many counties have already taken steps to do so. DHCS will support counties in adopting best practices in these areas through the initial phases of Behavioral Health Administrative Integration (calendar years (CY) 2023–2026[5]). Prior to 2027, certain integrated operations and best practices identified by DHCS will be required for counties that voluntarily enter into integrated contracts with the state. Certain other policy changes may apply statewide.

> ***Component 1. County-Operated 24/7 Access Line.*** Counties with integrated contracts will be expected to operate a single 24-hour access line for all beneficiaries seeking behavioral health services. With an integrated access line, a beneficiary can be triaged, screened for both mental health and SUD needs, and scheduled for appropriate follow-up appointments as part of the same call, without the beneficiary needing to dial additional numbers.

[4] This list of components has been adjusted since the Behavioral Health Administrative Integration initiative was described in the original CalAIM proposal, based on feedback from the landscape assessment described in Appendix 2.

[5] Unless otherwise stated, the dates in this concept paper refer to calendar years rather than State Fiscal Years.

Component 2. Screening, Assessment & Treatment Planning. The state and counties have taken steps in recent years to promote streamlined and client-centered clinical operations for individuals seeking behavioral health services, including under other CalAIM initiatives such as No Wrong Door and Documentation Redesign (which are described below on page 14). These efforts include the following:

- Streamlining screening and referral systems within and across behavioral health delivery systems, including implementation of the Screening and Transition of Care Tools for Medi-Cal Mental Health Services (described below on page 14)
- Ensuring that beneficiaries who present for behavioral health services can access flexible, client-centered assessment for both mental health and SUD treatment needs, regardless of the stated reason for their visit or the site where they seek services
- Enabling county behavioral health plans and providers to be reimbursed for appropriate care provided prior to confirming a diagnosis or diagnoses, subject to compliance with applicable program requirements
- Offering a client-centered, strengths-based treatment planning process that includes regular coordination among all relevant providers, including for individuals with co-occurring mental health and SUD needs
- Aligning and streamlining documentation and billing requirements across SMHS, SUD, and other health care services

Through Behavioral Health Administrative Integration, DHCS will continue to support these initiatives. In collaboration with stakeholders in the coming years (CY 2023–2026), DHCS will consider opportunities to support counties in identifying and implementing best practices through guidance and technical assistance. Certain best practices may eventually become requirements, particularly once counties adopt integrated contracts, as described below.

Component 3. Beneficiary Materials, Appeals & Grievances. Counties will be expected to distribute a single beneficiary handbook and provider directory with information needed to access both SMHS and SUD services, in addition to outlining a single set of beneficiary rights and procedures—including for appeals and grievances—that apply across all county-administered behavioral health services. DHCS will produce template materials for county use by 2025, with input from counties and consumer advocates.

B. Integrating County Structures & Processes

Whereas the first domain of Behavioral Health Administrative Integration focuses on the beneficiary experience, this second domain focuses on the structure of each county's Medi-Cal behavioral health delivery system (in accordance with its contract with DHCS) as well as the county's internal processes for data management and other functions. Streamlining and simplifying these administrative functions will create a stronger platform for administering coordinated and integrated care. Aside from the DHCS-county contracts, counties are currently able to integrate these components without

policy changes at the state level. Many counties have already made significant progress toward integration.

Component 4. DHCS-County Contracts. By 2027, all counties will enter into a single contract with DHCS that covers the administration of both SMHS and SUD services for Medi-Cal beneficiaries. (AB 133 currently provides for the statewide adoption of integrated contracts by January 1, 2027. DHCS welcomes feedback on this timeline, particularly if stakeholders anticipate significant implementation challenges with aligning the contract cycle with the calendar year, rather than the State Fiscal Year.)

DMC-ODS counties will be expected to operate a single PIHP managed care program for the delivery of behavioral health services,[6] as noted above, while DMC counties will adopt consolidated MHP/DMC contracts that promote integration goals while preserving the structure of an SMHS managed care program paired with a non-managed-care DMC program. Before statewide Behavioral Health Administrative Integration takes effect in 2027, DHCS hopes to offer interested counties the opportunity to voluntarily adopt integrated contracts beginning in 2025, subject to DHCS securing all necessary federal approvals (e.g., an amendment to DHCS's federal waiver under Section 1915(b) of the Social Security Act[7]).

Component 5. Data Sharing & Privacy. DHCS and counties are committed to ensuring that behavioral health data is shared and stored as efficiently as possible while maintaining privacy protections for beneficiaries, including the federal "Part 2" confidentiality rules for SUD-related information (so called because they are codified in Part 2 of Title 42 of the Code of Federal Regulations (CFR)). To support county programs and behavioral health providers in maintaining compliance with Part 2 and other privacy laws as they advance data-sharing capabilities and practices, DHCS will soon publish a template "universal release" form that can be used to secure individual authorizations for data sharing, including sharing with Medi-Cal managed care plans (MCPs) and other service providers. DHCS will also consider other opportunities for guidance.

Component 6. Cultural Competence Plans (CCPs). Counties with integrated contracts will be expected to develop integrated CCPs that include consideration of both SMHS and SUD services. DHCS will release an updated CCP template for county use, with appropriate consideration of the differences between DMC-ODS and DMC counties.

Component 7. Quality Improvement. Counties with integrated contracts will be expected to develop and implement an integrated quality improvement plan,

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[6] Counties will operate these integrated PIHPs on a non-risk basis, consistent with the current non-risk PIHPs that counties currently operate for their SMHS and DMC-ODS programs. At the same time, however, the CalAIM Behavioral Health Payment Reform initiative seeks to move counties away from the current model of cost-based reimbursement. These financing changes are intended to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal beneficiaries, in addition to eliminating the need for cost reconciliation procedures.

[7] California's 1915(b) waiver sets forth the federal parameters for Medi-Cal managed care programs, including MHPs and DMC-ODS. The current 1915(b) waiver and related materials are available at https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx.

including by convening a single integrated quality improvement committee, developing a comprehensive list of performance measures that address both SMHS and SUD services, and paying special attention to beneficiaries living with co-occurring needs.

C. Integrating DHCS Oversight Functions

To further reduce administrative burden on counties, providers, and state officials, DHCS is pursuing opportunities to align and streamline various requirements and oversight processes for county behavioral health programs, and for individual behavioral health providers. This domain may incorporate changes to SMHS, DMC, and DMC-ODS compliance requirements identified during the regulatory review and analysis DHCS will undertake during the course of phased implementation (see additional description below). DHCS action will be necessary to drive the integration of these oversight components, all of which involve substantive standards and review protocols established at the state level.

Component 8. External Quality Reviews (EQRs). After adopting integrated behavioral health contracts with DHCS, DMC-ODS counties will undergo a single annual EQR that addresses both SMHS and SUD, which will reduce counties' aggregate EQR-related administrative burdens. (DMC programs are not required to undergo EQRs.)

Component 9. DHCS Compliance Reviews. As with EQR, counties with integrated contracts will receive integrated DHCS compliance reviews that address both SMHS and SUD. In addition to aligning review timelines, DHCS will seek opportunities to streamline review protocols and documentation requirements, with the aim of reducing county administrative burdens and prioritizing review of areas with the greatest impact on beneficiary well-being and program integrity.

Component 10. Network Adequacy. Counties with integrated contracts will complete a single network certification submission, and DHCS will certify a single behavioral health provider network, with appropriate attention to both mental health and SUD capacity. In the long term, in consultation with stakeholders, DHCS will consider the merits of potential substantive revisions to the network adequacy standards, such as further aligning certain methodologies for measuring provider capacity across SMHS and SUD.

Component 11. Provider Oversight. DHCS is considering opportunities to modify the standards and procedures for the licensing and certification of behavioral health providers, with an eye toward promoting clinical integration and reducing administrative burdens.

Phased Implementation for Behavioral Health Administrative Integration

To achieve statewide Behavioral Health Administrative Integration in 2027, DHCS has developed a phased approach under which DHCS and counties may spread their efforts across multiple years, making early progress on integrating certain program elements while laying the groundwork for longer-term integration efforts on others. DHCS

envisions three phases for integration, as described below and as illustrated in Figure 2 on page 10:

Phase 1. Voluntary Integration of County Functions Under Existing Contracts (CY 2023–2024). In this first phase, counties may continue their efforts to integrate components that do not require any additional policymaking from DHCS, such as processes related to the 24/7 access line, screening, assessment, and treatment planning, as well as county data storage and data sharing. DHCS will consider opportunities for guidance to support counties and identify best practices for implementing recent and upcoming CalAIM reforms. Meanwhile, DHCS will analyze existing laws, regulations, and policies to identify opportunities to align compliance requirements for the SMHS and DMC/DMC-ODS programs through regulatory reforms and policy revision, and will develop template integrated contracts and other materials to prepare for Phase 2.

Phase 2. Voluntary Contract Integration (CY 2025–2026). Interested counties may voluntarily enter into integrated contracts with DHCS that cover both SMHS and SUD services (subject to all necessary federal approvals, as noted above). By integrating these contracts, DHCS and participating counties will gain early experience with integrating various administrative and oversight functions. Certain integration-related best practices identified in DHCS' Phase 1 guidance may be required for counties with integrated contracts, and certain policy changes may apply statewide to promote behavioral health care access and quality. DHCS will continuously engage with participating counties to ensure mutual understanding and support for operationalizing the integrated contracts. In addition, during Phase 2, DHCS will finalize regulatory reforms to update and streamline the requirements for Medi-Cal behavioral health programs, including revisions to promote behavioral health integration and other CalAIM goals.

Phase 3. Statewide Behavioral Health Administrative Integration (CY 2027+). All counties adopt integrated behavioral health contracts with DHCS and participate in integrated oversight activities, some of which may begin in SFY 2027–2028. DHCS and counties adjust their operations to account for the regulatory reforms finalized in Phase 2.

Note: AB 133 currently provides for the statewide adoption of integrated contracts by January 1, 2027. DHCS welcomes feedback on this timeline, particularly if stakeholders anticipate significant implementation challenges with aligning the contract cycle for either Phase 2 or Phase 3 with the calendar year, rather than the State Fiscal Year.

The phased implementation approach is described in greater detail in Part III of this concept paper. See Figure 2 on page 10 for a visual overview of county and DHCS activity in each phase for each component of Behavioral Health Administrative Integration.

Anticipated Challenges and Mitigation Approaches

Achieving the promise of Behavioral Health Administrative Integration will require sustained attention and investment at the state, county, and provider levels. DHCS understands that public officials and provider staff have limited capacity, and that Behavioral Health Administrative Integration is one of multiple ongoing CalAIM reforms.

Recognizing those constraints, DHCS developed the phased implementation approach described above. Throughout the five-year implementation timeline, DHCS will endeavor to support counties and providers in understanding any new requirements, assessing their options, and implementing effective reforms.

Certain aspects of SMHS and SUD operations are required under federal law. Even so, a significant degree of integration can be achieved within federal parameters, as confirmed by DHCS' landscape assessment (described in Appendix 2). DHCS will support counties' progress toward integration while maintaining compliance with federal requirements. Meanwhile, DHCS will be taking the necessary steps to amend state statutes and/or regulations, as needed, to enable successful implementation of Behavioral Health Administrative Integration.

In addition to modified policies and procedures, Behavioral Health Administrative Integration will require a cultural shift. This initiative seeks to reimagine a system that has, for decades, been designed and operated as two separate programs with two separate sets of structures, processes, financing streams, and clinical models. Progress toward integration is already underway, and DHCS is confident that California's dedicated local governments, public officials, and providers will succeed in achieving the goals of this initiative.

Conclusion

Through Behavioral Health Administrative Integration, DHCS aims to improve outcomes and the experience of care for Medi-Cal beneficiaries living with mental health and SUD needs through coordinated treatment across the behavioral health continuum of care. Integration will, in addition, reduce administrative burdens for counties, providers, and the state. DHCS looks forward to continued partnership with counties, providers, and Medi-Cal beneficiaries through the phased implementation timeline laid out in this concept paper.

Figure 2: Phased Implementation of Behavioral Health Administrative Integration

<table>
<tr><th>Component</th><th>Phase 1. Voluntary Integration of County Functions Under Existing Contracts (CY 2023 & 2024*)</th><th>Phase 2. Voluntary Contract Integration (CY 2025 & 2026*)</th><th>Phase 3. Statewide Behavioral Health Admin. Integration (CY 2027+*)</th></tr>
<tr><td>1. 24/7 Access Line</td><td rowspan="3">Counties continue their integration efforts.
DHCS issues guidance and templates that outline requirements, opportunities, and/or best practices for integration, including a template universal data release.</td><td rowspan="3">Counties may opt into integrated behavioral contracts; certain integration best practices may shift from voluntary to required, esp. for counties with integrated contracts.</td><td rowspan="11">All counties integrate all components, including:
Integrated contracts with DHCS for SMHS and SUD.
Adoption of best practices for integrating clinical and administrative components.
Integrated DHCS oversight procedures, some of which may begin in SFY 2027–2028.
DHCS and counties implement new/modified regulatory standards that were developed specifically for integrated behavioral health plans.</td></tr>
<tr><td>2. Screening, Assessment & Treatment Planning</td></tr>
<tr><td>5. Data Sharing & Privacy</td></tr>
<tr><td>6. Cultural Comp. Plans</td><td rowspan="2">Counties may voluntarily integrate their CCPs and quality improvement programs at any time.</td><td rowspan="2">Counties may opt into integrated behavioral contracts; integrated CCPs and quality improvement plans are required in counties with integrated contracts.</td></tr>
<tr><td>7. Quality Improvement</td></tr>
<tr><td>3. Beneficiary Materials, Appeals & Grievances</td><td rowspan="5">To prepare for contract integration, DHCS:
Develops integrated contract templates.
Amends CA’s 1915(b) waiver.
Contracts with a vendor for integrated EQR.
Develops integrated templates and policies for beneficiary materials, compliance reviews, and network adequacy.</td><td rowspan="5">Counties may opt into integrated behavioral contracts; these counties will use integrated beneficiary materials and undergo integrated EQRs, compliance reviews, and network adequacy certifications.
DHCS moves toward annual, risk-based compliance reviews across all behavioral health programs.[8]</td></tr>
<tr><td>4. State-County Contracts</td></tr>
<tr><td>8. External Quality Review</td></tr>
<tr><td>9. DHCS Compliance Reviews</td></tr>
<tr><td>10. Network Adequacy</td></tr>
<tr><td>11. Provider Oversight</td><td colspan="2">DHCS considers opportunities to promote integration and reduce administrative burdens for providers and counties, including strategies to streamline and simplify licensure and certification requirements</td></tr>
</table>

All Components	***Prep for Phases 2 & 3.*** *DHCS considers potential regulatory reforms to promote integration.*	***Prep for Phase 3.*** *DHCS finalizes rule changes to promote integration.*	

** AB 133 currently provides for the statewide adoption of integrated contracts by January 1, 2027. DHCS welcomes feedback on this timeline, particularly if stakeholders anticipate significant implementation challenges with aligning the contract cycle for either Phase 2 or Phase 3 with the calendar year, rather than the State Fiscal Year.*

Key: Italicized text = DHCS focused actions. Non italicized text = county focused actions

[8] See *Component* 9 on page 29 for additional information on DHCS risk-based compliance audits.

I. Background

A. Medi-Cal Behavioral Health Services Today

Mental health and substance use disorders (SUDs)—often collectively referred to as "behavioral health"—are among the most common health conditions faced by Californians.[9] The Medi-Cal program provides a significant portion of all behavioral health treatment services in the state. These services are administered through multiple different delivery systems, with features that vary depending on the nature and severity of an individual's behavioral health needs, as well as the county in which they reside. Specifically:

- Adults who (1) are 21 years of age and older and (2) have mild to moderate distress or impairment of mental, emotional, or behavioral functioning can receive **"non-specialty" mental health services** from the same Medi-Cal managed care plan (MCP) that covers their physical health needs.[10] For all enrollees, MCPs are also responsible for SUD screening, brief intervention, and referral as needed for other treatment.[11] Beneficiaries may access medications for addiction treatment in primary care settings, with services covered through the MCP or fee-for-service (FFS) delivery systems and Medi-Cal pharmacy benefits.
- Individuals with more serious mental health needs access care through the **specialty mental health services (SMHS)** delivery system. County-based Mental Health Plans (MHPs) provide inpatient and outpatient SMHS through a combination of county-operated and contracted providers. County MHPs are required to coordinate with members' Medi-Cal MCPs. In addition, for members who are under the age of 21 pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, county MHPs are required to cover all medically necessary mental services that are not otherwise covered as "non-specialty" mental health services by the MCPs or the FFS delivery system.
- **SUD treatment** is provided through county-based delivery systems that are separate from SMHS (although certain SUD services are covered by MCPs, as described above). The original DMC program did not involve a formal managed care structure. Since 2015, however, counties have had the option of participating in the DMC-ODS, in which counties operate an SUD managed care program (similar to the MHP model for SMHS) that includes coverage of

[9] California Health Care Foundation, *Substance Use in California* (2022), https://www.chcf.org/publication/2022-edition-substance-use-california/; California Health Care Foundation, *Mental Health in California* (2020), https://www.chcf.org/publication/mental-health-california/

[10] For a discussion of beneficiary access criteria for non-specialty mental health services, see DHCS All-Plan Letter 22-006 (Apr. 8, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-006.pdf.

[11] For a discussion of coverage for alcohol and drug screening, assessment, brief interventions, and referral to treatment, see DHCS All-Plan Letter 21-014 (Oct. 11, 2014), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf.

additional services beyond DMC.[12] As of the date of publication, DMC-ODS has been voluntarily implemented by 37 of California's 58 counties, representing 96% of the Medi-Cal population statewide. DMC and DMC-ODS programs must provide all levels of care described in the American Society of Addiction Medicine (ASAM) criteria.[13]

Approximately 40% of individuals with a serious mental illness also have a co-occurring SUD.[14] Under the current structure, however, Medi-Cal beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care. They may, for example, need to call separate numbers and visit separate locations for the screening, intake, and assessment processes.

Meanwhile, counties and providers must ensure compliance with rules for each program on issues such as service delivery and documentation and may be subject to multiple compliance reviews each year. Counties that opt into DMC-ODS, for example, administer two distinct managed care programs and must demonstrate compliance with federal managed care requirements with respect to each program, with duplicative processes and documentation on issues such as quality improvement, beneficiary protections, and program integrity.

B. CalAIM and Behavioral Health Administrative Integration

California Advancing and Innovating Medi-Cal

CalAIM reflects DHCS' long-term commitment to strengthening Medi-Cal, offering Californians a more equitable person-centered approach to maximizing their health and life trajectory. Through CalAIM's bold transformations, Medi-Cal is becoming a more standardized, simpler system that helps beneficiaries access the care needed to live healthy lives. CalAIM has three goals:

1. Identify and manage comprehensive needs through whole-person care approaches and social drivers of health.
2. Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
3. Make Medi-Cal a more consistent and seamless system for beneficiaries to navigate by reducing complexity and increasing flexibility.

Behavioral Health Administrative Integration

Several CalAIM initiatives seek to reduce complexity across all delivery systems, including behavioral health. Consistent with that goal, CalAIM proposed an initiative for

[12] DHCS initially received the federal authority to establish the DMC-ODS program under a Medicaid demonstration project approved by CMS under Section 1115 of the Social Security Act (SSA). As of January 1, 2022, however, the DMC-ODS program is authorized primarily under a waiver under SSA Section 1915(b), together with the federal authorization for MCPs and MHPs.

[13] *See* ASAM, *The ASAM Criteria*, https://www.asam.org/asam-criteria; DHCS, *DHCS Level of Care Designation,* https://www.dhcs.ca.gov/provgovpart/Pages/level-of-care-designation.aspx; DHCS, *Drug Medi-Cal Organized Delivery System*, https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx.

[14] National Survey on Drug Use and Health (Tables 8.5A & 8.11A), Substance Abuse & Mental Health Services Administration (2020), https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables.

Behavioral Health Administrative Integration, referring to (among other goals) the consolidation of specialty mental health and SUD services into a single county-based behavioral health program. In support of that goal, the California Legislature enacted AB 133 (2021), which provides that "commencing January 1, 2027," counties "shall provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal behavioral health delivery system contract."[15] (As noted above, DHCS welcomes feedback on this timeline, particularly if stakeholders anticipate significant implementation challenges with aligning the contract cycle for either Phase 2 or Phase 3 with the calendar year, rather than the State Fiscal Year.)

Behavioral Health Administrative Integration and "Full" Integration

The Behavioral Health Administrative Integration initiative is distinct from CalAIM's longer-term proposal for a "Full Integration Plan"—a pilot test for administrative consolidation of specialty behavioral health with other medical and oral health care under a single comprehensive MCP. DHCS has not yet established a timeline for the Full Integration Plan pilot program.

The primary goals of Behavioral Health Administrative Integration are to improve health care outcomes and the experience of care for Medi-Cal beneficiaries—particularly those with co-occurring mental health and SUD issues—and to reduce administrative burdens for counties, providers, and the state. For counties that have opted into DMC-ODS, the result of this CalAIM initiative will be a single prepaid inpatient health structure in each county or multicounty region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county. DMC counties will similarly adopt an integrated contract with DHCS that covers both SMHS and SUD services but may continue offering SUD services outside of the managed care structure.

CalAIM Behavioral Health Initiatives

The Behavioral Health Administrative Integration initiative intersects with and supports related CalAIM behavioral health initiatives such as:

- ***Behavioral Health Payment Reform***, scheduled to take effect in July 2023, will update the financing, billing, and reimbursement of behavioral health services. This will include updates to the code set used to submit claims for specialty behavioral health, aligning some coding practices for comparable SMHS and SUD services regardless of the beneficiary's diagnosis.
- ***Behavioral Health Documentation Redesign***, which took effect in July 2022, through which DHCS aligned and streamlined provider documentation requirements pertaining to behavioral health assessments, problem lists, and progress notes.
- ***No Wrong Door & Co-Occurring Treatment***, a set of reforms that took effect in July 2022 with the aim of ensuring that beneficiaries receive appropriate mental health services regardless of the delivery system where they seek care.
- ***Standardized Mental Health Screening & Transition Tools*** to support mental health screenings and referrals within and between systems of care, including SMHS and Medi-Cal MCPs. The tools were released in December 2022.

[15] California Welfare & Institutions Code (W&I) § 14184.404(a).

- ***The Behavioral Health Quality Improvement Program (BHQIP)***, an incentive payment program to support county MHPs and DMC/DMC-ODS programs as they prepare for and implement CalAIM reforms between 2021 and 2023. BHQIP incentives are tied to goals concerning the policy reforms described in this text box, as well as modernizing and streamlining data exchange within and between Medi-Cal delivery systems.
- ***The Behavioral Health Data Modernization Project***, which aims to streamline, update, and consolidate various aspects of behavioral health data collection and storage at the state level.
- ***The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration***, which will strengthen the continuum of community-based behavioral health services for adults with serious mental illness and youth with serious emotional disturbance in accordance with guidance from CMS.[16]

This concept paper will assess the implications of Behavioral Health Administrative Integration across 11 components, which are organized into three broad domains, as set forth below. Part II of this concept paper provides additional detail regarding the current status and future goals for each component. To achieve integration across all 11 components by SFY 2027–2028, DHCS and counties will collaborate on a phased implementation approach, as described in Part III.

Although not included as a component under Behavioral Health Administrative Integration, DHCS recognizes that a strong behavioral health workforce is another key aspect of this delivery system transformation, including licensed health care professionals, unlicensed providers, and administrators with the subject matter expertise needed to identify both mental health and substance use conditions and treat or refer beneficiaries appropriately. DHCS looks forward to continued partnership with counties, providers, and other stakeholders to maintain and enhance this critical system capacity.

The 11 Components of Behavioral Health Administrative Integration

Streamlining the Beneficiary Experience. These components focus on streamlining the experience of beneficiaries who seek behavioral health services, particularly for individuals with co-occurring mental health and SUD needs and the providers who serve them. DHCS and counties seek to integrate:

1. The county-operated ***24/7 Access Line*** that beneficiaries can call for behavioral health screenings and referrals to behavioral health providers.
2. County and provider processes for ***Screening, Assessment & Treatment Planning*** for beneficiaries with behavioral health needs.
3. ***Beneficiary Materials, Appeals & Grievances***, notably including the handbook that advises beneficiaries about their covered benefits and rights in SMHS and SUD programs.

[16] CMS, State Medicaid Director Letter 18-011 (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Integrating County Structures & Processes. These components focus primarily on integrating counties' administrative functions across SMHS and DMC/DMC-ODS. DHCS and counties seek to integrate:

4. The ***Contracts*** that establish responsibilities, payment, and oversight for both counties and DHCS with respect to the operation of MHPs and DMC/DMC-ODS programs.
5. ***Data Sharing & Privacy*** practices, including with respect to information exchange within and among county plans and providers, and between county plans and the MCPs that manage beneficiaries' physical health and lower-acuity mental health needs. Counties and providers grapple, in particular, with strict federal confidentiality and disclosure requirements for SUD-related data.
6. The ***Cultural Competence Plans*** in which counties define their processes for ensuring that care will be delivered in a culturally responsive manner.
7. The ***Quality Improvement*** activities through which counties measure and improve the quality of behavioral health services and delivery infrastructure.

Integrating DHCS Oversight Functions. These components focus on integrating and streamlining DHCS oversight activities for counties and providers, including an emphasis on avoiding duplicative processes and documentation.

8. ***External Quality Reviews*** for MHPs and DMC-ODS programs, conducted by a state-selected EQR Organization pursuant to federal Medicaid managed care requirements.
9. ***DHCS Compliance Reviews*** of county behavioral health programs and certain behavioral health providers.
10. The ***Network Adequacy*** standards and certification processes through which DHCS ensures that county behavioral health programs maintain adequate provider capacity and provide timely access to services.
11. ***Provider Oversight***, including the standards and processes for licensing and certification of mental health and SUD providers, Medi-Cal enrollment, and credentialing and contracting with individual county behavioral health programs.

II. Administrative Integration Components

For each of the 11 components of Behavioral Health Administrative Integration, this section describes:

- The current legal requirements and status of integration efforts
- The vision for integrating this component, including consideration of integration in the short and longer term, consistent with the phased implementation approach described below in Part III
- The concrete steps needed to achieve integration at the state and county levels

This overview reflects the CalAIM principles that have been codified in state law and is informed by a landscape assessment that included input from county behavioral health officials (as described in Appendix 2) and the CalAIM Behavioral Health Workgroup, which consists of consumer advocates, providers, and county and state representatives.

Notably, counties have the ability to achieve substantial integration on several components today, including by implementing flexibilities and standards that have recently been developed under CalAIM. For other components, integration will require policy changes or other action at the state level, potentially including an amendment to California's federal waiver under Section 1915(b) of the Social Security Act, which establishes the federal parameters for MHPs, DMC-ODS, and other Medi-Cal managed care programs.[17]

See Figure 3 below for a visual representation of the nature of DHCS action (if any) that is required to support integration for each of the 11 components. The level and type of effort necessary for any given component may vary between DHCS and counties due to their different roles in the Medi-Cal system, and may also vary among counties due to differences in the design of their behavioral health programs and their administrative operations.

Figure 3. DHCS Action Required for Each Component of Behavioral Health Administrative Integration

Streamlining the Beneficiary Experience	Integrating County Structures & Processes	Integrating DHCS Oversight Functions
1. County-Operated 24/7 Access Line*	**4. DHCS-County Contracts*** **	**8. External Quality Reviews*** **
2. Screening, Assessment & Treatment Planning*	**5.** Data Sharing & Privacy*	**9. DHCS Compliance Reviews*** **
3. Beneficiary Materials, Appeals & Grievances**	**6.** Cultural Competence Plans*	**10. Network Adequacy****
	7. Quality Improvement*	**11.** Provider Oversight***

Key:

- **One Asterisk (*):** Counties can integrate this component without further DHCS action**,** although DHCS guidance may be helpful *(e.g., template universal data release form)*.
- **Two Asterisks (**):** New state tools/templates needed for counties to integrate *(e.g., beneficiary handbook, network certification materials)*.
- **Three Asterisks (***):** Integration may require significant changes in state law, contracts, or procedures *(e.g., revised contracts with counties and with the EQR organization, compliance review protocols)*.
- **Bold Border:** Component cannot be fully integrated until counties enter into integrated behavioral health contracts with DHCS *(component 4)*.

[17] The federal managed care standards are set forth at 42 CFR Part 438. California's 1915(b) waiver and related materials are available at https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx.

A. Streamlining the Beneficiary Experience

This domain of Behavioral Health Administrative Integration captures DHCS and county efforts to streamline how Medi-Cal beneficiaries experience care as they learn about, request, and engage with the Medi-Cal behavioral health system. The impact of integration will be felt most strongly by beneficiaries with co-occurring serious mental health and SUD needs, who currently must interface with two separate systems of care.

Existing state policies allow counties to integrate each of the components in this domain to at least some degree, and many have already taken steps to do so. As DHCS and counties progress toward statewide Behavioral Health Administrative Integration in 2027, there will be opportunities for DHCS—working in collaboration with counties, beneficiaries, providers, and other stakeholders—to issue guidance, provide templates, and offer technical assistance, both for counties that are well on their way to integration and for counties that are earlier in the planning process. Certain best practices may be required prior to 2027 for counties that voluntarily enter into integrated behavioral health contracts with the state *(as described under component 4 below)*, in addition to any policy changes that may apply statewide.

Component 1. County-Operated 24/7 Access Line

Legal Requirements and Current Status. MHPs and DMC-ODS programs are required to maintain a 24-hour telephone access line.[18] DMC counties are not required to maintain a 24-hour SUD access line but do receive beneficiary requests for services and provide information and referrals via phone.[19]

Some counties operate two separate 24-hour access lines for SMHS and SUD services, while others have established a single line that connects beneficiaries to both types of behavioral health services, potentially including seamless integration with other services such as the 988 suicide prevention lifeline. Some counties with integrated lines have trained their access line staff to handle both SMHS and SUD requests, while others co-locate their SMHS and SUD staff and train them to provide warm handoffs as necessary. Counties vary on the extent to which they contract with a vendor to operate the access line, with some maintaining the access line in-house and others contracting out for nighttime and weekend calls.

The Vision for Integration. Under an integrated model, counties will operate a single 24-hour access line for all beneficiaries seeking behavioral health services. A beneficiary can be triaged, screened for both mental health and SUD needs, and scheduled for appropriate follow-up appointments as part of the same call, without the beneficiary needing to hang up and dial any additional numbers.

This type of integrated model would ease access for beneficiaries, particularly those with co-occurring conditions, who may otherwise need to call two separate numbers and undergo two separate screening processes, adding burden for beneficiaries and raising

[18] This requirement is in DHCS' MHP and DMC-ODS contracts with the counties. *See also* 9 California Code of Regulations (CCR) § 1810.405(d) ("Each MHP shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week."); 42 CFR § 438.206(c)(1)(iii) (requiring Medicaid managed care programs to "make services included in the contract available 24 hours a day, 7 days a week, when medically necessary").

[19] Further information about county SUD access lines can be found here.

the risk that a co-occurring need may not be timely identified and addressed. Providers, too, would benefit from an integrated county access line that facilitates access to care and promotes early identification of co-occurring needs, which may otherwise be discovered during the provider's own intake and assessment process, potentially prompting a referral outside of their delivery system.

Achieving Integration

- ***The State's Role.*** No changes in state law are needed for counties to voluntarily integrate their access lines and screening protocols in the short term. DHCS will seek opportunities to support counties by issuing guidance on best practices. In the long term, once counties enter into an integrated behavioral health contract that covers both SMHS and SUD services *(as described under component 4, below)*, those contracts will require counties to operate an integrated access line in accordance with state standards.
- ***Counties' Role.*** The counties will be key drivers in implementing the necessary operational changes, such as moving from two access lines to one and modifying workflows for the access team. Depending on how a county's access line is currently structured, there may also be a need for trainings to bridge knowledge gaps and promote a cultural shift among access line staffers who have historically specialized in specific populations, functions, and/or a specific delivery system.

Best Practices: Integrated 24/7 Access Line. Riverside County previously operated multiple access lines for different types of mental health and SUD services, but it began planning for an integrated access line in 2018 with the aim of providing beneficiaries with a seamless experience. The county began by consolidating the two access line teams under one manager in a shared workspace. The county proceeded to design and train staff on integrated protocols and workflows, including cross-training to ensure that all team members understand each other's capabilities and areas of specialization. The county also performed outreach and education to increase awareness of the new integrated approach.

Now, when a Medi-Cal beneficiary calls seeking behavioral health services, they use a touchtone menu to select either mental health or SUD as their primary need and are referred to an appropriate counselor to begin the screening process. Both screening protocols include questions to identify potential co-occurring needs, however. Riverside's SUD counselors are trained to provide both SUD and mental health screenings, so they're able to perform integrated screenings as needed. Riverside's mental health counselors are not able to perform ASAM screenings for SUD, but if they determine an SUD screening would be appropriate, they connect the beneficiary with an SUD counselor as part of the same call.

Component 2. Screening, Assessment & Treatment Planning

Legal Requirements and Current Status

- ***Screening.*** High-level parameters for behavioral health intake, screening, and referral are defined in state law, DHCS guidance, and DHCS' contracts with counties.[20] In addition:
    - Pursuant to AB 133, DHCS and counties are currently implementing Statewide Mental Health Screening and Transition of Care Tools for adults and youth. These standardized tools will be used by both MHPs and MCPs to identify which delivery system the individual should be referred to for a mental health assessment.
    - As part of the CalBH-CBC demonstration, inpatient and residential treatment facilities offering mental health treatment will eventually be required to screen beneficiaries upon admission for co-occurring SUD (and physical health) needs and have the capability to address those needs directly or facilitate referrals to providers for treatment.[21]
- ***Assessment***
    - Under the CalAIM Behavioral Health Documentation Redesign initiative, DHCS has established a "domains-based" approach for SMHS assessments, as outlined in Behavioral Health Information Notice (BHIN) No. 22-019, released on April 22, 2022.[22] DHCS requires the use of the Child and Adolescent Needs and Strengths (CANS) tool for beneficiaries under the age of 21[23] but has not required or encouraged the use of a particular assessment tool for adults.
    - For SUD assessments (DMC-ODS and DMC), state law requires counties to use the criteria developed by ASAM to "determine the appropriate level of care for substance use disorder treatment services."[24]

  Other, more general parameters for SMHS and SUD assessments are defined in state statutes and regulations, the Medi-Cal State Plan, and DHCS' contracts

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[20] *See, e.g.,* 22 CCR § 51341.1(b)(13); DHCS, BHIN No. 22-011 (Mar. 31, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf.

[21] CMS, State Medicaid Director Letter 18-011 (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[22] DHCS, BHIN 22-019 (Apr. 22, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf; *see also* W&I §§ 14705(b) & 14705.5; 9 CCR § 1810.204.

[23] *See* BHIN 22-019; Mental Health & Substance Use Disorder Information Notice (MHSUDS IN) 18-007 (Jan. 25, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN-18-007%20CANS/IN_18-007_CFT_CANS_Joint_Letter.pdf, MHSUDS IN 17-052 (Nov. 14, 2017), https://www.dhcs.ca.gov/services/MH/Documents/FMORB/Info_Notice_17-052_POS_Functional_Assessment_Tool.pdf.

[24] W&I § 14184.402(e)(1); *see also* DHCS BHIN 21-075 (Dec. 17, 2021), https://www.dhcs.ca.gov/Documents/BHIN-21-075-DMC-ODS-Requirements-for-the-Period-2022-2026.pdf; DHCS BHIN 21-071 (Dec. 3, 2021), https://www.dhcs.ca.gov/Documents/BHIN-21-071-Medical-Necessity-Determination-Level-of-Care-Determination-Requirements.pdf; *see also* DHCS, *Drug Medi-Cal Organized Delivery System*, https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx.

with the counties.[25] Under California's "No Wrong Door" policy—as enacted in AB 133 and described in BHIN 22-011—SMHS and nonresidential SUD services are reimbursable during the assessment process before the beneficiary's diagnosis has been confirmed.[26] Under the CalAIM initiative for Behavioral Health Payment Reform (scheduled to take effect in July 2023), DHCS will standardize and update certain billing and coding requirements for assessments and other behavioral health services.

- ***Treatment Planning.*** Federal and state regulations define treatment planning and documentation requirements for certain SMHS and SUD services (e.g., Targeted Case Management, Peer Support Services, Narcotic Treatment Programs). With BHIN 22-019—and consistent with Behavioral Health Documentation Redesign—DHCS sought to streamline and align documentation requirements for treatment planning and progress notes across SMHS and SUD services within the limits of federal and state law.

The Vision for Integration. DHCS and counties will continue their work under other CalAIM initiatives to streamline and standardize the processes and documentation requirements for screening, assessment, and treatment planning across SMHS, SUD services, and other health care services. With respect to the Behavioral Health Administrative Integration initiative, DHCS will consider opportunities to support these implementation efforts—with special attention to beneficiaries with co-occurring mental health and SUD needs—through the integration of DHCS-county contracts, county structures and processes, and DHCS oversight, as described in this concept paper. In collaboration with stakeholders, DHCS and counties may identify and implement best practices regarding, for example:

- ***Screening*** protocols for co-occurring mental health and SUD needs when an individual calls a county's 24/7 access line *(see component 1 above)*.
- ***Assessment*** protocols that include appropriate consideration of co-occurring behavioral health needs, regardless of the stated reason for the beneficiary's visit or the site where the beneficiary seeks services. As one example, DHCS and stakeholders could explore a modular approach to behavioral health assessments, in which discrete sets of questions on various issues may be "activated" based on the beneficiary's responses to preliminary screening questions. Depending on the volume and nature of necessary assessment questions, as well as the beneficiary's preferences, the assessment could be conducted over the course of multiple visits and/or conducted jointly by multiple providers.
- ***Treatment Planning*** should be client-centered and strengths-based, and should include regular communication among all relevant behavioral health providers—including mental health and SUD providers, as needed—to promote information sharing, alignment of treatment goals, and coordination of services. *(For*

[25] *See, e.g.*, DHCS BHINs 22-019, 21-075 & 21-071, all available at https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx W&I § 14184.402(e)(1); § 14059.5.

[26] W&I § 14184.402(f); BHIN 22-011 (Mar. 31, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf.

additional detail regarding confidentiality and data sharing, see component 5 below.)

Achieving Integration

- ***The State's Role***
  - The state has taken steps to promote streamlined and client-centered screening, assessment, and treatment planning, including the Legislature's enactment of AB 133 and DHCS' work under other CalAIM initiatives such as No Wrong Door, Documentation Redesign, and Standardized Screening and Transition Tools.
  - In the coming years (CY 2023–2024), in collaboration with counties and other stakeholders, DHCS will consider opportunities to support implementation, clarify existing requirements, and promote best practices regarding screening, assessments, and treatment planning, potentially including additional state-developed templates or guidelines. These templates may be optional, or DHCS may establish a minimum baseline on which counties may build.
  - In the longer term, DHCS will, in consultation with stakeholders, consider the merits of:
    - Defining requirements for screening, assessment, and treatment planning for co-occurring mental health and SUD needs under the integrated behavioral health county contracts *(as described under component 6, below).*
    - Identifying potential policy and regulatory changes that would further support integrated and client-centered assessments, treatment planning, and care.
- ***Counties' Role.*** Counties are implementing the recent state policy changes outlined above. There are also longer-term efforts in many counties to align and streamline clinical operations across SMHS and SUD. Because federal and state standards leave room for flexibility in many areas, counties and their providers can define and operationalize best practices. County behavioral health agencies play an important role in fostering cultural shifts among county and provider staff who have historically operated in siloes focused specifically on SMHS or SUD, and who are familiar with prior state requirements built around the identification of a "primary" diagnosis (SMHS vs. SUD) for each beneficiary.

Component 3. Beneficiary Materials, Appeals & Grievances

Legal Requirements and Current Status. Under federal law, managed care plans such as MHPs and DMC-ODS programs must offer their beneficiaries a handbook that describes covered benefits, how to access their benefits, and beneficiaries' legal rights, including the ability to file a grievance or appeal.[27] DHCS requires counties to use templates provided by the state, which currently has separate templates for SMHS and DMC-ODS. MHPs and DMC-ODS programs must also develop and maintain a provider directory in accordance with state requirements. Currently, DMC counties are not required to provide beneficiary handbooks or provider directories, although DHCS plans

[27] 42 CFR § 438.10.

to include these requirements in future DMC contracts. Beneficiaries with co-occurring mental health and SUD needs must navigate separate materials, with often overlapping information (e.g., regarding grievance and appeal procedures) for each delivery system.

The Vision for Integration. Counties will distribute a single handbook and provider directory with all the information needed to access both SMHS and SUD services. Counties will apply a single set of beneficiary rights and procedures, including procedures for appeals and grievances, for all covered behavioral health services.

Achieving Integration

- ***The State's Role.*** DHCS will produce a template handbook and guidance for an integrated provider directory, with input from counties and consumer advocates. Integrated beneficiary materials will be required for counties that enter into integrated behavioral health contracts that cover both SMHS and SUD services in 2025 *(as described under component 4 below)*, and could potentially be used (with appropriate modifications) even in counties that have not yet entered into integrated contracts.
- ***Counties' Role.*** Counties will adapt and distribute the template handbook, and will also be responsible for ensuring that their beneficiary rights and procedures are aligned across their behavioral health programs.

B. Integrating County Structures and Processes

Whereas the first domain of Behavioral Health Administrative Integration focuses on the beneficiary experience, this second domain focuses on the structure of each county's behavioral health delivery system (as defined under its contract with DHCS) as well as the county's internal processes for data management and other functions. Streamlining and simplifying these administrative functions will create a stronger platform from which to offer more coordinated and integrated care to beneficiaries.

Establishing integrated behavioral health contracts between DHCS and the counties *(component 4)* will require significant investment from both DHCS and counties, and will in turn support the integration of several additional components. Meanwhile, counties already have the ability to integrate the remaining components under this domain—data sharing and privacy, cultural competence plans, and quality improvement—without any policy changes at the state level. Many counties have already made significant progress toward integration in these areas.

Component 4. DHCS-County Contracts

Legal Requirements and Current Status. Currently, counties enter into separate contracts with DHCS for their MHP and for their DMC-ODS or DMC program. MHP and DMC-ODS contracts must satisfy all federal requirements for PIHP managed care contracts, as well as California's federal 1915(b) waiver.[28] In addition, DHCS has incorporated some of these same requirements into its contracts with DMC counties, and it may pursue additional alignment in future iterations of the DMC contract.

[28] The federal managed care standards are set forth at 42 CFR Part 438. As noted above, California's 1915(b) waiver and related materials are available at https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx.

Operating two separate managed care programs means that counties must comply with certain reporting and oversight functions separately for each program, as described below under subsection C (DHCS Oversight Functions).

The Vision for Integration. By 2027, each county will enter into a single contract with DHCS that covers the administration of both SMHS and SUD services for Medi-Cal beneficiaries.[29] (AB 133 currently provides for the statewide adoption of integrated contracts by January 1, 2027. As noted above, DHCS welcomes feedback on this timeline, particularly if stakeholders anticipate significant implementation challenges with aligning the contract cycle for either Phase 2 or Phase 3 with the calendar year, rather than the State Fiscal Year.) An integrated contract will support clinical integration by establishing a single unified set of requirements and expectations for clinical operations and quality of care, including for beneficiaries with co-occurring needs. Similarly, an integrated contract will support the integration of DHCS oversight by significantly reducing the number of compliance reviews, which are currently conducted separately for SMHS and SUD services.

DMC-ODS counties will operate a single PIHP managed care program for the delivery of both SMHS and SUD services.[30] DMC counties, meanwhile, will enter into consolidated contracts that promote the integration goals while preserving the structure of an SMHS managed care program paired with a non-managed-care SUD program. The integrated contracts may allow for certain areas of county-specific variation, as under the existing program-specific contracts. In addition, as under the existing structure, DHCS will work with groups of counties that seek to establish regional behavioral health programs.

Integrated county contracts can create administrative efficiencies for providers as well, particularly those that offer both SMHS and SUD services. Currently, those providers must execute separate contracts with the county's MHP and the county's DMC-ODS or DMC program and must submit separate bills to each program. A single set of contract terms at the county level could facilitate simplification or integration of provider contracts. *For additional discussion of provider contracting and related issues, see component 11 below.*

Before statewide Behavioral Health Administrative Integration takes effect in 2027, DHCS hopes to offer interested counties the opportunity to voluntarily adopt integrated contracts, likely beginning in 2025.

Achieving Integration

- ***The State's Role.*** DHCS is responsible for securing the necessary federal approvals for contract integration from CMS,[31] in addition to confirming all

[29] Although counties will operate one integrated Medi-Cal behavioral health program from the perspective of state and federal law, counties will also remain at liberty to structure their internal operations as they see fit. For example, some counties have already opted to consolidate their behavioral health personnel under a single county department, while other counties may choose to maintain separate departments (or divisions within a department) for SMHS and SUD operations.

[30] Counties will operate these integrated PIHPs on a non-risk basis, consistent with the current non-risk PIHPs that counties currently operate for their SMHS and DMC-ODS programs.

[31] Contract integration will require an amendment to California's CMS-approved 1915(b) waiver. CMS will, in addition, review the final integrated contracts, as executed, for compliance with federal managed care requirements.

appropriate authorities under state law. DHCS will, in addition, develop the integrated boilerplate contracts, with input from counties.

- ***Counties' Role.*** County feedback will inform the development of the integrated boilerplate contracts. Counties will be responsible for making modifications to their clinical and administrative operations in accordance with the terms of the integrated contracts, either as part of the voluntary early integration effort in 2025 or as part of statewide Behavioral Health Administrative Integration in 2027.

Component 5. Data Sharing and Privacy

Legal Requirements and Current Status. Counties and health care providers must comply with a variety of federal and state laws governing the confidentiality and security of health care information.[32] Of these, the federal restrictions on the disclosure of SUD information present the greatest challenges for behavioral health integration. Dubbed the "Part 2" rules (because they are codified at 42 CFR Part 2), these standards generally require federally assisted SUD programs to secure a patient's written consent before disclosing any records containing SUD information, including disclosures to other health care providers treating the same patient. The Part 2 rules impose additional limitations on the redisclosure of SUD-related data by those who receive it directly from the original SUD provider. In March 2020, Congress directed the U.S. Department of Health and Human Services (HHS) to relax the Part 2 rules in certain respects and also gave HHS the authority to impose greater penalties for violation of the Part 2 rules. At the time of publication, HHS has proposed, but not yet finalized, corresponding regulatory revisions.[33]

Counties vary widely in their current approaches to behavioral health data storage and data sharing, reflecting a combination of county-specific approaches to comply with Part 2 requirements and the legacy of prior county-specific decisions about data management. With respect to data sharing protocols, for example, some counties have developed a "universal release" document that allows an individual to authorize (or not authorize) the release of multiple types of data with a single form. While agreeing on the importance of integrated care teams to support care coordination for individuals with co-occurring needs, counties vary in how they operationalize the requirements for collecting and documenting patient authorizations, granting data access to appropriately authorized individuals, and rescinding that access if a patient revokes their authorization.

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[32] These laws include generally applicable health care confidentiality laws, such as the California Confidentiality of Medical Information Act (CMIA) and the federal Health Insurance Portability and Accountability Act (HIPAA), as well as laws that pertain specifically to behavioral health information. For additional background, see California Office of Health Information Integrity, *Sharing Behavioral Health Information in California* (last modified Sept. 2021), https://www.chhs.ca.gov/ohii/shig/. Notably, AB 133 authorized DHCS to modify state and local confidentiality requirements as necessary to permit data sharing among counties, providers, and other entities as necessary to promote CalAIM goals, subject to compliance with applicable federal laws. W&I § 14184.102(j) (as added by AB 133).

[33] *See* Coronavirus Aid, Relief and Economic Security (CARES) Act, Pub. L. 116-136 § 3221 (Mar. 27, 2020); HHS, Proposed Rule: Confidentiality of Substance Use Disorder (SUD) Patient Records (Dec. 2, 2022), https://www.federalregister.gov/public-inspection/2022-25784/confidentiality-of-substance-use-disorder-patient-records.

Similarly, with respect to electronic health records (EHRs), some counties maintain separate systems for their mental health and SUD records, meaning that a state official or provider with "full" access to a given individual's data must log into two separate platforms to view all relevant information, and must access both systems to update generally applicable information like a beneficiary's cellphone number. Other counties operate a single behavioral health EHR system with internal firewalls for SUD information, which can be activated or deactivated on a user-by-user basis.

To support county efforts to enhance data sharing within and across behavioral health delivery systems, DHCS is offering counties incentive payments in 2022 and 2023 through the Behavioral Health Quality Improvement Program, as noted above. Specifically, BHQIP "Goal 3" incentivizes measures such as technological upgrades to enhance interoperability, as well as demonstrated capacity to share data with an MCP and/or health information exchange.

The Vision for Integration. DHCS and counties seek to ensure that behavioral health data is shared and stored as efficiently as possible while maintaining compliance with applicable laws. In particular, DHCS and counties seek to prevent avoidable disruptions to clinical integration that arise out of misunderstandings concerning Part 2's requirements regarding care coordination or EHR design, or from insufficiently developed protocols for data authorizations. DHCS recently released guidance advising counties and other stakeholders on compliance with behavioral health confidentiality standards,[34] and it is currently developing a template universal release form for county use.

If and when HHS finalizes its proposed revisions to the Part 2 rules, as described above, DHCS can further support counties in understanding those revised standards and making appropriate use of any new areas of regulatory flexibility.

In addition to supporting counties with integration of data sharing and data storage, DHCS' Comprehensive Behavioral Health Data Systems Project aims to streamline, update, and consolidate behavioral health data reporting and storage at the state level.

Achieving Integration. County programs and individual SUD providers are each responsible for ensuring their own compliance with Part 2 and other privacy laws as they pursue Behavioral Health Administrative Integration, relying as appropriate on DHCS guidance and the forthcoming template universal release form. DHCS will consider other opportunities to support smooth data sharing and data management consistent with legal requirements.

Best Practices: Universal Release and Integrated EHRs. Yolo County has pioneered the development of an integrated EHR that enables staff to access both mental health and SUD treatment information for beneficiaries receiving services from both systems. Yolo developed a universal Authorization for Release of Information that allows beneficiaries to indicate the specific staff and/or organization(s) that may access their personal health information. The Authorization for Release of Information has been operationalized in the county's integrated EHR, which allows clinical staff to navigate specific levels of access according to the authorization agreed upon by the beneficiary.

[34] DHCS, *CalAIM Data Sharing Authorization Guidance* (March 2022), https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance.pdf.

This system has improved communication between providers and increased the ability of staff to respond to beneficiary needs in an efficient and timely manner.

Component 6. Cultural Competence Plans

Legal Requirements and Current Status. With respect to their MHPs and DMC-ODS programs, counties are required to develop a CCP that describes the county's objectives and strategies for ensuring culturally and linguistically concordant care.[35] DMC counties are not required to complete a SUD CCP, although some choose to do so.

DHCS has defined several criteria that must be included in a CCP and has released a CCP template for county use, which was last updated in 2011. Counties are permitted to develop an integrated CCP that addresses both SMHS and SUD services, and about a third of the counties have opted to do so, including San Luis Obispo County and Yolo County.

Alongside the Behavioral Health Administrative Integration initiative, DHCS has established the Community Mental Health Equity Project (CMHEP) in partnership with the California Department of Public Health's Office of Health Equity. CMHEP includes a review of current state standards for CCPs, with the aim of releasing an updated template that reflects the most recent federal standards for Culturally and Linguistically Appropriate Services, in addition to other potential improvements in state and county CCP practices.[36]

Meanwhile, CMS has announced its intention to issue regulations in the coming years that would "establish culturally competent and person-centered requirements" for Medicaid programs.[37] DHCS will adjust California's CCP standards as needed to comply with new federal standards.

The Vision for Integration. All counties with integrated contracts will be expected to develop integrated CCPs that include consideration of both SMHS and SUD services, including attention to individuals with co-occurring behavioral health needs. Counties will use an updated CCP template released by DHCS, which will include appropriate consideration of the differences between DMC-ODS and DMC counties. In the shorter term, counties can voluntarily integrate their CCPs at any time under the existing template.

Achieving Integration. No changes in state law are needed for counties to voluntarily integrate their CCPs. In the longer term, integrated CCPs will be required once counties adopt integrated behavioral health contracts *(as described under component 4 above).*

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[35] These requirements are defined in counties' contracts with the state. Additional requirements regarding MHPs appear at W&I § 14684(a)(9) and 9 CCR 1810.211, 1810.310 & 1810.410.

[36] For additional detail regarding CCPs, including current reform efforts, see DHCS, *Efforts to Reduce Disparities in Behavioral Health*, https://www.dhcs.ca.gov/Pages/Efforts-to-Reduce-Disparities-in-Behavioral-Health.aspx.

[37] CMS, *Culturally Competent and Person-Centered Requirements to Increase Access to Care and Improve Quality for All*, Spring 2022 Regulatory Agenda, https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202204&RIN=0938-AU91.

In addition, DHCS will develop and release integrated CCP protocols and templates, drawing on the CCP enhancements achieved under CMHEP.

Component 7. Quality Improvement

Legal Requirements and Current Status. As managed care programs, MHPs and DMC-ODS programs must establish a quality improvement committee and identify and track performance measures.[38] These requirements do not apply to DMC programs.

Some counties have already integrated their quality improvement activities to varying extents. From a compliance perspective, however, MHP and DMC-ODS quality improvement activities are considered separately *(as described in components 8 and 9 below)*.

The Vision for Integration. Counties with integrated contracts will be expected to develop an integrated quality improvement plan, including a single integrated quality improvement committee, a comprehensive list of performance measures that address both SMHS and SUD services, and special attention to beneficiaries with co-occurring needs.

Achieving Integration. No changes in state law are needed for counties to voluntarily integrate their quality improvement activities to a large extent. In the longer term, integrated quality improvement activities will be required once counties enter into an integrated behavioral health contract *(as described under component 4 above).*

C. DHCS Oversight Functions

The components in this section pertain to DHCS' oversight of counties and providers to verify compliance with federal and state standards, and to ensure that Medi-Cal beneficiaries have timely access to high-quality behavioral health services. By integrating SMHS and SUD oversight functions, DHCS seeks to reduce the number and frequency of compliance reviews, which are currently performed separately for each program. To further reduce administrative burden on counties, providers, and state officials, DHCS is pursuing opportunities to align and streamline the requirements and oversight processes for county behavioral health programs and individual providers.

DHCS action will be necessary to drive the integration of these oversight components, all of which involve substantive standards and review protocols established at the state level. This domain will require regulatory review and analysis by DHCS and may incorporate substantive regulatory and policy changes to align SMHS, DMC, and DMC-ODS compliance requirements. Counties will be partners in this effort, including by supporting DHCS in identifying opportunities to address requirements that currently differ between, or otherwise impede integration of, SMHS and SUD programs and services.

[38] 42 United States Code (USC) § 1396u-2(c)(1); 42 CFR Part 438, Subpart E. MHPs are, in addition, subject to state-law requirements regarding quality improvement. *See* W&I §§ 14707.7, 14684(a) & 14725; 9 CCR 1810.440(a).

Component 8. External Quality Reviews

Legal Requirements and Current Status. As managed care programs, MHPs and DMC-ODS programs must undergo an annual EQR, in which a state-selected EQR Organization confirms that they are providing high-quality services in compliance with applicable requirements.[39] Counties must develop separate performance improvement projects (PIPs) for each program, although integrated PIPs can be developed with the EQR Organization on a case-by-case basis. These EQR requirements do not apply to DMC counties with respect to their SUD activities.

DHCS currently contracts with the same vendor to perform EQRs for both MHPs and DMC-ODS programs. As a result, counties can request a consolidated review, in which the EQR Organization schedules the MHP and DMC-ODS reviews as part of a single encounter. The two reviews remain formally separate, resulting in the delivery of two separate EQR reports to DHCS. However, counties that have opted for this approach report increased efficiency due to the overlap in documentation and review activities across the two programs. The increased awareness and collaboration between mental health and SUD staff during the integrated reviews have also helped counties identify additional opportunities for program integration and streamlining.

The Vision for Integration. After entering into integrated behavioral health contracts with DHCS *(as described under component 4 above),* DMC-ODS counties will undergo a single annual EQR that addresses both SMHS and SUD, thereby minimizing the administrative burdens on counties. Counties may, in addition, adopt integrated behavioral health PIPs as appropriate. EQR for non-DMC-ODS counties will continue to focus on MHP services and may include attention to certain integration-related goals that may be included in the integrated MHP/DMC contracts.

Achieving Integration. To enable integrated EQRs, DHCS must enter into an appropriate contract with the statewide EQR organization, in addition to developing and executing integrated behavioral health contracts with the counties.

Component 9. DHCS Compliance Reviews

Legal Requirements and Current Status. DHCS reviews county SMHS and SUD programs for compliance with federal and state requirements. In addition to being conducted by separate DHCS teams, these reviews are currently conducted on separate schedules and pursuant to different protocols:

- MHPs undergo a review every three years.[40] The triennial review includes an examination of patient charts. Currently, DHCS is planning a transition to biennial reviews of MHPs, as part of a long-term transition to annual reviews.
- DHCS performs annual reviews with respect to county SUD programs (DMC-ODS and DMC). These county reviews do not include review of patient charts, but DHCS does perform chart reviews of individual SUD providers identified

[39] 42 USC § 1396u-2(c)(1); 42 CFR Part 438, Subpart E. MHPs are, in addition, subject to state law requirements regarding external quality review. *See* W&I §§ 14714(g) & 14717.5; 9 CCR 1810.380(a)(7).

[40] The SMHS review protocol for SFY 2021–2022 is available here: https://www.dhcs.ca.gov/Documents/BHIN-21-053-Annual-Review-Protocol-for-SMHS-FY-2021-22-Enclosure-1.pdf. *See also* W&I §§ 14714(g), 14718(b).

based on a risk assessment. In addition, counties must perform annual reviews for all providers and report their results to the state.

The Vision for Integration. DHCS will combine county compliance reviews for SMHS and SUD into a single integrated review process upon the development of an integrated contract. In addition to aligning the review timelines, DHCS will consider opportunities to streamline review protocols and documentation requirements with the aim of minimizing county administrative burdens and prioritizing review of the areas with the greatest impact on beneficiary wellbeing and program integrity.

Achieving Integration. DHCS will:

- Develop a timeline for moving toward annual SMHS reviews (consistent with the current SUD review timeline) and ultimately integrated behavioral health reviews following the execution of integrated contracts *(see component 4 above)*.
- Develop streamlined review protocols for both SMHS and SUD, paving the way toward an integrated, risk-based protocol for integrated compliance reviews.[41]
- Develop and implement cross-training for DHCS auditors and compliance review teams to ensure that integrated reviews are conducted by individuals with the necessary expertise in both mental health and SUD.

Component 10. Network Adequacy

Legal Requirements and Current Status. Counties must currently certify the adequacy of separate provider networks for their SMHS and SUD programs.[42] These requirements apply under federal and state law to MHPs and DMC-ODS programs. DHCS also expects to adjust DMC contracts to include additional reporting and access standards. Meanwhile, CMS has announced its intention to revise the federal standards for network adequacy and timely access in managed care programs in the coming years.[43] Those forthcoming federal regulations may require DHCS to modify California's approach to defining and measuring network adequacy and access in MHPs and DMC-ODS programs.

The state's standards touch on areas such as network capacity and composition, time and distance standards for providers, timely access, and language assistance capabilities.[44] The state has taken steps to align the reporting processes across programs. Counties submit their MHP and DMC-ODS network adequacy certifications at the same time, for example, and the state has released integrated behavioral health

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[41] DHCS risk-based compliance audits evaluate input from other DHCS program areas, statutes and regulations, and contractual obligations across the audited delivery system to identify and prioritize areas for examination. Following the identification and prioritization of the system areas, a team of clinicians and audit staff plan and conduct their audit work in alignment with the assessed areas of risk. This work results in an issued audit report communicating evaluated system areas, identified findings of non-compliance, and recommendations to remediate any reported findings."

[42] *See* W&I § 14197; DHCS, BHIN 22-033 (June 24, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-033-2022-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf. California establishes its network adequacy and access standards in accordance with federal managed care regulations at 42 CFR §§ 438.68, 438.206 & 438.207.

[43] CMS, *Assuring Access to Medicaid Services*, Spring 2022 Regulatory Agenda, https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202204&RIN=0938-AU68.

[44] BHIN 22-033.

templates for domains that do not materially vary by service type, such as infrastructure, policies and procedures, language capacity, and Indian health care facilities.

Different reporting tools are required, however, where the substantive requirements differ across programs, notably including the "capacity & composition" methodologies: For SMHS, capacity is assessed based on the number of "full-time equivalent" clinicians, while SUD capacity is assessed at the facility level.

The Vision for Integration. Once counties have entered into integrated behavioral health contracts with DHCS *(as described under component 4, above)*, counties will complete a single set of network certification documents, and DHCS will certify a single integrated behavioral health network.

In the longer term, DHCS is open to feedback from counties and other stakeholders on the merits of potential substantive revisions to the network adequacy standards, such as aligning the capacity methodologies across SMHS and SUD services, as well as additional alignment with the network adequacy methodologies for MCPs.

Achieving Integration. With the benefit of county input, DHCS will develop the templates and protocols for integrated network adequacy certifications, and it will consider potential changes to California's network adequacy standards to comply with regulatory reforms at the federal level and/or to further CalAIM goals, including Behavioral Health Administrative Integration.

Component 11. Provider Oversight

Legal Requirements and Current Status. DHCS' multifaceted oversight of behavioral health providers includes requirements for licensing, certification, and Medi-Cal enrollment, as well as requirements for credentialing and contracting with individual county behavioral health programs.

Unlike the other components of Behavioral Health Administrative Integration, licensing and certification requirements extend beyond the Medi-Cal program: like many other types of health care providers, behavioral health providers must apply for and maintain their license or certification in order to provide health care services, regardless of how those services are reimbursed.

Separate licensure and certification requirements exist for various classes of mental health and SUD clinicians and counselors, and for facilities that provide various types of inpatient, residential, and outpatient behavioral health services. With respect to inpatient and residential facilities, these standards typically require separate physical space to be set aside for each type of service, which generally means that a single space cannot be "dually licensed" for multiple classes of inpatient and residential services.

Some counties have established integrated behavioral health "campuses" in which multiple provider types are co-located within a complex or perhaps even within the same building (e.g., in adjacent suites or on neighboring floors). When counties seek to license multiple new behavioral health providers at once, DHCS is able, in some circumstances, to work with counties to streamline application procedures, such as by aligning timelines and site visits. In general, however, each license or certification

requires a separate application and must be renewed on a timeline that varies by provider type.

In order to receive Medi-Cal reimbursement, specialty behavioral health providers must obtain the necessary licensures and/or program certifications and take the additional steps of enrolling with Medi-Cal as participating providers. They must also contract with, and be credentialed by, individual county MHPs or SUD programs. If a provider offers both SMHS and SUD services, the provider may need to complete program/site certifications, execute contracts, and undergo credentialing with each program.

DHCS recently published a toolkit for SUD treatment facilities that outlines each step in this process.[45]

The Vision for Integration. DHCS is considering opportunities to modify licensure and certification standards and procedures to promote clinical integration and reduce administrative burdens for both counties and providers. For example:

- Once counties execute integrated behavioral health contracts with DHCS *(as described under component 4 above)*, providers that offer both SMHS and SUD services may no longer need to undergo two separate credentialing and contracting processes at the county level.
- As part of the Behavioral Health Data Modernization Project, DHCS is considering potential avenues for digitizing licensure and certification processes, allowing providers to dispense with paper-based applications and renewals.
- DHCS will, based on input from counties, providers, beneficiaries, and other stakeholders, consider the merits of regulatory or sub-regulatory reforms that would:
    - Align the application and renewal timelines and processes across classes of licensure/certification.
    - Promote coordination within DHCS to facilitate parallel processing of applications for licensure/certification and Medi-Cal enrollment, with the aim of minimizing gaps between a provider's initial licensure/certification approval and the provider's ability to begin billing Medi-Cal for services rendered to beneficiaries (subject to compliance with applicable laws and program requirements).
    - Promote clinical integration by facilitating provider co-location or dual licensure of facilities, including co-location of multiple levels of care and residential treatment.

Achieving Integration. DHCS will be the primary driver of Behavioral Health Administrative Integration for this component. Provider licensure, certification, and Medi-Cal enrollment are regulated at the state level. As for county-level credentialing and contracting, those functions cannot be fully integrated until the county has adopted an integrated behavioral health contract with DHCS *(as described under component 4 above)*.

Best Practices: Co-Location of Mental Health and SUD Programs. To better serve its Medi-Cal beneficiaries with co-occurring needs, Imperial County has established

[45] DHCS, *Substance Use Disorder Licensing and Certification Toolkit*, https://www.dhcs.ca.gov/provgovpart/Documents/SUD-Toolkit.pdf.

behavioral health "campuses" with co-located services, including two sites in El Centro targeted to adults and adolescents, respectively, that offer both mental health and SUD services either in the same building or within walking distance. Similarly, in Calexico, the county designed a plaza that offers both mental health and SUD services for adults. Imperial worked with a contractor to ensure that each facility was appropriately licensed for the services provided, and it worked with DHCS to align the timing of site visits and other certification steps across facilities that were established at the same time.

During treatment, if the treating mental health or SUD provider identifies a need for co-occurring treatment, the beneficiary is referred to the appropriate provider by physically walking the beneficiary to the referral location. This process supports timely referral and linkage to needed services and allows provider staff to coordinate care more efficiently.

III. Phased Implementation for Behavioral Health Administrative Integration

To achieve statewide Behavioral Health Administrative Integration by SFY 2027–2028, DHCS will work with counties using a phased approach under which different components will be integrated to different degrees at different times. This phased approach allows DHCS and counties to spread their efforts across multiple years, making early progress on integrating certain program elements while laying the groundwork for longer-term integration efforts on others, including components that may require approval from CMS or modifications to state laws, regulations, guidance, or contracts. DHCS envisions three phases for integration:

Phase 1. **Voluntary Integration of County Functions Under Existing Contracts (CY 2023 & 2024*).** In this first phase, counties may continue their efforts to integrate components that do not require any additional policymaking from DHCS, including certain components related to streamlining the beneficiary experience and county structures and processes. DHCS will consider opportunities for guidance to support counties and identify best practices for implementing recent and upcoming CalAIM reforms. DHCS will, in addition, undertake regulatory review and analysis as needed to develop the updated contracts and other materials necessary for Phase 2.

Phase 2. **Voluntary Contract Integration (CY 2025 & 2026*).** In this phase, interested counties may enter into integrated contracts with DHCS that cover both SMHS and SUD services, thereby enabling integration of various administrative and program oversight functions. Counties that enter into integrated contracts may also be required to implement certain integration-related best practices identified in DHCS' Phase 1 guidance. During Phase 2, DHCS will also finalize regulatory reforms to update and streamline the requirements for Medi-Cal behavioral health programs, including revisions to promote behavioral health integration and other CalAIM goals.

Phase 3. **Statewide Behavioral Health Administrative Integration (CY 2027+*).** All counties enter into integrated behavioral health contracts with DHCS and participate in integrated oversight activities. DHCS and counties adjust their operations to account for the regulatory reforms finalized in Phase 2. These

phases are described further in the sections that follow and are summarized at a high level in Figure 2 on page 10.

**This timeline presumes that the statewide adoption of integrated contracts will take place on January 1, 2027. As noted above, DHCS welcomes feedback on this timeline, particularly if stakeholders anticipate significant implementation challenges with aligning the contract cycle for either Phase 2 or Phase 3 with the calendar year, rather than the State Fiscal Year.*

A. Three Phases of Behavioral Health Administrative Integration (2023–2027)

Phase 1. Voluntary Integration of County Functions Under Existing Contracts (2023 & 2024)

Key Actions During Phase 1

- ***DHCS issues guidance, describes best practices, and/or provides templates*** regarding the integration of:
  - *County-Operated 24/7 Access Line; Screening, Assessment & Treatment Planning,* potentially including best practices or other guidance for providing and billing for screenings, assessments, and treatment planning in accordance with CalAIM behavioral health initiatives such as No Wrong Door, Documentation Redesign, and Payment Reform.
  - *Data Sharing & Privacy,* including a template universal release form that addresses both the federal Part 2 requirements for SUD data as well as other federal and state confidentiality requirements.
- ***Counties may also voluntarily integrate the following activities*** under existing law, if they have not already done so:
  - *CCPs.*
  - *Quality Improvement.*
  - *External Quality Review* (by requesting that the EQR Organization review their MHP and DMC-ODS as part of a single encounter).
- ***DHCS provides staff training and county technical assistance*** to support these Phase 1 activities.

Preparing for Phases 2 & 3

- ***In preparation for voluntary contract integration in Phase 2, DHCS:***
  - Develops the templates for integrated *DHCS-County Contracts*.
  - Secures any necessary legal authorizations for contract integration, notably including an amendment to California's CMS-approved 1915(b) waiver.
- ***In connection with the integrated behavioral health contracts***, DHCS also develops integrated templates, protocols, and other guidance regarding:
  - *Beneficiary Materials, Appeals & Grievances*, including beneficiary handbooks and guidance for provider directories.
  - *CCPs.*

  - *EQRs*, including by contracting with an EQR organization for integrated reviews.
  - *DHCS Compliance Reviews*, including progress toward aligning the review cadence and protocols across SMHS and SUD programs.
  - *Network Adequacy.*

- ***DHCS considers and begins developing regulatory and policy reforms*** to support statewide behavioral health integration in Phase 3, including reforms to:
  - Codify the integrated specialty behavioral health benefit and contract structures in state law and regulations, where needed.
  - Align and streamline requirements across SMHS and SUD services, including repealing or updating outdated regulations, policies, and terminology.
  - Implement substantive reforms deemed necessary to promote Behavioral Health Administrative Integration and other CalAIM goals, potentially including reforms to Medi-Cal requirements and to provider licensure/certification more generally.

Phase 2. Voluntary Contract Integration (2025 & 2026)

Key Actions During Phase 2

- ***Interested counties may voluntarily enter into integrated behavioral health contracts with DHCS*** that cover both SMHS and SUD services. These contracts include all current legal requirements for MHPs and for DMC/DMC-ODS but are adjusted to eliminate duplication of overlapping requirements and implement other integration goals, as feasible. In addition, integrated *DHCS-County Contracts* enable the integration of various administrative and oversight functions, including:
  - *Beneficiary Materials, Appeals & Grievances*.
  - *CCPs.*
  - *Quality Improvement*.
  - *EQRs.*
  - *DHCS Compliance Reviews*.
  - *Network Adequacy.*

- ***Certain clinical best practices become mandatory.*** Based on county, provider, and beneficiary experiences with the clinical and data-sharing integration in Phase 1, DHCS may require counties that enter into integrated contracts to implement certain integrated practices in addition to any policy changes that apply to counties statewide.

- ***DHCS provides staff training and county technical assistance*** to support these Phase 2 activities.

Preparing for Phase 3

- ***DHCS modifies the integrated contract templates and related policies and procedures*** based on the early experience with voluntary contract integration in Phase 2.

- ***DHCS finalizes the regulatory and policy reforms*** described above under Phase 1, including streamlining and updating existing requirements and

promulgating new policies that specifically address Behavioral Health Administrative Integration.

Phase 3. Statewide Behavioral Health Integration (2027+)

Key Actions During Phase 3

- ***All counties integrate all 11 components of Behavioral Health Administrative Integration***, including entering into an integrated behavioral health contract with DHCS. Certain integrated oversight functions will begin in SFY 2027–2028***.***
- ***DHCS and counties implement the regulatory reforms*** described under Phase 1 and finalized under Phase 2, including new or modified standards for Medi-Cal behavioral health service delivery and program operations that were developed with Behavioral Health Administrative Integration specifically in mind.
- ***DHCS provides staff training and county technical assistance*** to support ongoing integration efforts.

B. Stakeholder Engagement Plan

Prior to the release of this concept paper, stakeholders were engaged through a landscape assessment of county behavioral health departments and internal teams at DHCS. Through written surveys and interviews, DHCS sought to assess the current status of behavioral health integration efforts, goals for continued integration, potential barriers to achieving integration, and potential strategies for addressing those barriers. For additional detail regarding the landscape assessment, see Appendix 2.

As DHCS and counties implement Behavioral Health Administrative Integration, DHCS will continue to engage stakeholders regularly through multiple channels.

The diverse stakeholders that make up the Behavioral Health CalAIM Workgroup typically meet quarterly and will have the opportunity to provide input on proposed Behavioral Health Administrative Integration implementation strategies, materials, and evaluation process, as well as provide input on key policy decisions. As the initiative evolves, Behavioral Health CalAIM Workgroup subcommittees may be developed to address and prepare for specific aspects of integration.

In addition to regular Workgroup meetings, DHCS will coordinate with the County Behavioral Health Directors Association of California (CBHDA) on an ongoing basis to gather input on initiative proposals and materials, review policy and operational decisions, and understand how initiative activities impact counties and align with or compete with other county priorities. CBHDA will play an integral role in ensuring that county feedback is understood and incorporated throughout the development and implementation of the phased approach.

C. Training and Technical Assistance Plan

Throughout the implementation of Behavioral Health Administrative Integration, DHCS will provide comprehensive training and technical assistance support to counties and providers. This support will include written guidance, webinars, learning collaboratives,

and one-on-one support. DHCS will partner with stakeholders to ensure that these resources are responsive to county and provider needs.

Written Guidance. To ensure that stakeholders have the resources they need to successfully implement Behavioral Health Administrative Integration, DHCS will, as appropriate, issue guidance in the form of implementation guides, templates, answers to frequently asked questions, and descriptions of case studies and best practices. Materials will be determined based on need and in consultation with stakeholders.

Webinars. To support public engagement and understanding of DHCS' written guidance, DHCS will host informational and training webinars. Informational webinars will be public and take place virtually to maximize access for stakeholders. Trainings will be targeted to counties and will coincide with the release of new or revised templates. The training curriculum will be interactive and actionable, addressing not only new information but also the cultural shifts that will be required to implement the given template or policy specifically.

Learning Collaborative. DHCS will consider hosting a learning collaborative for counties as they implement the various components of integration. If desired by county stakeholders, these virtual meetings could take place at a regular cadence starting in CY 2023 and running through CY 2028. The learning collaborative sessions would provide a forum for counties to share best practices and address implementation challenges with their peers across the state.

Targeted Engagement Around Voluntary Contract Integration in Phase 2. Beginning in CY 2023, DHCS will engage counties that express interest in potentially adopting integrated contracts in 2025 under Phase 2 of this initiative. DHCS will provide information and answer questions to help counties decide whether to participate in Phase 2, and it will regularly solicit feedback to ensure that the integrated contracts are developed and implemented in a manner that is responsive to county concerns and priorities.

One-on-One Support. DHCS will be available throughout the implementation period to provide technical assistance and support to counties on a one-on-one basis, as needed.

D. Anticipated Challenges and Mitigation Approaches

Behavioral Health Administrative Integration offers the promise of significant benefits for beneficiaries, providers, counties, and the state. Meaningful integration will require sustained attention and investment at the state, county, and provider levels to adapt to the shifting regulatory and policy landscape, develop and implement new policies and procedures, educate staff and stakeholders, develop a workforce with the necessary competencies, and continuously search for opportunities for improvement. DHCS acknowledges that staff time is limited and that stakeholders at all levels are hard at work implementing other elements of the bold CalAIM vision. DHCS has developed the Behavioral Health Administrative Integration phased implementation approach with those capacity constraints in mind, including an awareness of the frontloaded CalAIM reforms in the period from CY 2021 through 2024. Throughout the phased implementation, DHCS will endeavor to support counties and providers in understanding any new requirements, assessing their options, and implementing effective reforms.

In addition, Behavioral Health Administrative Integration seeks to reimagine a system that has, for decades, been designed and operated as two separate programs with two separate sets of administrative structures, financing streams, covered services, core provider types, and billing and documentation requirements. The legacy of dual-track operations is that some providers and public officials have spent their careers identifying as either an "SMHS person" or an "SUD person," learning to write either "SMHS progress notes" or "SUD progress notes," and accepting that an individual with co-occurring needs may be required to engage with separate providers and follow separate procedures to have those needs met. CalAIM's goal of administrative integration will require shifts in culture and attention to workforce training and competencies, as well as shifts in policies and procedures. That work is already underway, and DHCS is certain that California's dedicated public officials and providers will succeed.

As noted above, California law specifies how existing funding streams for specialty behavioral health may be used to support mental health and/or SUD services. These restrictions will not be addressed as part of CalAIM Behavioral Health Administrative Integration and will continue to necessitate dual processes for certain fiscal and accounting functions at the county level.

Finally, DHCS acknowledges that certain requirements for SMHS or SUD operations are fixed under federal law, and so are not within DHCS' authority to modify. These include the treatment planning requirements for certain services *(summarized above in Part II.A)*, the Part 2 confidentiality rules for the use or disclosure of SUD information *(described in Part II.B)*, the requirements governing Medicaid managed care programs *(as codified at 42 CFR Part 438)*, and the terms of the federal grants that many counties use to finance their behavioral health programs, such as the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. DHCS is confident, however, that a significant degree of integration can be achieved within the parameters set by federal law and will support counties in progressing toward integration while maintaining compliance with federal requirements.

Conclusion

Through Behavioral Health Administrative Integration, DHCS aims to improve outcomes and the experience of care for Medi-Cal beneficiaries with mental health and SUD needs through coordinated treatment across the behavioral health continuum of care. Integration will, in addition, reduce administrative burdens for counties, providers, and the state. DHCS looks forward to continued partnership with counties, providers, and Medi-Cal beneficiaries through the phased implementation timeline laid out in this concept paper.

Appendices

Appendix 1. List of Acronyms

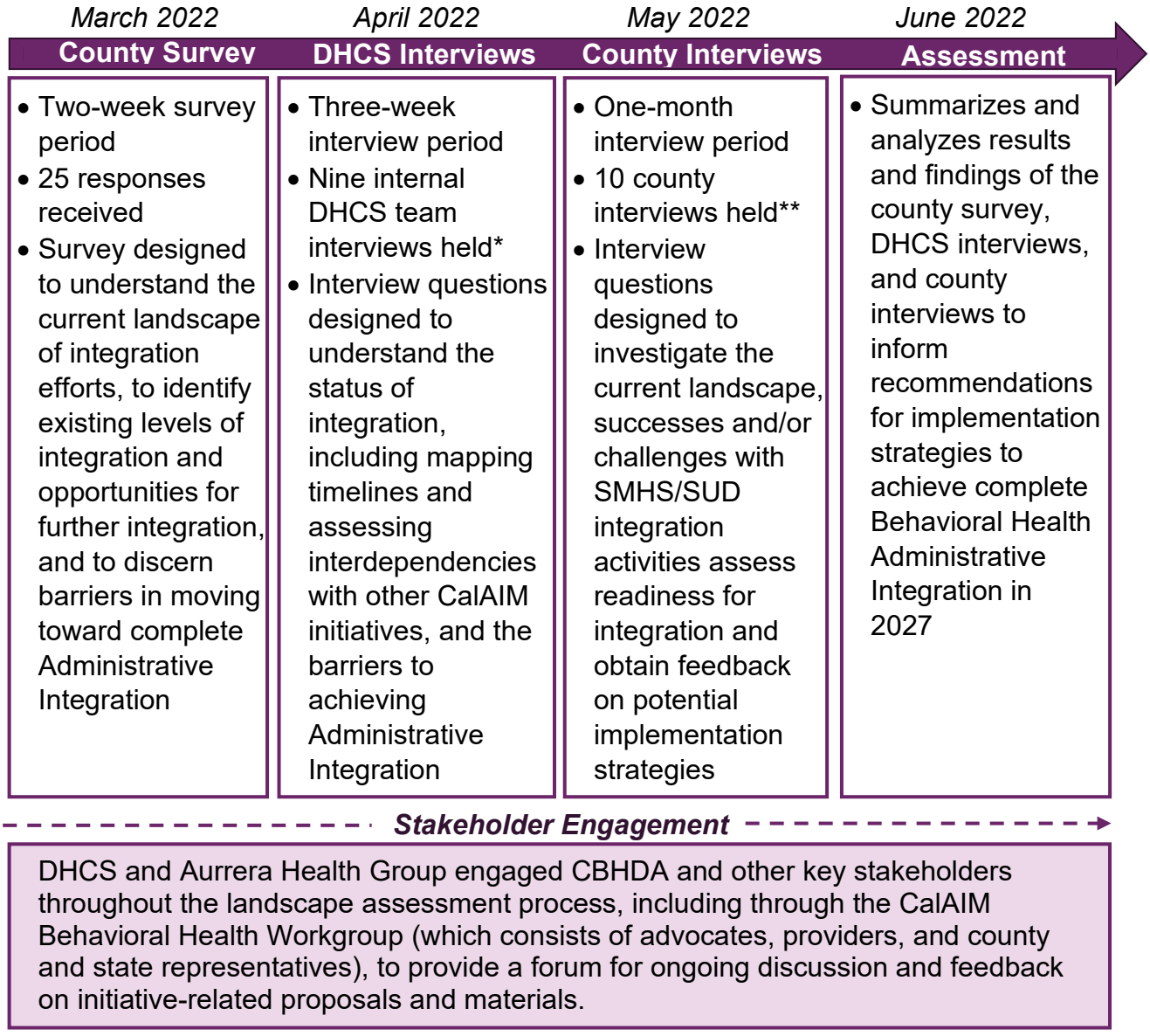
Acronym	Definition
ASAM	The American Society of Addiction Medicine, which establishes criteria for assessing the appropriate level of care for SUD treatment
BHIN	Behavioral Health Information Notice
BHQIP	Behavioral Health Quality Improvement Program
CalAIM	The California Advancing and Innovating Medi-Cal Proposal
CalBH-CBC	The California Behavioral Health Community-Based Continuum Demonstration
CANS	Child and Adolescent Needs and Strengths tool
CBHDA	California Behavioral Health Directors Association
CCP	The cultural competence plan that counties are required to develop with respect to their MHPs and DMC-ODS programs
CCR	California Code of Regulations
CFR	Code of Federal Regulations
CMHEP	The Community Mental Health Equity Project
CMS	The federal Centers for Medicare & Medicaid Services, which administers the Medicaid program
CY	Calendar year
DHCS	The California Department of Health Care Services, which administers the Medi-Cal Program
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System, a managed care model that counties may opt into for the provision of SUD services
EHR	Electronic health record
EPSDT	Early and periodic screening, diagnostic and treatment
EQR	External quality review, a required process for managed care programs
FFS	Fee for service
HHS	U.S. Department of Health and Human Services
LCD	The Licensing and Certification Division within DHCS
MCP	Managed Care Plan
MHP	Mental Health Plan, a county-administered plan that covers SMHS
MHSUDS IN	Mental Health & Substance Use Disorder Services Information Notice, a precursor to the BHIN
PAVE	The online Provider Application and Validation Enrollment portal
PED	The DHCS Provider Enrollment Division
PIHP	Prepaid Inpatient Health Plan, a form of managed care program defined under federal law; county MHPs and DMC-ODS programs are both structured as PIHPs

Acronym	Definition
PIPs	Performance improvement projects, which are required for managed care programs
SFY	State Fiscal Year, which runs from July 1 to June 30
SMHS	The specialty mental health services that are covered by Medi-Cal and administered through county MHPs
SUD	Substance use disorder

Appendix 2. Landscape Assessment Methodology

To assess the opportunities and challenges associated with Behavioral Health Administrative Integration, DHCS commissioned a landscape assessment comprising a written survey sent to county behavioral health departments, followed by interviews with a selection of county officials and internal DHCS teams. The assessment also included a limited literature review of existing stakeholder feedback and reports addressing considerations related to integration to supplement findings gathered through the survey and interview process. Figure 4, below, provides additional information.

Figure 4. Landscape Assessment Activities Overview



***Internal DHCS Interviews.** The following internal DHCS teams were interviewed:

1. The Office of Legal Services (OLS)
2. Licensing and Certification (L&C)
3. Audits and Investigations (A&I)
4. Office of Regulations (OOR)
5. Enterprise Data and Information Management
6. Medi-Cal Behavioral Health Division (MCBHD)
    a. Quality and Network Adequacy Oversight (QI/NA)
    b. County/Provider Operations and Monitoring (CPOM)
    c. Program Policy, Legislation, and Regulations
7. Behavioral Health Financing – Local Government Financing Division

****County Behavioral Health Department Interviews.** The following ten counties were interviewed:

1. Glenn
2. Imperial
3. Los Angeles
    a. Department of Mental Health (DMH)
    b. Department of Public Health Substance Abuse Prevention and Control (SAPC)
4. Marin
5. Merced
6. Riverside
7. San Diego
8. San Luis Obispo
9. Tulare
10. Yolo