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CHCF Issue Brief

CalAIM Behavioral Health Payment Reform

Executive Summary

California is now in the second year of a five-year initiative to reform how Medi-Cal is financed and organized. The initiative, known as CalAIM (California Advancing and Innovating Medi-Cal), seeks to orient the Medi-Cal program toward providing whole-person care, addressing social influences on health, and reducing health disparities.[1] Achieving these goals requires that CalAIM address the state's complex system for financing and delivering behavioral health care. The behavioral health components of CalAIM are designed to support whole-person, integrated care; move the administration of Medi-Cal behavioral health to a more consistent and seamless system by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through improvements to behavioral health policies and the launch of behavioral health payment reform.[2] The majority of these policy changes launched in 2022, but implementation will continue through 2027.

The behavioral health payment reform component of CalAIM means that payment for specialty behavioral health services will transition from cost-based reimbursement to a fee-for-service (FFS) system. This issue brief is based on *CalAIM and Specialty Behavioral Health Care: Lessons from Other States on Value-Based Payment*. It describes the organization of mental health and substance use disorder (SUD) services in Medi-Cal, the ways in which these services have been financed and paid, and the changes to those systems as a result of CalAIM Behavioral Health Payment Reform.[3]

Organization and Delivery of Behavioral Health Services in Medi-Cal

To understand the motivations for and potential implications of financing reforms in the Medi-Cal behavioral health system, knowledge of how the system has been structured and funded is important. Figure 1 shows the system's current organization. Behavioral health care in Medi-Cal is divided across two distinct systems, one that covers physical health and non-specialty mental health services and one that covers only specialty behavioral health services (mental health and SUD treatment).[4] This type of system is known as a "carve-out" because specialty behavioral health services are financed separately from general health services. California differs from many states that "carve in" behavioral health, meaning that they integrate financing for behavioral health and general health care.

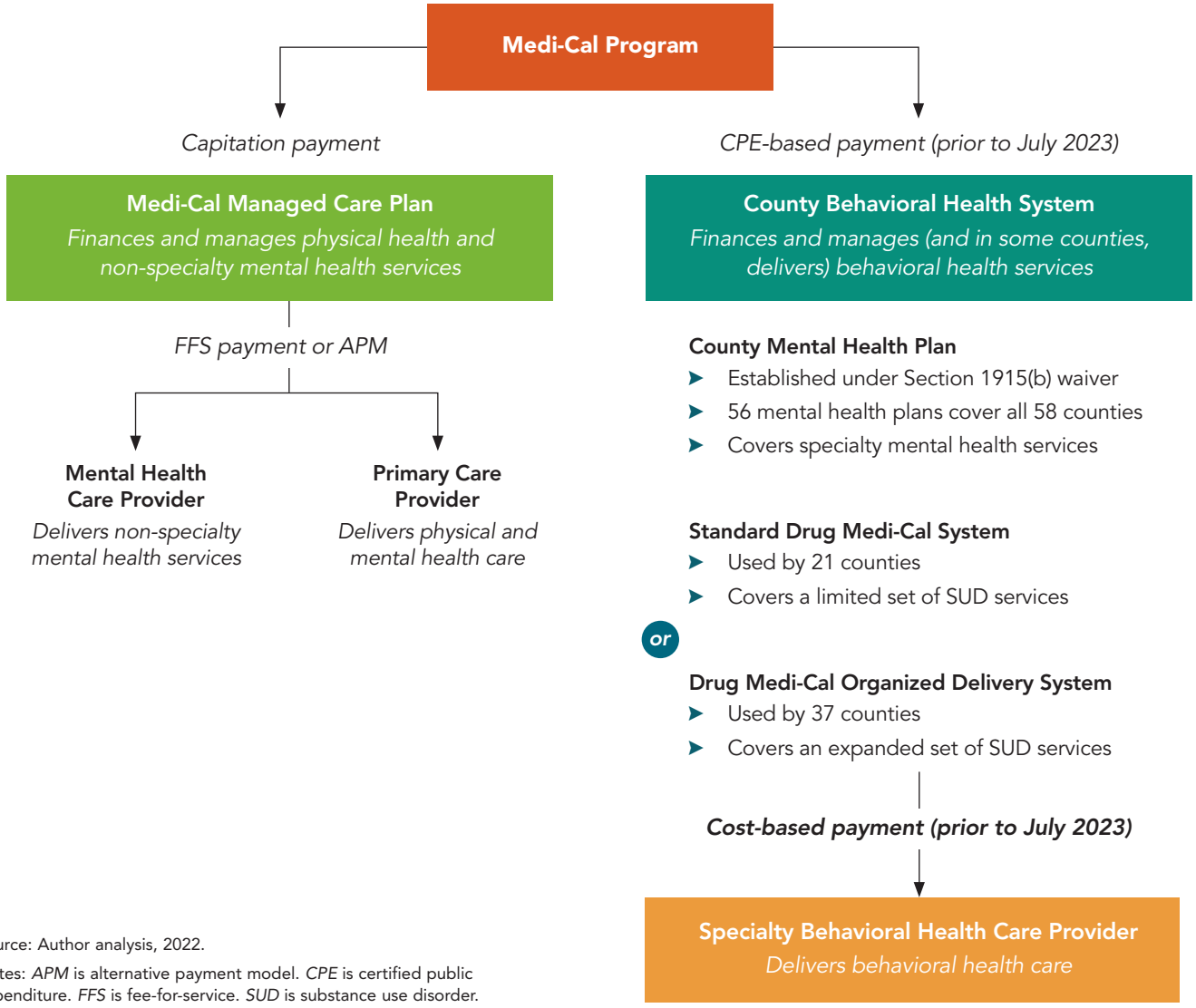
While both the general medical care system and the specialty behavioral health system are responsible for providing behavioral health care, their responsibilities are distinguished by the services they provide and the needs of the enrollees they treat. The general medical care system, where care is primarily organized through managed care plans (MCPs), provides all physical health care services and a limited set of non-specialty mental health services for adults and children. In January 2022, 84.5% of Medi-Cal enrollees were enrolled in an MCP for their physical health care.[5] The specialty behavioral health system, operated by county governments typically through county behavioral health departments or equivalents, is responsible for providing specialty mental health and almost all

SUD services. Populations that may use specialty behavioral health services include adults who experience significant distress or impairment due to their mental health conditions, children or youth whose needs may be more complex because of their conditions or life circumstances, and people of all ages who need specialty SUD treatment.

Medi-Cal Managed Care Plans

A variety of MCP types operate throughout California, including plans organized or administered by county governments as well as plans offered by for-profit and nonprofit insurance companies.[6] Each MCP receives a capitation payment — a per-person, per-month amount for each person enrolled in the plan — that is then used to pay health care provider organizations

Figure 1. Medi-Cal Behavioral Health System



Source: Author analysis, 2022.

Notes: *APM* is alternative payment model. *CPE* is certified public expenditure. *FFS* is fee-for-service. *SUD* is substance use disorder.

for services rendered to Medi-Cal enrollees. Since they are fully risk-bearing, MCPs must maintain funds in reserve.

MCPs cover the following non-specialty mental health services:

- Mental health evaluation and treatment, including individual, group and family psychotherapy
- Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements[7]

Non-specialty mental health services may be delivered by primary care providers if within their scope of practice, or by mental health providers in the MCP's network. Most MCPs contract with behavioral health organizations to manage the mental health component of their coverage.

County Behavioral Health Systems

Medi-Cal specialty behavioral health services have historically been administered through separate benefits, contracts, and delivery systems for mental health and SUD services. In each California county, the specialty behavioral health system consists of county Mental Health Plans (MHPs), which finance and manage specialty mental health services, and the Drug Medi-Cal program or, in most counties, the Drug Medi-Cal Organized Delivery System (DMC-ODS), which finances and manages SUD services. The term *county behavioral health plans* is used to refer to these systems together.

County MHPs can directly employ individual providers and operate treatment facilities, contract with independent community-based providers or provider organizations that operate their own facilities, or both. This means that many counties play dual roles as both managed care payers and direct service providers. Smaller counties tend to provide most services directly through county-operated facilities and providers, while larger counties administer a more sizeable share of services through contracting.

Counties cover Medi-Cal specialty SUD services through one of two systems. Some continue to provide a limited set of SUD services through a legacy fee-for-service Drug Medi-Cal program that is administered by counties on behalf of the state. However, most (37 out of 58 counties, covering 96% of Medi-Cal enrollees) now participate in DMC-ODS, which was established under a Medicaid Section 1115 demonstration waiver in 2015. DMC-ODS is now a permanent part of the Medi-Cal program operating under the Medi-Cal state plan and a Section 1915(b) waiver. Counties that participate in DMC-ODS function as MCPs for specialty SUD services and cover an expanded set of SUD services. These services include residential treatment and care coordination services, which was formerly known as case management.[8] As with specialty mental health services, counties may directly provide specialty SUD services and/or contract with community-based service providers, or both, and many function as both payer and provider.

County Behavioral Health Financing

County behavioral health plans are embedded in larger county health and social services systems, financing and providing many services outside those covered by Medi-Cal. Counties receive dedicated public funds for behavioral health services from multiple sources. Depending on the funding source, these dollars may be used for the nonfederal share of Medi-Cal services or to complement and supplement such services. For instance, funds from the Mental Health Services Act (MHSA) are used to fund Medi-Cal specialty mental

health services as well as to support services outside the scope of Medi-Cal benefits such as housing, outreach and engagement, and prevention services. Counties also finance inpatient psychiatric care that may not be reimbursable by Medi-Cal because it is provided in institutions for mental disease (IMDs), which are defined as inpatient psychiatric hospitals or residential facilities with more than 16 beds.[9] Under federal law, state Medicaid programs cannot claim federal funds to finance IMD care for enrollees age 21–64. California has a waiver allowing reimbursement for care in IMDs through the DMC-ODS program and has announced plans to seek a similar waiver for mental health care.[10]

Since county behavioral health plans are part of county governments, the specialty behavioral health services they provide are often integrated with a broad range of social services also managed at the county level. Many counties braid Medi-Cal funds with other county funds to support programs that integrate behavioral health services with other supports, such as mental health services in homeless shelters.[11] County behavioral health plans often have relationships with agencies involved in criminal justice to support diversion and reentry programs; probation services; and special drug or mental health courts. To serve children, county behavioral health plans work closely with county-administered child welfare and social services agencies, and frequently have relationships with school districts to enable the provision of specialty behavioral health and behavioral health prevention services on site in schools.

County behavioral health plans are financed through realignment, wherein the state formally delegates administrative responsibility to counties, and allocates state tax funds directly to them through dedicated revenue sources on an annual basis. The amount available statewide is based on available revenue from sales and vehicle license taxes, and is not adjusted to reflect changes in behavioral health care caseloads, utilization, or demand. Along with MHSA funds, which may be used to support outpatient specialty mental health services in Medi-Cal, each county's share of designated state funds serves as its primary source of nonfederal "match" for Medi-Cal reimbursable services. Because the total funds available to finance specialty behavioral health services can fluctuate year to year based on the income that the state receives from those designated sources, counties must budget carefully each year to fulfill the county's Medi-Cal entitlement obligations within their available global budgets. The basic realignment structure and core financing mechanisms are not slated to change under CalAIM.

Historically, county behavioral health agencies have received cost-based reimbursement for Medi-Cal specialty behavioral health services through a financing method known as a certified public expenditure (CPE). Under the Medi-Cal CPE model, county behavioral health plans first use county funds to pay for services believed to be within the Medi-Cal coverage guidelines. The county certifies these public expenditures for Medi-Cal services and submits FFS claims to the Department of Health Care Services (DHCS) to draw down the federal share of payment for each specialty behavioral health service on an interim basis.

The Medi-Cal CPE reimbursement process requires that counties and most subcontracted specialty behavioral health providers report their annual costs for behavioral health services. The state then audits county cost reports to ensure that the federal reimbursement paid out through the claiming process equals, but does not exceed, the allowable costs of administering covered services.[12] Often, costs are disallowed based on the auditor's assessment of whether costs were properly documented. If a county has received payments that exceed its allowable costs, it must repay funds. If a county has not claimed the full amount of its allowable costs, it can receive additional federal funds. The cost report audit and reconciliation process can take years, forcing counties to carry significant fiscal risk for their Medi-Cal expenditures and face increased budget uncertainty over time. This model constrains counties' abilities to develop service infrastructure, and the

state's ability to introduce value-based payment (VBP) models for behavioral health services.

CalAIM Behavioral Health Payment Reform

These processes will be altered by the CalAIM Behavioral Health Payment Reform proposal.[13] In July of 2023, the state will shift from the CPE financing model to an alternative model known as intergovernmental transfer (IGT) that will use the same funding resources but reduce reporting burdens and uncertainties. With IGT, counties transfer the nonfederal share of their anticipated spending on Medi-Cal behavioral health services to DHCS. Then, the federal government provides DHCS with the federal share of the Medi-Cal payment, following which counties draw down the funds from DHCS through FFS payments.

IGT financing will eliminate the lengthy and labor-intensive auditing and cost reconciliations required under CPE. For specialty mental health and SUD services, county behavioral health plans will receive a single and final payment for each covered service based on a predetermined fee schedule, as well as Medi-Cal payments for administrative functions, utilization management tasks, and quality assurance activities that they must carry out as MCPs.

In tandem with payment reform, the state will require county behavioral health plans and their subcontracted behavioral health providers to update the service codes used to claim specialty behavioral health services. Rather than relying exclusively on the small number of Healthcare Common Procedure Coding System (HCPCS) Level II codes previously used for behavioral health claiming, county behavioral health plans and providers will adopt an expanded array of HCPCS Level I (i.e., Current Procedural Terminology, or CPT) codes. This more granular set of service codes will support improved quality measurement by capturing additional data on specialty behavioral health services rendered.

Fee schedules, readiness checklists, and technical documents, including CPT code transitions and billing manuals, have been published by DHCS and are available online.[14]

Conclusion

Financing using FFS should reduce the administrative burden on DHCS, counties, and contracted providers because it does not require cost reconciliation. The payments available to the county for covered specialty behavioral health services will be established by the plan fee schedule. Counties may negotiate payment rates with subcontracted behavioral health providers, and neither counties nor providers are required to report detailed costs or engage in cost settlement or cost report audits.

In time, the new payment model should simplify county budgeting. Assuming rates are adequate, it may also create opportunities for county behavioral health plans to save money that can be invested in other services or infrastructure. However, due to California's unique specialty behavioral health financing structure and history of cost-based reimbursement, the FFS model could also increase the risk borne by county behavioral health plans. If the rates paid by DHCS to the counties do not cover the costs of maintaining an appropriate network of providers, plans may sustain significant losses with no guarantee of future state rate adjustments or compensatory payments (although DHCS has committed to rate increases to account for inflation).

The new payment model also could be a stepping-stone to further financial reforms, laying the foundation for potential introduction of capitation or other VBP models that would give county behavioral health plans and behavioral health care providers additional flexibility in providing care while conditioning payment on the quality of care provided to Medi-Cal enrollees with serious mental illness, serious emotional disturbance, and SUD.

About the Authors

This issue brief is based on the report *CalAIM and Specialty Behavioral Health Care: Lessons from Other States on Value-Based Payment*, written by staff at the RAND Corporation. Joshua Breslau, PhD, ScD, Marcela Horvitz-Lennon, MD, MPH, and Nicole Eberhart, PhD, are senior scientists; Jonathan Levin, PhD, and Jonah Kushner, MPP, are policy researchers; and Mallika Bhandarkar, MPH, is a policy analyst at the RAND Corporation. This work was conducted through the RAND Health Care Division, which seeks to improve health care systems by providing decision-makers, practitioners, and the public with actionable, rigorous, objective evidence.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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