CHCF Fact Sheet

CalAIM: Behavioral Health Proposals

People insured through Medi-Cal who seek behavioral health services must navigate three separate systems of care — one each for physical health, mental health, and substance use disorder (SUD) care.

Mental health services are further divided between those provided by a managed care plan (MCP), which covers a set of outpatient services, and "specialty mental health services" provided through a county-run mental health plan (MHP), typically available to people with acute need or significant functional impairment and representing a much more expansive set of inpatient psychiatric hospital and rehabilitative services. While some providers participate in both MCP and MHP networks, many do not.

SUD care in Medi-Cal is provided through the Drug Medi-Cal benefit. Most Medi-Cal enrollees live in counties that participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS), a county-operated managed care plan for SUD services launched in 2015. That's when the state received the nation's first Medicaid Section 1115 waiver to expand and deliver SUD services according to medically recognized standards of care. Thirty counties are participating in this voluntary program, representing 93% of Medi-Cal enrollees. California's remaining counties provide services under the standard Drug Medi-Cal program.

These systems often do not communicate well about enrollees' care, leading to poorly coordinated services, delays in care, and poor health outcomes. This is a frustrating experience for Medi-Cal patients, the providers who serve them, and administrators at all levels of government.

In October 2019, California's Department of Health Care Services (DHCS) released a multiyear initiative called California Advancing and Innovating Medi-Cal, or CalAIM. The initiative proposes broad delivery system, program, and payment reform across the Medi-Cal program, including but not limited to changes that California would request in Medicaid program waivers from the federal Centers for Medicare & Medicaid Services (CMS). A number of the proposals that are part of CalAIM take steps to standardize and simplify how Californians insured through Medi-Cal access mental health and SUD services.

For more information on *CalAIM*'s behavioral health proposals, please see the materials posted on the DHCS website, where you can also sign up for updates. For more behavioral health resources from CHCF, visit our online collection.

Behavioral Health Proposals

Behavioral Health Payment Reform

Under California's Specialty Mental Health 1915(b) waiver, counties are reimbursed a percentage of their actual expenditures (certified public expenditures, or CPE) based on the Federal Medical Assistance Percentage. Counties are reimbursed an interim amount throughout the fiscal year based on approved Medi-Cal services and interim billing rates that are then reconciled to actual expenditures through the year-end cost report settlement process. While counties do receive interim payments from the state, it often takes more than six years for reimbursements to be verified through county, state, and federal levels. Under the CalAIM proposal, DHCS seeks to work with counties to transition them from this cost-based approach to one that is more streamlined and expeditious. Payment reform is an essential step to drive delivery system transformation and value-based payment arrangements, which could in turn support better coordination and integration between physical and behavioral health.

Revisions to Behavioral Health Medical Necessity

When California implemented the Affordable Care Act in 2014, it expanded the mental health benefit in Medi-Cal and required MCPs to provide some outpatient mental health services for enrollees. This set of services is described as being for people with "mild-to-moderate" mental illness and is similar to outpatient mental health coverage in Medicare and by commercial payers. These services are intended to be part of a continuum, with county MHPs offering a broader and more intensive service set to people who require specialty mental health services. But the division of responsibility for the continuum of mental health services is not clearly defined or understood across different plans and counties, is confusing to consumers, and in the worst cases provides incentives for one system to push responsibility for care onto another.

Behavioral Health System for Medi-Cal Patients

Medi-Cal Managed Care Plans

Physical health services and mild-to-moderate mental health services

County Mental Health Plans

Specialty mental health services for serious mental illness

County Substance Use Disorder Services

Services to treat substance use and addiction

CalAIM proposal to redefine medical necessity rules would modify the existing criteria to standardize benefit definitions statewide. The proposal under consideration includes development of statewide screening tools and changes to documentation requirements.

Administrative Behavioral Health Integration Statewide

Roughly one-third of people who have a serious mental illness have a co-occurring substance use disorder. But in California, people who receive treatment for serious mental illness and SUD must navigate two separate county-operated delivery systems, making it difficult for consumers with co-occurring disorders to access integrated treatment, and requiring many counties to administer two separate managed care structures. Counties participating in mental health and SUD

managed care are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost-reporting structures. This CalAIM proposal would make state and county changes such that each county (or region, see below) would provide SUD and specialty mental health services through one administrative system.

Behavioral Health Regional Contracting

While counties hold most of the responsibility for SUD and mental health services for people enrolled in Medi-Cal, some of California's counties lack resources to administer these services in an increasingly complex environment. For example, some counties do not have staffing to conduct the myriad administrative tasks — building networks, conducting quality improvement, etc. — that are required for them to operate as Medi-Cal plans. Under CalAIM, DHCS would encourage counties to develop regional approaches to administration and delivery of behavioral health care.

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

In 2015, the Drug Medi-Cal Organized Delivery System (DMC-ODS) was authorized under a Section 1115 demonstration waiver. As of August 2019, 30 California counties are participating, representing 93% of the state's Medi-Cal population. With that 1115 waiver sunsetting December 31, 2020, DHCS proposes to incorporate most of DMC-ODS into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, county mental health plans, and county SUD plans. (California will still seek expenditure authority for residential services in a renewal of the 1115 waiver.) Counties not currently participating in DMC-ODS would have the opportunity to join. DHCS also intends to improve the SUD managed care program based on lessons learned from the first several years of implementation.

Serious Mental Illness / Serious Emotional Disturbance Institutions for Mental Disease Expenditure Waiver

Since Medicaid's inception in 1965, federal policy has barred using federal Medicaid funds for care provided to most patients in mental health and substance use disorder residential and inpatient treatment facilities larger than 16 beds — known as "institutions for mental disease" (IMD). This federal policy is known as the IMD exclusion. In 2018, federal policy changed to allow states to seek a waiver of this rule if certain requirements are met. DHCS plans to assess stakeholder interest in pursuing such a waiver, which could offer an opportunity to free up local funds to invest in other community services and supports that many communities say are sorely lacking. Such a waiver would require that communities develop and demonstrate a robust continuum of care so that patients could be "stepped down" to community-based care as their condition improves. But some groups are raising concerns that allowing a waiver of the IMD exclusion risks incentivizing institutional care.

Full Integration Plans

Under this proposal, DHCS would test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted managed care entity in order to improve enrollees' access, outcomes, and experience. The goals of having a single entity responsible for all aspects of beneficiary health care include improving care coordination through integrating data; reducing complexity and the need for enrollees to navigate multiple delivery systems; aligning funding, data reporting, quality, and infrastructure; using savings from preventable high-acuity care to invest in prevention; and more-appropriately aligning incentives. Given the complexity of policy and financial considerations as well as administrative requirements, DHCS assumes pilots would not go live until 2024, after extensive stakeholder engagement.

Other CalAIM Proposals Related to Behavioral Health Integration

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management (ECM) benefit that would provide clinical and nonclinical services in a whole-person approach to Medi-Cal members with the most complex needs.

The benefit would replace the current Health Homes Program and Whole Person Care pilots and be administered by managed care plans.

In-Lieu-Of Services and Incentive Payments

In-lieu-of services (ILOS) are flexible wraparound services that address combined medical and social determinants of health needs either as a substitute for, or to avoid, unnecessary higher levels of care.

DHCS has developed 13 ILOS proposals that MCPs may voluntarily implement to build upon and transition the work done under the county-based Whole Person Care program pilots, which sunset at the end of 2020. The goal is that a managed care plan could fill gaps in benefits through ILOS to address medical or social determinants of health needs. Examples of ILOS could include housing deposits, recuperative care (also called medical respite), and sobering centers.

While neither enhanced care management nor in-lieu-of services are behavioral health benefits per se, some of the target populations for ECM are those with mental illness and/or SUD, and populations such as people who are homeless, who have high rates of these illnesses. Therefore, the rollout of these new benefits, along with the more specific behavioral health proposals detailed elsewhere, are important to the Medi-Cal behavioral health program.

About the Foundation

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

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

For more information, visit www.chcf.org.