CHCF

CalAIM and Specialty Behavioral Health Care

Lessons from Other States on Value-Based Payment

APRIL 2023

AUTHORS
Joshua Breslau, PhD, ScD; Marcela Horvitz-Lennon, MD, MPH; Jonah Kushner, MPP; Nicole Eberhart, PhD; Mallika Bhandarkar, MPH; Jonathan Levin, PhD

About the Author

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 decisionmakers, practitioners, and the public with actionable, rigorous, objective evidence.

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.

DESIGN BY EMILY LEMOS

Contents

Executive Summary

California is beginning the second year of a five-year initiative to reform how its Medicaid program, 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 whole-person care, social influences on health, and reduction of health disparities.[1] Achieving these goals will require that CalAIM address the state's complex system for financing and delivering behavioral health care. Behavioral health care is critical to the success of CalAIM because of the complex social and medical needs of people with mental illnesses and substance use disorders and the complexity of the delivery systems that treat people with these conditions.

One component of CalAIM is a change in the way that specialty mental health services provided through California's county-based systems of care are financed. Under CalAIM, financing for these county-based systems will transition from cost-based reimbursement to a fee-for-service (FFS) system. The FFS system is also intended as a potential stepping stone to further financial reforms, laying the foundation for potential introduction of new payment models, known as value-based payment (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 (SMI), serious emotional disturbance (SED), and substance use disorder (SUD).

To inform discussion about the next steps that California might take in this policy direction, RAND Health Care, with support from the California Health Care Foundation, conducted an analysis of VBP in behavioral health. The team undertook the following activities:

- Reviewed the literature on VBP in Medicaid behavioral health
- Interviewed national policy experts
- Compiled case studies of five examples of VBP implementation in other states through document reviews and interviews with state officials
- Interviewed county and state policymakers in California

This report summarizes RAND's evaluation of existing research about VBP models as well as issues described by state interviewees related to implementation of VBP models in their states' Medicaid programs. It includes a series of recommendations related to steps California could take in the short term to inform its future decisionmaking processes related to VBP.

Literature Review and Case Studies

The literature review revealed that implementation of VBP models has occurred more slowly in behavioral health care than in other areas of medicine. Since few VBP models have been implemented, and those that have been have not involved the significant financial risk that is characteristic of more advanced models, there is little empirical evidence about their impact on care for people with SMI, SED, and SUDs.

Based on the literature review and additional recommendations from interviewed policy experts, the authors selected five VBP models for detailed case studies:

- Certified Community Behavioral Health Clinic Prospective Payment System (national)
- Baltimore City Capitation Project (Maryland)
- Vermont Mental Health Case Rate
- Pennsylvania Value-Based Purchasing
- New York State Value-Based Payment Roadmap

Through the case studies, the team identified three key issues that states have grappled with as they designed and implemented their systems: quality measurement, scope of services covered, and contracting strategies to ensure accountability.

Quality Measurement

All state interviewees emphasized that VBP models depend on the development of robust quality measurement. Developing these measures has been a complex, multistage process. First, behavioral health care quality measures must be defined. Next, information technology (IT) and the data analytics capacity needed to collect, analyze, and report the measures must be built. Finally, proponents must develop trust in the measures among stakeholders.

Interviewees identified challenges with accomplishing these tasks. Existing behavioral health care measures often do not include outcomes (e.g., improvement in depression symptoms), nor process measures that cover the full scope of services needed to treat behavioral health conditions. In response, some states have created their own measures, but the development of new measures required time and stakeholder engagement. In addition, the IT capacity needed to calculate and report behavioral health care quality measures is limited among many behavioral health providers. Finally, technological and legal barriers make it challenging to share patients' mental health and SUD information.

Scope of Services Covered

The case studies also highlighted the need to specify the scope of services covered by a VBP model. A model can include or exclude a broad array of health care services — such as acute and community mental health services, SUD treatment services, physical health care, and pharmacy services — as well as social services that historically have not been financed using Medicaid funds. While the services covered by VBP models in the case studies varied, three common themes emerged. First, the provider that receives value-based payment should have influence over the services covered by a VBP model. Second, VBP models should target known inefficiencies in the behavioral health care system. Third, the scope of services that should be covered may depend on local conditions, and local stakeholders may be in the best position to inform the design of VBP models.

Contracting Strategies to Ensure Accountability

Finally, the case studies highlighted the need to consider steps that protect patients, providers, and payers from unintended adverse consequences of VBP models. Examples of protective strategies include monitoring behavioral health care spending to ensure that resources are not shifted away from care for the highest-need patients, reviewing managed care contracts and monitoring provider network quality, and using specific payment mechanisms and other strategies to protect providers and payers from undue risk.

Conclusions

Given the lack of research, the authors cannot make specific evidence-based recommendations regarding the use of VBP models to cover care for people with SMI, SED, and SUDs at this time. However, based on expert opinions and the experiences of other states, the authors suggest two sets of recommendations that California could follow to inform future behavioral health payment reforms.

The first set represents actions that California can take now, as it transitions to FFS payment for Medi-Cal specialty behavioral health services. These recommendations will benefit patients today and improve California's capacity to make decisions about VBP in the future:

1. Develop a comprehensive behavioral health quality strategy.
2. Build analytic capacity and expertise in contracting at the state level.

The second set of recommendations will help California design and implement VBP in the future if it chooses to follow that path:

1. Incentivize services for patients with complex needs.
2. Allow for flexibility in tailoring VBP models to local circumstances.
3. Address equity and population health issues in VBP designs.
4. Use VBP models to promote delivery system integration.

Together, these recommendations will benefit patients in the short run while laying a foundation for successfully implementing VBP models in the future.

Introduction

CalAIM and Payment Reform for Medi-Cal Behavioral Health

California is in the early stages of a five-year initiative to reform how its Medicaid program, Medi-Cal, is financed and organized, with an overall goal of orienting the program toward whole-person care, social needs, and reduction of health and health care disparities. As part of this plan, known as CalAIM (California Advancing and Innovating Medi-Cal), the state is making a number of changes to the specialty behavioral health (mental health and substance use disorder) system managed by California's counties. One of these is "behavioral health payment reform," scheduled to take effect in July 2023, which changes how counties receive the federal share of their Medicaid funding, moving from a cost-based to a fee-for-service (FFS) model.

While this move is intended to produce significant immediate improvements in Medi-Cal behavioral health services by reducing the administrative burden on county Mental Health Plans (MHPs), it is also designed to enable further financial reforms in the future. Specifically, the FFS model is intended to be a stepping stone toward future design and implementation of new financing models, known as value-based payment (VBP) models,[2] that would allow MHPs and mental health providers greater flexibility in providing individualized care while holding them accountable for the quality of care received by Medicaid enrollees.[3] This report aims to inform the policy discussion about VBP models for Medi-Cal behavioral health services by drawing on the experiences of other state Medicaid programs that have implemented such models.

Reform of behavioral health financing is aligned with the overall CalAIM goal of orienting the Medi-Cal program toward whole-person care, social drivers of health, and reduction of health and health care disparities.[4] (See the sidebar on page 7 for additional detail on CalAIM.) Medi-Cal enrollees with behavioral health disorders are more likely than enrollees without such conditions to have complex, multisystem medical conditions that require whole-person approaches to care and to experience extremes of social disadvantage — including poverty, homelessness, incarceration, and social isolation — that negatively affect their mental and physical health.[5] People with serious mental illness have higher morbidity and mortality from chronic physical health conditions than the general population, with a deficit in life expectancy of about 10 years.[6] Moreover, disparities in behavioral health care across racial and ethnic groups are large and persistent.[7]

Since VBP models make use of quality measurement, the future of VBP models for behavioral health care also involves another California Department of Health Care Services (DHCS) initiative, the 2022 Comprehensive Quality Strategy (CQS), which updates the 2018 Quality Strategy, aligning it with CalAIM's quality, health equity, and population health goals.[8] As part of the CQS, DHCS has redesigned its quality management infrastructure and created the Quality and Population Health Management (QPHM) program. The new program will centralize and standardize DHCS's quality measurement and monitoring activities, providing technical expertise to quality, equity, and performance improvement efforts, and enabling greater transparency and sophistication in policy design and implementation. The CQS sets five high-priority goals for the state, two of which are related to behavioral health care. One aims for a 50% improvement in the rate of screening for depression in mothers and adolescents and is focused on primary care services. The other aims for a 50% improvement in follow-up after an emergency department visit for a mental health or substance use condition and focuses on specialty behavioral health care.

California Advancing and Innovating Medi-Cal

California Advancing and Innovating Medi-Cal (CalAIM) is a long-term plan to improve the health and quality of life of Medi-Cal enrollees by reforming Medi-Cal's health care delivery and payment systems. It has the following goals:[9]

- Identify and manage comprehensive needs through whole-person care approaches and social drivers of health.
- Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
- Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.
- CalAIM focuses on promoting wellness and prevention, addressing health-related social needs, providing enhanced care management to the highest-need enrollees, and strengthening the state's behavioral health care system.[10]

A set of initial CalAIM reforms became effective in January 2022, and the California Department of Health Care Services (DHCS) expects that remaining reforms will be phased in through 2027.[11]

To develop this report, the authors reviewed literature on VBP models applied in other states to cover behavioral health care, focusing on care for adults with serious mental illness and substance use disorders (those most similar to the populations treated in California's specialty behavioral health systems). The authors also interviewed academic experts, state officials, and experts in other states that have implemented VBP models for behavioral health services in Medicaid, and California officials at the county and state levels. The literature review and interviews were designed to answer questions about VBP models in Medicaid behavioral health services and understand implications for VBP models in California. Specifically, the authors sought to answer the following questions:

- What kinds of VBP models have been implemented for Medicaid behavioral health services in other states?
- What evidence exists on how these VBP models are working in other states?
- What lessons can be drawn from other states' experiences?

The Move to Value-Based Payment Models

Behavioral health payment reform under CalAIM will change how counties receive the federal share of their Medicaid financing. In the current system, the federal share is allocated through a cost-based approach; counties must document the actual costs of care and are subject to an administratively burdensome and lengthy reconciliation process that can take years to finalize. Under CalAIM, the state will move to a fee-for-service (FFS) payment system whereby counties will be reimbursed by the state according to a fixed FFS rate schedule. While the move to an FFS system is considered by advocates and policymakers to be an improvement over the existing cost-based system, FFS systems also have well-known limitations. In an FFS system, providers are paid for each service based on a fee schedule. Although FFS systems have historically been very common, policy experts agree that misaligned incentives and other shortcomings limit their utility for achieving population health goals. Four key limitations of FFS systems are discussed in the literature:

1. **FFS incentivizes quantity rather than quality.** Since providers are paid for each service rendered, they have an incentive to provide as many services as possible. This may conflict with the goal of providing the right service, in the right amount, to the right person.[12]
2. **FFS constrains provider flexibility.** Payment is limited to services on the fee schedule, which may limit providers' ability to adequately meet patients' specific needs. This can be problematic for behavioral health because patients' health and social needs are strongly interconnected.[13]
3. **FFS does not promote care integration.** Providers are largely paid only for services rendered in patient-facing encounters. However, patients with more than one treating clinician, particularly those with chronic illnesses, need their treaters to communicate and work together to address mental health, substance use, and physical health problems.[14]
4. **FFS does not promote equity.** Providers are not accountable for the distribution of services or health outcomes in the general population.[15]

Potential Benefits of Value-Based Payment Models

In recent years, health care researchers and policymakers have turned to VBP models designed to address the limitations of FFS payment and better align financial incentives with principles of equitably distributed, high-quality care.[16] These models tend to use a combination of two design features: bundled payments and quality-based incentives.

Bundled payments are fixed rates paid for a group of services commonly provided together.[17] For instance, a fixed amount may be paid for a common but complex procedure, such as a knee replacement. The bundle includes not only the surgical procedure but the associated visits before and after surgery, all related procedures conducted in the hospital, and any anticipated or unanticipated medical or rehabilitative follow-up. If the payment for the bundle is set correctly, the costs will average out over a large number of cases despite case-to-case variation. Since the fixed payment covers all of these costs, providers are incentivized to deliver quality care that prevents unnecessary follow-up care.[18] Moreover, the bundled payment reduces the incentive to provide as many procedures as possible for each case, and the provider has greater flexibility to tailor each procedure to the clinical needs of each patient. Payments can be bundled for episodes of care or for certain categories of patients. Capitation, where a fixed payment is made for each individual per unit of time they are covered, is another example of a bundled payment. Bundled payments involve risks and rewards for their recipients. If their average costs exceed the bundled payment, recipients are at risk for the unreimbursed costs. If their average costs are less than the bundled payment, they earn additional profit.

Quality-based incentives are mechanisms whereby some amount of payment is conditional on the provider's performance on quality measures. A simple example is a quality bonus payment, where a provider receives a bonus payment if their performance on measures of the quality of care meets an accepted standard. More complicated arrangements involve potential losses if quality standards are not met. Several types of quality measures can be referenced in VBP models, including process measures that assess how care is delivered and outcome measures that measure health-related or other improvements as a result of care.

The bundling and quality measurement components of VBP models play complementary roles. Bundling of services can remove incentives to provide excessively high volumes of care and allow providers flexibility in decisionmaking to meet individual patient needs. However, bundling also creates an incentive to undertreat patients, since

providers will be paid the same amount regardless of the specific services they provide. The quality measurement components of VBP models balance the flexibility of a bundled payment with accountability to provide high-quality care. If the quality measures are strong — meaning, they can validly distinguish high from low quality of care — payers may use these measures along with broadly defined bundles of services to give providers wide flexibility in decisionmaking. If quality measures are not strong and payers lack effective means to hold providers accountable, payers may need to be more cautious about the flexibility they allow.

VBP models can be implemented at different levels of the Medicaid system. First, the state can pay health plans, including managed care plans (MCPs) or county behavioral health plans, using VBPs. For example, a state Medicaid program could make capitation payments to a Medicaid health plan, such as California's county-operated specialty behavioral health plans, and adjust the payments for quality of care. The CalAIM proposal focuses on this level of payment. Second, health plans can contract with provider organizations using VBP to finance the care. In this model, a plan might contract with a provider for services for a group of enrollees, where the provider organization shares risk with the plan. Other models are also possible where the state contracts directly with providers, or provider organizations contract with other providers.

VBP models do not necessarily address inequities in health care. In fact, concerns have been raised in the literature that VBP models can put providers who care for patients with low incomes or people of color at a disadvantage relative to other providers and thereby intensify existing disparities.[19] These concerns are particularly relevant to behavioral health care, where evidence shows that quality of care is lower for Black and Latino/x patients relative to White patients,[20] and for patients with low incomes relative to patients with higher incomes.[21]

Some reasons for these differences, which include numerous nonclinical barriers to care and lack of resources for disease management, may be beyond the control of clinicians. Conditioning payment on these measures can then create incentives for providers to avoid these patients or financially punish plans or providers responsible for their care. However, VBP models can also be designed in ways that mitigate these adverse effects[22] and incentivize plans and providers to equitably address population health goals in ways not possible under FFS systems.[23]

Figure 1. Payment Methods Described by the Health Care Payment Learning & Action Network's Value-Based Payment Framework

Category 1: FFS with no link to quality

Providers receive a payment for each service rendered with no link to performance on quality (not a VBP).

Category 2: FFS with link to quality

A. Foundational payments for infrastructure and operations. Providers receive payments for investments that can improve quality of care, such as care coordination staff and health information technology investments.

B. Pay for reporting. Providers receive incentive payments for reporting quality data to payers or the public, or penalties for not reporting data.

C. Pay for performance. Providers receive incentive payments for performance on quality or penalties for not performing well. For example, they may receive a percentage increase or reduction on claims paid depending on whether they meet quality goals.

Category 3: FFS with shared savings or shared risk and link to quality

A. Shared savings. Providers share a portion of savings they generate for payers by meeting cost or service use goals if quality goals are also met.

B. Shared savings and downside risk. Providers share a portion of savings they generate for payers by meeting cost or service use goals if quality goals are also met. In addition, providers return a portion of financial losses that result for payers when cost or service use targets are not met.

Category 4: Population-based payment with link to quality

A. Condition-specific population-based payment. Providers receive prospective payment that reflects total costs of care for a primary condition (e.g., diabetes or cancer) or a set of specialty services (e.g., all primary care or behavioral health).

B. Comprehensive population-based payment. Providers receive prospective payment that covers all of an individual's health care needs.

C. Integrated finance and delivery system. These systems bring together insurance plans and delivery systems within the same organization and cover all of an individual's health care needs.

Source: Sam Nussbaum, Mark McClellan, and Grischa Metlay, "Principles for a Framework for Alternative Payment Models (PDF)," JAMA 319 (2018): 653–54.
Notes: *FFS* is fee-for-service. *VBP* is value-based payment.

The Health Care Payment Learning & Action Network Framework

Given the many ways that bundling and quality-based payments can be structured, it helps to have a consistent way to describe and analyze them. The Health Care Payment Learning & Action Network (HCPLAN or LAN) framework, described in Figure 1, was developed by the Centers for Medicare & Medicaid Services (CMS) to provide a set of clearly defined terms for VBP arrangements. CMS developed the framework to align payment approaches across the public and private sectors of the US health care system. The LAN convened a broad network of public and private health care stakeholders — including providers, insurance plans, employers, consumers, states, and federal agencies — to assess VBP models in use and develop terms and concepts for categorizing and measuring VBP adoption. A variety of public and private sector organizations use the LAN framework to monitor progress on health care payment reform. For example, 11 states used the LAN framework to monitor the percentage of payments made by MCPs to providers through VBP arrangements as of 2019.[24]

The LAN framework can help stakeholders illustrate important design differences between VBP options that might be considered for Medi-Cal behavioral health financing. For example, the current CalAIM plan will move financing for behavioral health care to Category 1 in the framework. As described in the next section, there are pragmatic reasons for moving sequentially up the levels described in the LAN framework in order, rather than jumping straight to models at Category 3 or 4. The distinctions built into the framework help describe this stepwise progression. It is also important to point out that the LAN framework focuses on payment arrangements between health care payers, such as commercial insurance plans, and provider organizations, such as clinics and hospitals. However, the same principles can be applied to relationships between payers or other organizations "above" the level of provider organizations. For example, state Medicaid programs could provide incentive payments for quality or adjust capitation payments for MCPs. In the Medi-Cal behavioral health system, described later in this paper, VBP mechanisms could exist at different levels. For example, the state could use VBPs to finance county Mental Health Plans, and these plans could use VBPs to finance contracted providers.

Value-Based Payment Adoption Outside of Behavioral Health Care

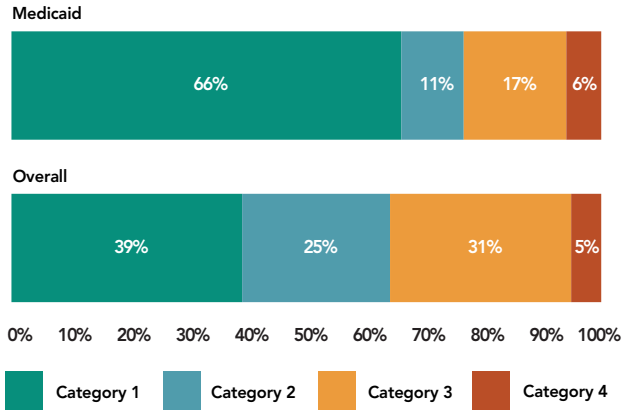
Within the last decade, federal and state policymakers have expressed interest in increasing VBP adoption and launched multiple high-profile initiatives to promote VBP use. The sidebar on page 12 presents examples of these initiatives. Initial VBP efforts focused on Medicare; however, state Medicaid programs have recently begun using managed care contracting to promote VBP arrangements. States have used a variety of approaches, with different levels of flexibility, to define VBP arrangements in managed care organization (MCO) contracts. For example, Minnesota and Tennessee required Medicaid MCOs to adopt specific VBP payment models. Minnesota required MCOs to adopt an accountable care organization (ACO) model like the Medicare Shared Savings Program (summarized in the sidebar on page 12); Tennessee required MCOs to adopt a patient-centered medical home model and episode-of-care models. New Mexico required MCOs to launch VBP pilot projects with specific provider types and approved metrics. In contrast, other states have required MCOs to pay a specific percentage of total dollars to provider organizations through approved VBP arrangements, but have given MCOs broad flexibility to determine those arrangements. States may also require Medicaid MCOs to participate in or align with VBP initiatives involving other payers, such as Medicare Advantage or commercial insurance plans.[25]

Important Value-Based Payment Initiatives

- Accountable care organizations (ACOs) are groups of physicians, hospitals, and other providers that agree to be held accountable for the quality, cost, and experience of care of a specific group of enrollees. The Medicare Shared Savings Program (MSSP), authorized by the Affordable Care Act and launched in 2012, enabled ACOs to share in savings from meeting cost and quality goals for Medicare fee-for-service (FFS) enrollees.[26]
- Comprehensive Primary Care Plus (CPC+), a five-year demonstration launched in 2017 by the federal Center for Medicare & Medicaid Innovation, provides primary care practices with payments to support care management services and reward quality performance. CPC+ brings together Medicare and other payers, including commercial insurance plans and state Medicaid agencies, to provide financial support for improving care delivery.[27]
- The Medicare Access and CHIP Reauthorization Act (MACRA), enacted by Congress in 2015, created the Quality Payment Program (QPP). Launched in 2017, QPP allowed physicians to earn performance-based payment adjustments for services provided to Medicare patients or incentive payment for participating in a value-based payment (VBP) model focused on specific clinical conditions, care episodes, or populations. Under QPP, both ACOs and CPC+ count as VBP models.[28]
- In 2015, the Centers for Medicare & Medicaid Services (CMS) committed to linking 90% of payments from Medicare's FFS program to quality or value and channeling 50% of payments through advanced VBPs by 2018.[29]
- Medicaid programs in multiple states use contracts with managed care organizations (MCOs) to promote VBPs. As of fiscal year 2019, 21 states required specific targets for provider payments or plan enrollees that MCOs must include in VBP models. Of these states, 14 reported that their contracts included incentives or penalties for meeting or failing to meet the targets, and 11 reported that their targets were linked to the Health Care Payment Learning & Action Network (LAN) framework. In addition, 16 states reported that their contracts required MCOs to participate in specific VBP initiatives or develop VBP arrangements within state-specified guidelines.[30]

Using information from a sample of health insurers, state Medicaid programs, and the federal Medicare program, LAN estimated the proportion of total dollars paid to providers through payment models in each category in 2018. Figure 2 presents the estimates for total Medicaid spending and for all US health care spending (including Medicare and commercial insurers). The proportion of payments made though VBPs — that is, Category 2 or higher — was 61% overall but only 34% in Medicaid. The proportion in Category 3 or higher, LAN's goal for payment reform, was 36% overall and 23% in Medicaid. Note that these 2018 figures are not specific to behavioral health care. As discussed in a later section, implementation of VBP models has been slower for behavioral health than for other areas of health care.

Figure 2. Percentage of Dollars Paid Through Value-Based Payment Arrangements by Health Care Payment Learning & Action Network Category and Payer (2018)



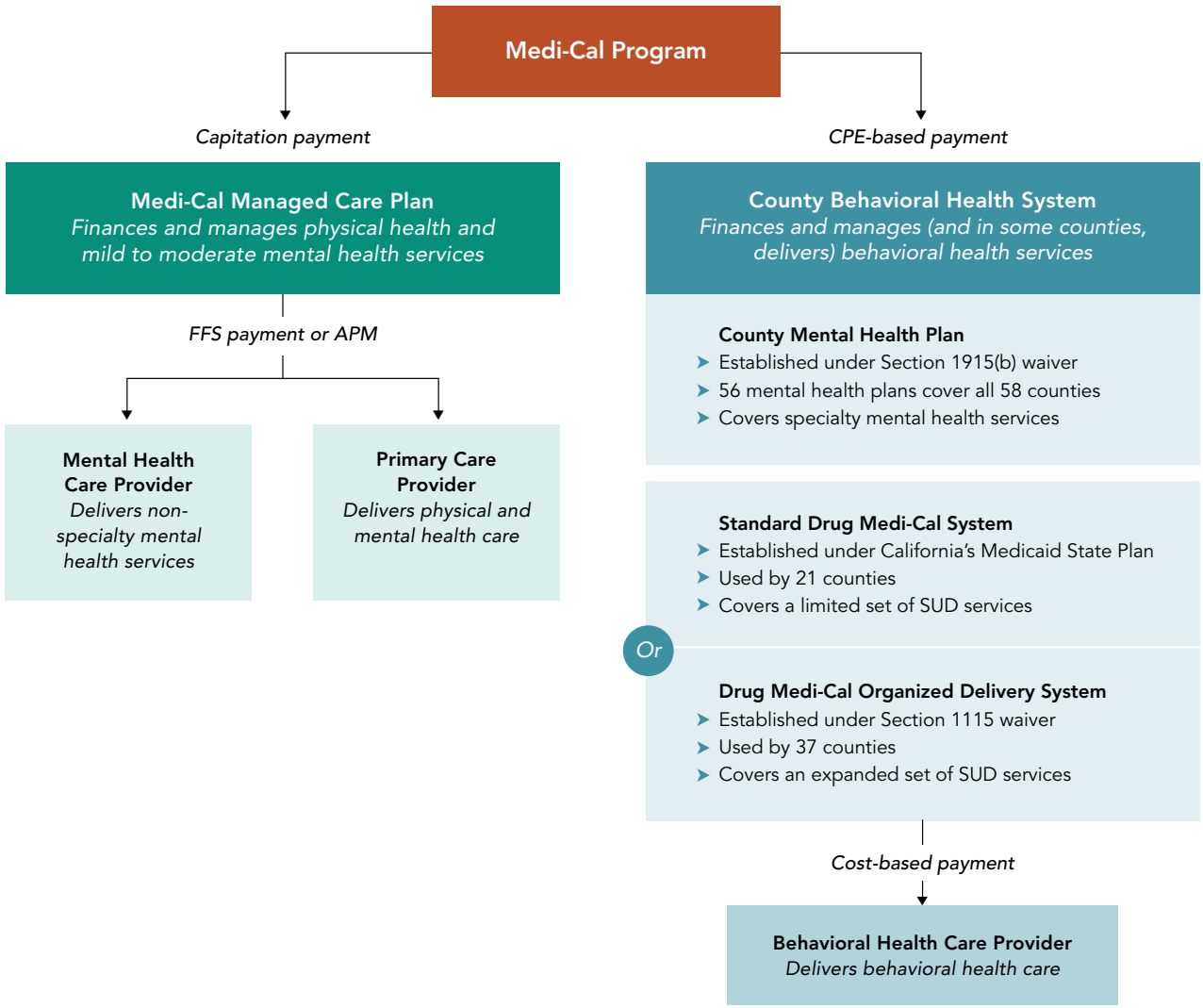
Source: *APM Measurement: Progress of Alternative Payment Models: 2019 Methodology and Results Report (PDF)*, Health Care Payment Learning & Action Network, 2019.

Organization and Financing 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 is currently structured and funded is important. Figure 3 shows the system's current organization. Behavioral health care in Medi-Cal is divided across two distinct systems, one that covers general medical care and mental health services and one that covers only specialty behavioral health services (mental health and substance use disorder treatment).[31] 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 financing for behavioral health and general health care are integrated.

While both the general medical care system and the specialty behavioral health system are

Figure 3. 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.

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 MCPs, provides all physical health care services and a limited set of non-specialty mental health services for adults and children with "mild-to-moderate" conditions. In January 2022, 84.5% of Medi-Cal enrollees were enrolled in an MCP for their physical health care.[32] The specialty behavioral health system, operated by county governments, typically through county behavioral health departments or the equivalent, is responsible for providing "specialty" mental health and almost all SUD services. Populations that may use these 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 and plans offered by for-profit and nonprofit insurance companies.[33] Each MCP receives a capitation payment — a per-person per-month amount — for each person enrolled in the plan and uses the capitation payments to pay health care provider organizations for services rendered to Medicaid enrollees. Since they are fully risk-bearing, MCPs must maintain funds in reserves (tangible net equity) to adequately face penalties or downside risk.

MCPs cover mental health services within a primary care provider's scope of practice, as well as psychological services delivered by a psychologist, clinical social worker, or marriage and family therapist licensed by the state. They also cover outpatient services for monitoring drug therapy, psychiatric consultation, and some other outpatient mental health services.[34] Each MCP establishes its own payment rates with provider organizations. Most plans have moved away from FFS payment, where the plan pays the provider a fixed rate for each service rendered, to capitated payment arrangements, where the plan pays a fixed rate to cover all services needed by a group of enrollees assigned to the provider.[35] Most MCPs contract with behavioral health organizations (BHOs) 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. Throughout the remainder of this report, the term *county behavioral health plans* will be used to refer to these systems together.

County MHPs can directly employ individual providers and operate treatment facilities, contract with independent providers or provider organizations, or both. This means that many counties play dual roles in the delivery and financing of specialty mental health services, as both managed care payers and providers of services. Smaller counties tend to provide services directly, through county-operated facilities and providers, while larger counties administer a larger share of services through contracting.

Counties cover Medi-Cal SUD services through one of two systems. Some counties continue to provide a limited set of SUD services through a legacy fee-for-service Drug Medi-Cal program,

administered by counties on behalf of the state. However, most counties (37 out of 58, covering 96% of Medi-Cal enrollees) now participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS),[36] established under a Medicaid Section 1115 demonstration waiver in 2015 and now a permanent part of the Medi-Cal program operating under 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, including residential treatment and case management.[37] As with specialty mental health services, counties may directly provide specialty SUD services and/or contract with community-based service providers; many counties function as both payer and provider.

County Behavioral Health Financing

County behavioral health plans are embedded in larger county health and social services systems, and finance and provide 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 but may also be used to complement and supplement these services. For instance, funds from the Mental Health Services Act (MHSA) are used to fund Medi-Cal specialty mental health services, and also support housing, wraparound, prevention, and early intervention services outside the scope of Medi-Cal benefits. Counties also finance essential behavioral health services not covered by Medi-Cal, including inpatient psychiatric care that may not be reimbursable by Medi-Cal because it is provided in institutions for mental disease (IMDs; inpatient psychiatric hospitals or residential facilities with more than 16 beds).[38] Under federal law, counties cannot use Medi-Cal funds to finance IMD care for enrollees age 21–64. (The state 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.)

Since county behavioral health plans are integrated into county governments, the specialty 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 integrated behavioral health services, such as mental health services in homeless shelters.[39] Counties often have relationships with agencies serving those with criminal justice involvement, including the public defender (to support diversion and reentry programs), probation, and special drug or mental health courts. To serve children, counties tend to have relationships with school districts as well as child and family services.

County behavioral health plans are financed through realignment, so called because the state has formally delegated (i.e., "realigned") administrative responsibility to counties, with funding allocated directly to counties through dedicated revenue sources. Each county receives an annual allocation of state tax funds for behavioral health services. The amount available statewide is based on available revenue from sales and vehicle license taxes and not on, or adjusted for changes in, behavioral health care caseloads, utilization, or demand. The amount can fluctuate year to year, based on the income that the state receives from the designated funds. The share of these designated funds made available to each county serves as the county's primary source of nonfederal "match" for Medi-Cal reimbursable services, along with MHSA funds, which may be used to support outpatient specialty mental health services in Medi-Cal. These funding mechanisms mean that counties must budget each year to fulfill the county's Medi-Cal entitlement obligations within their available, global budgets.[40] The basic realignment structure and 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, using a financing method known as a certified public expenditure (CPE). This model constrains the state's ability to introduce VBP models for behavioral health services and counties' ability to develop service infrastructure.

Under the Medi-Cal CPE model, county behavioral health plans first use county funds to pay for services they believe to be within the Medi-Cal coverage guidelines. The county certifies these public expenditures for Medi-Cal services and submits FFS claims to 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 audits county cost reports to ensure the federal reimbursement paid out through the claiming process equals, but does not exceed, the allowable costs of administering covered services.[41] 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 the 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 uncertainty about budgets over time.

CalAIM Behavioral Health Payment Reform

These processes will be altered by the CalAIM Behavioral Health Payment Reform proposal. 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 the reporting burden and uncertainty. With IGT, counties transfer the nonfederal share of their anticipated spending on Medi-Cal behavioral health services to DHCS. The federal government provides DHCS with the federal share of the Medi-Cal payment, and counties draw down the funds from DHCS through an FFS system.

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 service they deliver based on a predetermined schedule of reimbursement rates. County behavioral health plans will also receive reimbursement for administrative functions and utilization management/quality assurance activities that they must carry out as MCPs. The FFS health plan rate schedules may be stratified by groups of peer counties, which are groups of counties that share similar costs of doing business.[42]

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.

Financing using FFS should reduce the administrative burden on DHCS, counties, and contracted

providers because it does not require a reconciliation to costs. Reimbursements levels will be established by the fee schedule and do not require additional audit. 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 on some services and invest more 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 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.

Implementation of Value-Based Payment for Medicaid Behavioral Health Services in Other States

To inform California's future decisions about implementing VBP for Medi-Cal behavioral health services, the authors examined how these payment models have been implemented in other states, including state-level Medicaid payment reforms and a federally initiated financing model developed for the Certified Community Behavioral Health Clinics demonstration project.

The authors' approach had two components, described in greater detail in Appendix A. First, they conducted an environmental scan, including a literature review and interviews with policy experts, to identify VBP models covering Medicaid behavioral health services and evidence that these models have affected mental health services. The scan targeted models that cover a range of specialty behavioral health services with a focus on treatment for serious mental illness. Second, based on this scan, the authors selected five VBP models in Medicaid behavioral health for detailed case studies. The cases illustrate variation in model designs and in the context in which they were implemented, including states where behavioral health is carved into the physical health care contracts and states where behavioral health is carved out.[43]

Research results are presented in two sections. First, the VBP models identified and investigated are described, with their common and distinctive characteristics highlighted. Second, themes related to the design and implementation of VBP models that arose from interviews with policy experts and state officials are summarized.

Value-Based Payment Implementation and Impact in Medicaid Behavioral Health

Evidence from studies evaluating VBP models' effect in Medicaid behavioral health is scarce. The studies conducted have examined a limited range of potential VBP designs and a limited set of important outcomes. A systematic review published in 2020 examined studies of payment reforms for behavioral health care conducted between 1997 and 2019.[44] Out of 17 payment reforms that were included in the systematic review, only three were implemented in Medicaid and were focused on specialty mental health services. These three state reforms all involved accountable care organizations (ACOs) that were implemented as part of the CMS State Innovation Models grant program in Maine, Vermont, and Minnesota.[45] Assessment of the three models was limited to use of acute care services (inpatient and emergency department), mental health quality measures, and total costs of care. Findings were promising but mixed. Inpatient hospitalizations decreased in one state, increased in

another, and did not change in the third. Emergency department visits decreased in two states and did not change in the third. Only one of eight tests for impacts on quality measures indicated significant improvement. In one of the states total costs of care decreased; no effect on costs was found in the other two states.[46]

While studies are scarce, the authors also found several non–peer-reviewed reports that describe relevant models. All the reports emphasized that VBP efforts have focused more on physical health than on behavioral health. Factors that explain the limited adoption of VBP for behavioral health care include the relatively small size of behavioral health care providers, which limits their capacity to implement VBP models and assume financial risk; the lack of engagement with behavioral health care providers by MCOs, ACOs, and health systems; the prevalence of VBP models focused on primary care, in which behavioral health care providers have limited ability to influence the total costs of care; and the existence of separate state government departments and MCOs that oversee and manage physical health care and behavioral health care.[47]

Five Value-Based Payment Models in Medicaid Behavioral Health

The authors selected five real-world VBP models for in-depth investigation, all with potential relevance for California. The sample includes four VBP models developed by state Medicaid systems and one developed at the federal level for a federal demonstration project. The authors investigated the selected payment models through additional literature searches and direct conversations with stakeholders to better understand the models' structures and context, as well as issues with implementation that might not be reflected in available documentation.

Table 1 presents key characteristics of each VBP model. These include the population and services covered by the model (i.e., scope), the kinds of organizations and payment mechanisms included (i.e., structure), and the type of metrics used to monitor and incentivize performance. Three of the models — those in Pennsylvania, New York, and Vermont — are recent initiatives by state Medicaid agencies to reform behavioral health financing. In New York and Pennsylvania, the reforms were part of larger VBP initiatives that cut across all of Medicaid financing. The Certified Community Behavioral Health Clinic model was developed by the federal government as part of a demonstration project for comprehensive outpatient mental health services. The Maryland model is the oldest of the models identified and covers highly vulnerable individuals at the highest risk for incarceration and homelessness.

Since CalAIM's goal is to focus Medi-Cal financing on whole-person care, it is useful to compare the range of services included within a payment model with the full scope of services commonly used by people with a serious mental illness, serious emotional disturbance, or substance use disorder, including behavioral health care. These services are shown in six categories in Figure 4.

Following Figure 4, each of the models is described in more detail.

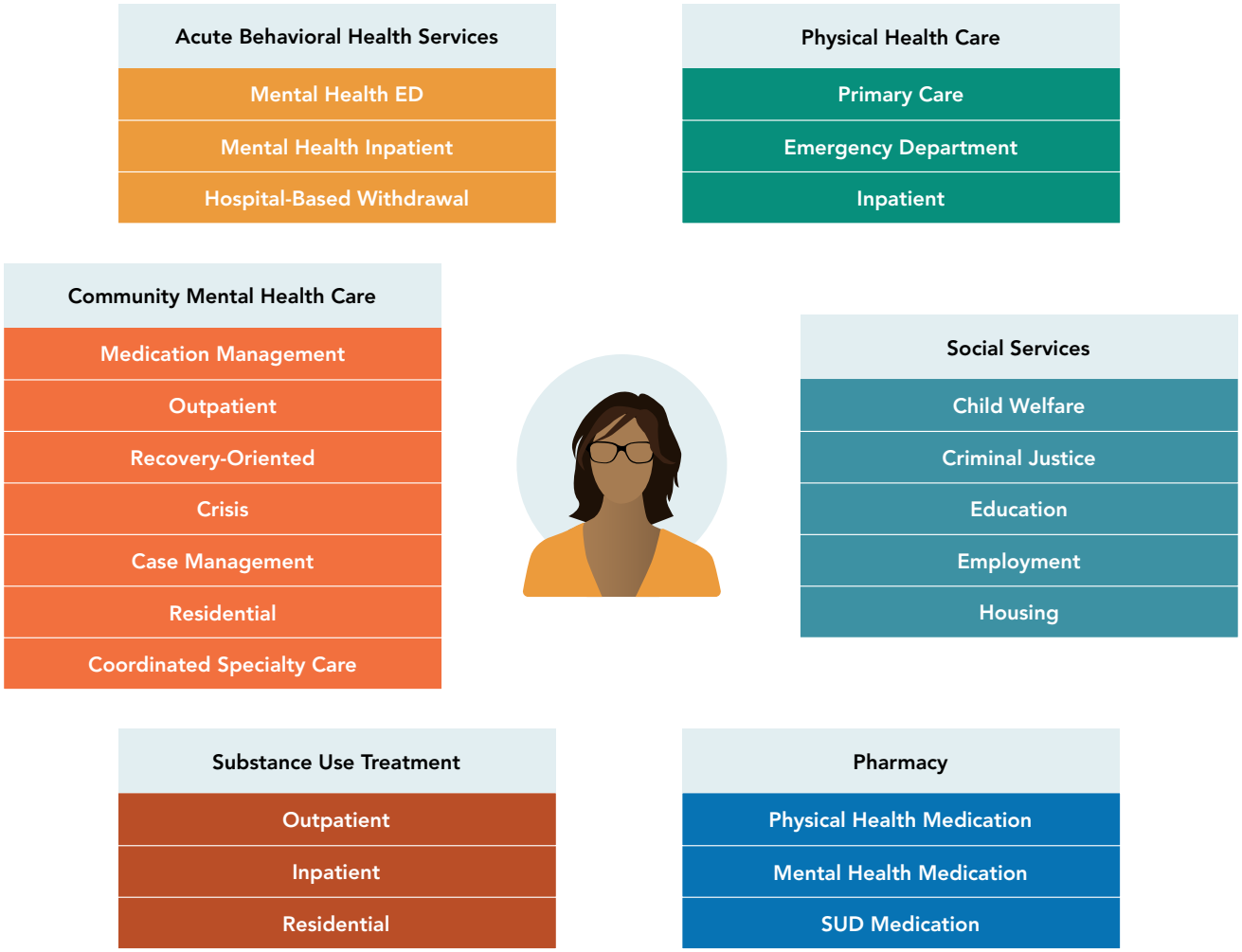
Table 1. Characteristics of Selected Value-Based Payment Models

Model	Scope	Structure	Metrics
Certified Community Behavioral Health Clinics (CCBHCs; multiple states)	Comprehensive outpatient BH services, including psychiatric treatment, recovery-oriented, substance use, and crisis services.	CCBHCs receive prospective daily or monthly payment based on operating costs and quality bonus payment.	Measures of access to care, medication management, care transitions, management of physical health conditions, and experience of care.
Baltimore City Capitation Project (Maryland)	All BH care	Provider organizations receive per-person per-month payment and bonus payments for outcome metrics.	Frequency of ED visits, physical health status, social outcome metrics.
Vermont Mental Health Case Rate	Mental health outpatient services, emergency services.	Nonprofit community mental health centers receive per-person per-month payment to cover most services they provide and bonus payments for outcome metrics.	Measures of access (timely appointment, timely follow-up care) and quality (use of standardized screening and assessment tools for children and adults) developed by the state
Pennsylvania Value-Based Purchasing	Varies by VBP arrangement; examples include VBP arrangements covering inpatient services, MAT, ACT services, and FQHC-based services.	State defines VBP categories aligned with LAN framework; BH MCOs must meet VBP targets; counties contract with MCOs to manage specialty MH care and select VBP arrangements (between MCOs and providers) from a "menu" offered by MCOs.	Quality metrics determined by counties, except for metrics that MCOs use across counties.
New York State Value-Based Payment Roadmap	Varies by VBP arrangement	State defines VBP categories aligned with LAN framework; MCOs that offer mainstream and special needs plans must meet VBP targets; options include population-based arrangements where providers assume responsibility for total costs of care as well as bundled payment arrangements.	Preventive care and screening for physical health problems; follow-up after ED visit for mental illness or alcohol and other drug dependence; pharmacotherapy for alcohol or opioid use disorder; avoidable MH-related readmissions; social outcomes (employment, housing, arrests); metrics defined by NCQA, CMS, AMA PCPI, and New York State.

Source: Author analysis, 2022.

Notes: *ACT* is Assertive Community Treatment. *AMA PCPI* is American Medical Association Physician Consortium for Performance Improvement. *BH* is behavioral health. *CMS* is Centers for Medicare & Medicaid Services. *ED* is emergency department. *FQHC* is Federally Qualified Health Center. *LAN* is Health Care Payment Learning & Action Network. *MAT* is medication-assisted treatment. *MCO* is managed care organization. *MH* is mental health. *NCQA* is National Committee for Quality Assurance. *VBP* is value-based payment.

Figure 4. Categories of Services Commonly Used by People with Behavioral Health Conditions



Source: Author analysis, 2022.

Notes: *ED* is emergency department. *SUD* is substance use disorder.

The service categories and their funding sources are as follows:

- **Community mental health care.** All mental health services provided in the community, including outpatient psychotherapy, medication management, support programs, and supported residences. In California, some of these services (e.g., outpatient psychotherapy and medication management) can be covered by MCPs for a segment of the Medi-Cal population. The remainder are financed primarily through county behavioral health plans.
- **Acute behavioral health services.** Psychiatric inpatient hospitalizations, hospital-based withdrawal management, and emergency department visits for mental health or substance use conditions. Emergency department visits are financed through MCPs, but psychiatric inpatient services are financed through MHPs. Hospital-based withdrawal management can be financed by behavioral health plans (through the DMC-ODS) or under Medi-Cal fee-for-service.
- **Physical health care.** The full scope of medical care for physical health conditions, including primary care, inpatient hospitalization, and emergency department visits. Primarily financed through MCPs or Medi-Cal fee-for-service.
- **Substance use treatment.** All specialty treatment for SUDs provided in an array of community-based settings. Primarily financed by behavioral health plans, through legacy Drug Medi-Cal or DMC-ODS. Some coverage for medications for addiction treatment provided in office-based or primary care settings is also available through MCPs or Medi-Cal fee-for-service/pharmacy benefits.
- **Pharmacy.** Provision of medications for all health conditions. Primarily financed through a fee-for-service carve-out inclusive of medications for both physical and behavioral health conditions.
- **Social services.** The broad range of services administered and financed by counties in California, including housing, child welfare, and education, with specialized behavioral health services often integrated into nonmedical settings such as homeless shelters, schools, and jails. Financed through behavioral health plans and other county-based mechanisms.

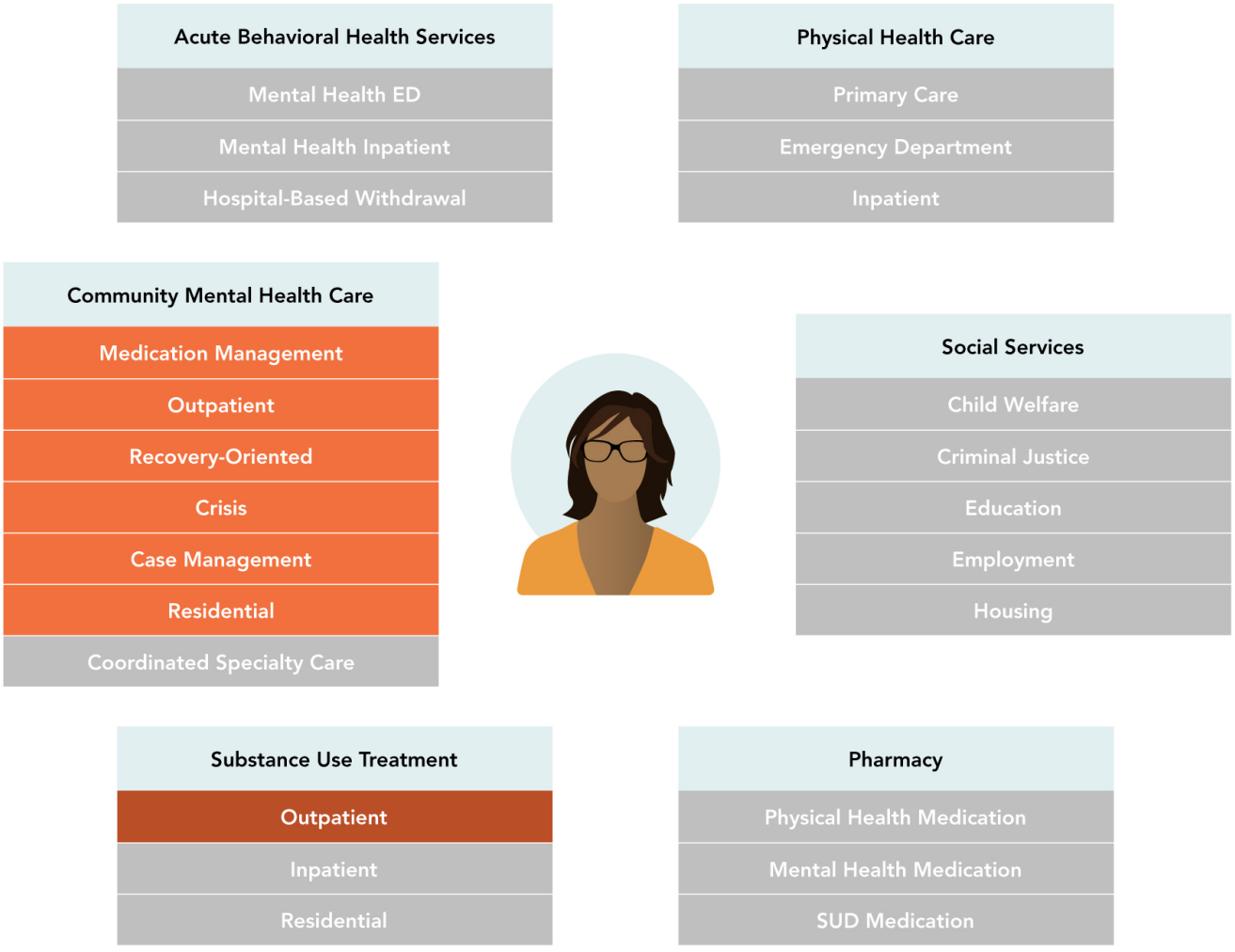
The six categories of services shown in Figure 4 represent the full range that a person with SMI, SED, or SUD might need. Services included in each of the following VBP models are highlighted in color, while services paid for outside it are grayed out (see Figures 5 through 9).

Model 1: Certified Community Behavioral Health Clinics

CCBHCs are comprehensive behavioral health outpatient clinics that are financed through a fixed daily or monthly rate.

- The rate covers all outpatient behavioral health services but does not include inpatient or emergency services.
- In most states, CCBHCs are eligible for quality bonus payments, but each state has developed its own set of performance criteria.

Figure 5. Services Covered by the Certified Community Behavioral Health Clinic Model



Source: Author analysis of Certified Community Behavioral Health Clinic Models, 2022.

Notes: Colored blocks indicate services covered by the model (see Figure 4). Gray blocks indicate services not covered by the model. *BH* is behavioral health. *CCBHC* is Certified Community Behavioral Health Clinic. *ED* is emergency department. *SUD* is substance use disorder.

The Certified Community Behavioral Health Clinic (CCBHC) is a comprehensive outpatient behavioral health clinic certified as providing a broad array of non-pharmacy behavioral health services.[48] The model was authorized by Congress in 2014 for a two-year demonstration in eight states and has since been extended and expanded to additional states. CCBHCs are financed through one of two cost-based methodologies: a daily rate or a monthly rate, at state option. The daily rate provides the clinic a fixed payment for each day a beneficiary receives clinic services, following a model used to fund Federally Qualified Health Centers (FQHCs). The monthly rate provides the clinic a fixed payment for each month during which a beneficiary has at least one visit. In both cases, the rates are designed to cover the total cost of providing the full scope of services to clinic patients, based on cost reports submitted by the clinics. The payment that CCBHCs receive is generally higher than historical FFS rates, which fell considerably below the costs of providing care.[49] Both the daily and the monthly rate are VBPs because they bundle all clinic services — including outpatient psychiatric treatment, recovery-oriented services, substance use services, and crisis services — into a single payment.

The value-based component of the CCBHC payment systems is a quality bonus payment (QBP). The QBP was required for states that chose the monthly rate and optional for states that chose the daily rate, but five of the six original demonstration states that chose the daily rate also chose to implement a QBP system.[50] Each state designed its own QBP, drawing on a mix of required and optional quality measures. States vary in the sources of funds used to cover the QBP systems, the size of the payments, and the performance thresholds used as criteria for the payments.

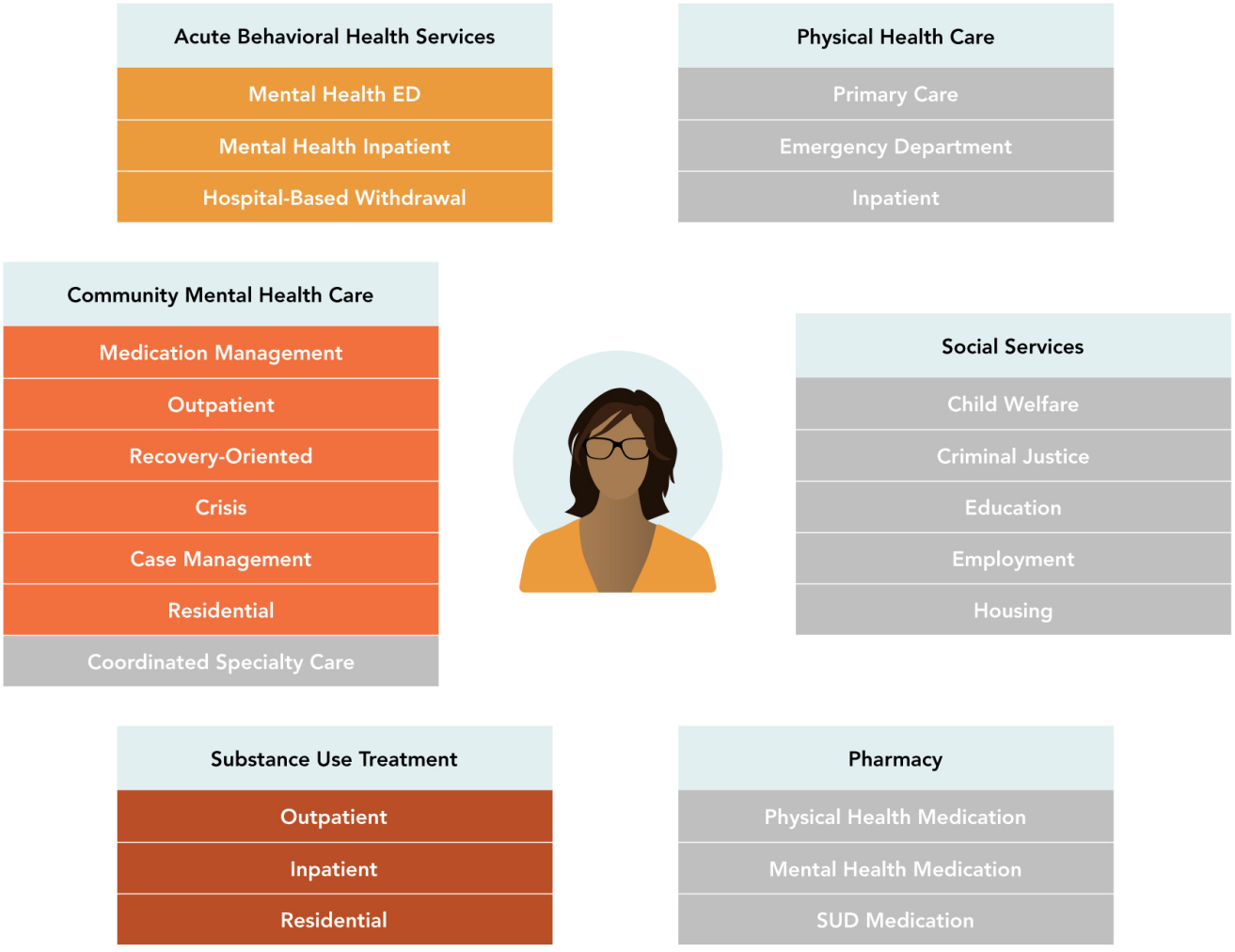
Evaluation of the CCBHC demonstration is ongoing, but qualitative surveys of participating clinics have found that the payment method can positively influence the clinics' scope of service and organization of care.[51] The prospective payment system's flexibility has allowed many clinics to reorganize their services to focus on the highest-need patients by deploying multidisciplinary teams. However, the QBP systems have not played a significant role in the CCBHC demonstration to date. Bonus payments have varied widely, with some states awarding payments to all CCBHCs, and others to none. A major reason for this is that when QBP systems were designed, a strong base of empirical data on quality measure performance did not exist. The lack of historical information made designing QBP systems with realistic expectations for future performance and attainable quality targets difficult.[52]

Model 2: Baltimore City Model for High-Need Adults with Serious Mental Illness

Baltimore finances comprehensive services for a small number of very high-need patients through capitation program with a quality incentive payment.

- The PMPM rate covers all outpatient, emergency, and inpatient behavioral health services. It does not cover outpatient or inpatient physical health care.
- A portion of payment is withheld for quality-based incentive payment.

Figure 6. Services Covered by the Baltimore City Capitation Project



Source: Author analysis of Baltimore City Capitation Project, 2022.

Notes: Colored blocks indicate services covered by the model (see Figure 4). Gray blocks indicate services not covered by the model. *BH* is behavioral health. *ED* is emergency department. *PMPM* is per-member per-month. *SUD* is substance use disorder.

The Baltimore City Capitation Project is a VBP model used for over 20 years to finance Medicaid services for high-need adults with serious mental illness. It is administered by the City of Baltimore, acting as a health plan in Maryland's carved-out behavioral health system. Services are managed by two contracted provider organizations: Chesapeake Connections, operated by the Sheppard Pratt Health System; and Creative Alternatives, operated by the Johns Hopkins Bayview Medical Center.[53] Eligibility for the program is based on a history of multiple inpatient hospitalizations within a year and/or incarceration. Enrollees can be identified by the state and referred to the program or identified by the program through regular visits to state psychiatric hospitals and approved by the state. The VBP model covers all non-pharmacy behavioral health care, including outpatient and inpatient mental health and substance use disorder treatment, residential support services, and recovery-oriented rehabilitative services. It does not cover psychiatric medications, general medical care, or housing costs, but does cover residential support services. Provider agencies are required to certify that housing providers meet local, state, and federal requirements. The provider agencies receive a per-patient per-month payment and assume risk for the total cost of covered care, including costs of inpatient psychiatric hospitalization. The value-based component is a withhold paid out to the provider agencies as a bonus payment conditional on performance on a set of quality measures.

The organization of care in the Chesapeake Connections program was described by its program director as a multidisciplinary team that provides comprehensive supports for enrollees for as long as they are needed. The program has two such teams, each composed of eight or nine case managers, a prescriber, and a registered nurse, and all teams have access to a therapist. Each team has a caseload of about 60 enrollees. According to Chesapeake Connections' program director, most services are provided by team members. The program includes some integrated care for physical health conditions, but — as noted previously — primary care services are out of scope for the VBP model. The team nurse helps coordinate physical health care services, working closely with an FQHC, often accompanying participants to their primary care visits.

A primary benefit of the program, according to the Chesapeake Connections director, is the flexibility to provide a wide variety of services, including some that contribute to recovery and stability but are not medical. The program has supported participation in educational and vocational training programs, including cosmetology school and vocal training. Services are often provided by partner community-based and faith organizations. All expenditures are based on individualized treatment plans.

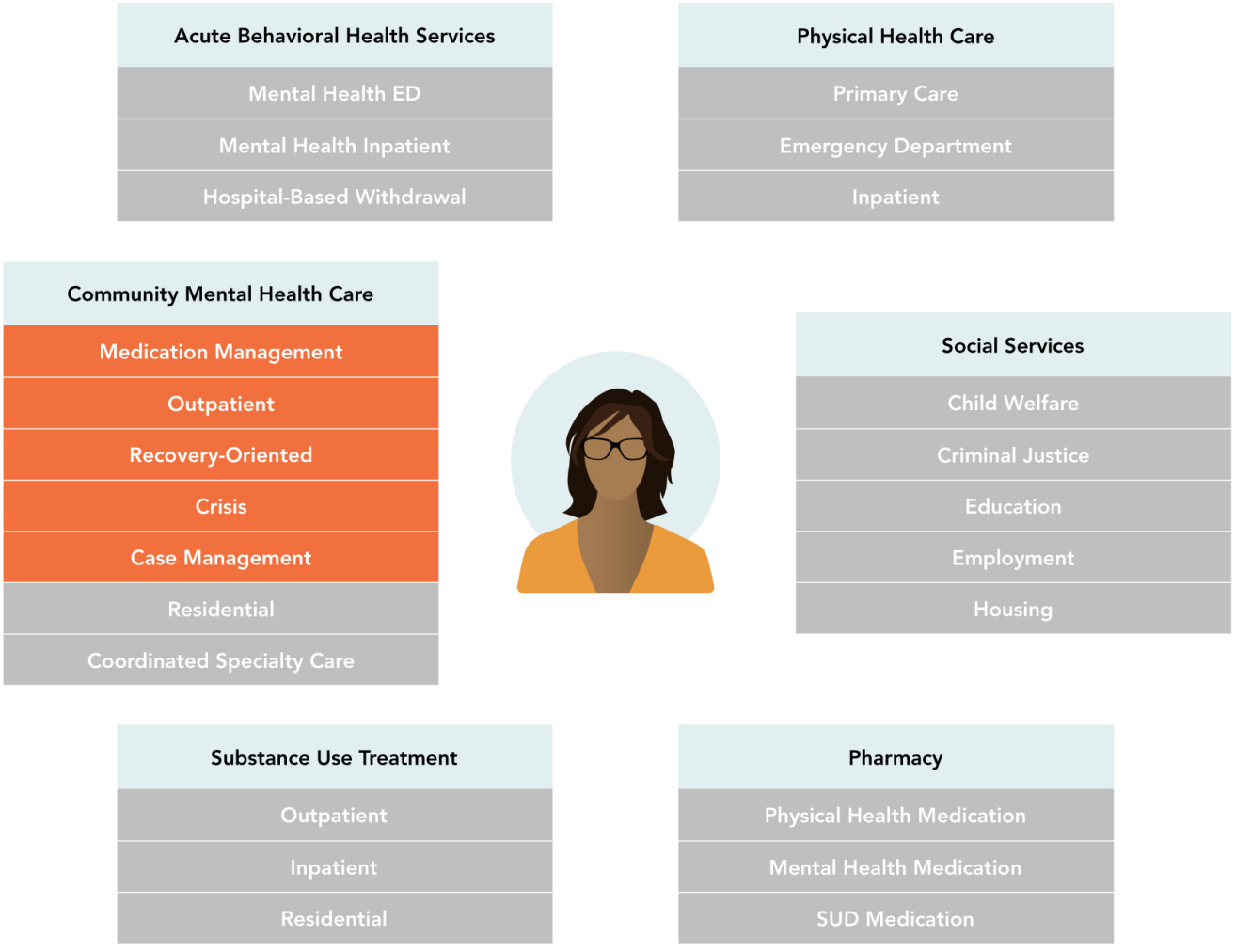
In the Baltimore City Capitation Project, programs must meet quality benchmarks to receive the withheld funding. The measures assess emergency department use, working situation and residential tenure, physical health, and progress toward smoking cessation, and each measure has a specified threshold percentage that defines qualifying level of performance. The measures are assessed through twice-yearly programmatic audits, which also examine the patient-centeredness of the treatment plans, the evaluation and intake process, and the quality of supportive housing services.

Model 3: Vermont Mental Health Case Rate

Vermont finances a system of community mental health centers using a case rate and plans to introduce quality-based incentives.

- The rate covers all outpatient MH services but does not include SUD treatment, inpatient or emergency services for mental health or physical health, or primary care services.
- Vermont postponed implementation of the VBP components due to the COVID-19 pandemic and began paying quality bonuses in 2021.

Figure 7. Services Covered by the Vermont Mental Health Case Rate Model



Source: Author analysis of Baltimore City Capitation Project, 2022.

Notes: Colored blocks indicate services covered by the model (see Figure 4). Gray blocks indicate services not covered by the model. *ED* is emergency department. *MH* is mental health. *SUD* is substance use disorder. *VBP* is value-based payment.

The state of Vermont finances Medicaid mental health outpatient services using prospective monthly case rates for all enrollees who receive services in the state's system of community mental health agencies. In this system, the community health agencies receive a fixed payment for each person they treat in a month. The state has 10 such agencies, each with a defined catchment area. The agencies receive over 90% of their funding from the state Department of Mental Health, primarily through the state Medicaid program. Annually, the agencies see about 7,000 adult patients in outpatient treatment and 7,500 adults for emergency services. Of these, about 2,800 are adults with serious mental illness.

Vermont's case rate financing system includes an incentive payment tied to performance on quality measures. The state legislature passed a rate increase equal to 1% of the total annual mental health allocation, and the Department of Mental Health withholds these funds for quality bonus payments. The state plans to introduce performance-based criteria over time, to determine eligibility for quality incentive payments.

Incentives matter, even tiny ones. We saw timely and complete data rates increase and lots of reconfiguration on how people come into the door. There were great conversations and thought about improving initial assessments, where do you do it. Case management has gone up a ton. People can get non-SMI services, and nontraditional therapies are expanding.

— Vermont interviewee

However, given concerns about the readiness of the community mental health agencies, the state has been introducing requirements incrementally, starting with pay-for-reporting criteria. Under these criteria, agencies qualify for the bonus payment if they report their encounter data in a timely manner; there is no quality component. Moreover, agencies that do not meet the criteria for a bonus payment are also provided funds to support their information infrastructure development. The first pay-for-performance elements were introduced in 2021, and, at the time of the authors' interview, 60% of the agencies were on track for the full bonus payment.

The state has worked with the mental health agencies to develop quality measures for the quality bonus payment system, but progress has been slow. The state has considered introducing measures based on consumer satisfaction surveys, but the sampling methods used by the various agencies were not consistent. The state is now considering establishing sampling standards. The state also considered using a measure of access to care based on the proportion of patients who were offered a clinical appointment within five days of initial contact. A challenge was reaching consensus across agencies on whether to base the measure on the offer or acceptance of an appointment, and specifications for this measure remain in progress. The state continues to work with the agencies on measurement using standardized clinical assessment tools, needs assessments, and measures of progress on plan of care.

The state has considered measures of emergency department and hospital utilization as potential indicators. However, trends in the use of emergency department and inpatient services have been affected in unexpected ways by the COVID-19 pandemic and the consequent difficulty in accessing routine in-person care. Policymakers were concerned that related quality measures could incentivize reduced access to these services.

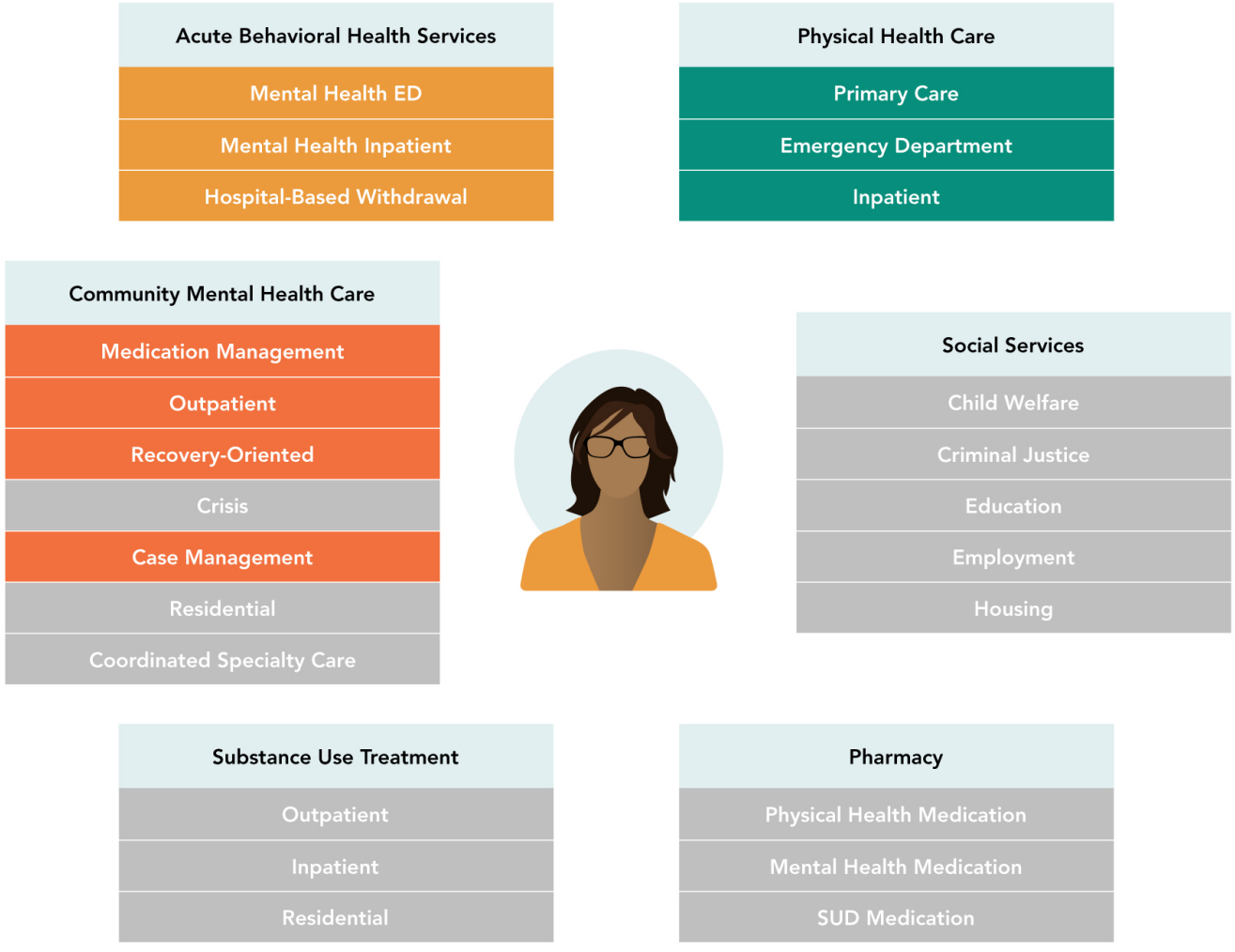
While it is too early to assess the impact of Vermont's VBP model, the state has observed improvements in encounter data reporting and agencies' engagement in conversations about measurement and quality improvement. The agencies have worked to improve access by reconfiguring pathways to care, and evidence shows that use of case management has increased. Finally, implementation of the VBP model has also led some of the smaller community mental health agencies to consider consolidating, since on their own they have few patients across whom to spread risk and very small operating margins.

Model 4: Pennsylvania Value-Based Purchasing

In Pennsylvania, behavioral health organizations (BHOs) are required to have a portion of payments through VBPs and are free to design modules with county input. As a result, Pennsylvania has multiple APMs jointly developed by BHOs and counties.

- This figure presents one VBP model, which combines specialty MH with primary care and involves shared risk for hospitalizations.

Figure 8. Services Covered by a Pennsylvania Value-Based Payment Model — Example 1: Mental Health and Physical Health Care Integration

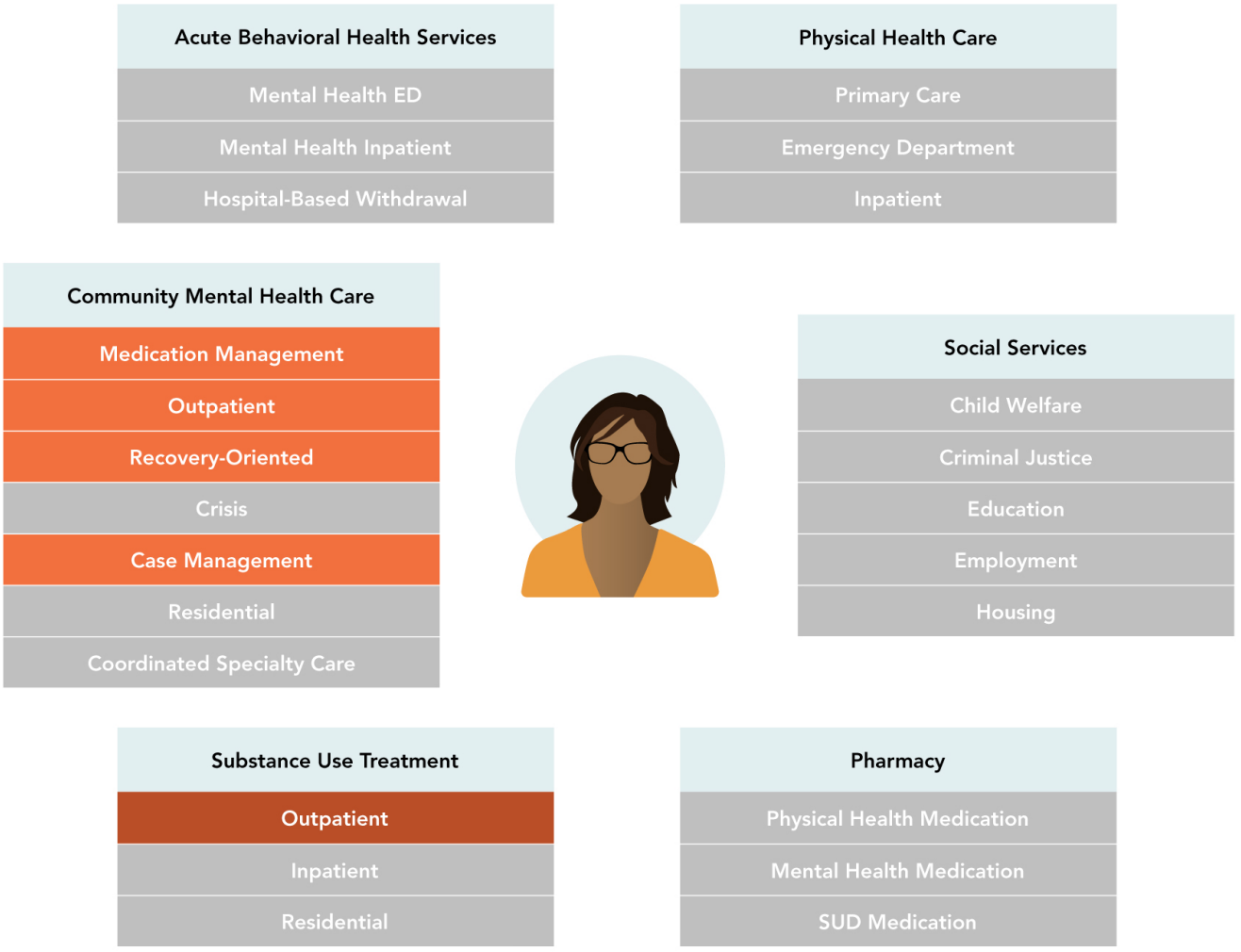


Source: Author analysis of Pennsylvania Value-Based Purchasing, 2022.

Notes: Colored blocks indicate services covered by the model (see Figure 4). Gray blocks indicate services not covered by the model. *APM* is alternative payment model. *BHO* is behavioral health organization. *ED* is emergency department. *MH* is mental health. *SUD* is substance use disorder. *VBP* is value-based payment.

➤ This figure presents another VBP model in Pennsylvania, which combines MH and SUD outpatient treatment.

Figure 9. Services Covered by a Pennsylvania Value-Based Payment Model — Example 2: Community Mental Health and Substance Use Treatment Integration



Source: Author analysis of Pennsylvania Value-Based Purchasing, 2022.

Notes: Colored blocks indicate services covered by the model (see Figure 4). Gray blocks indicate services not covered by the model. *ED* is emergency department. *MH* is mental health. *SUD* is substance use disorder. *VBP* is value-based payment.

Pennsylvania finances Medicaid services through its 67 counties and carves out behavioral health care. Each county contracts with one or more MCPs for its Medicaid physical health care services and with a separate BHO for Medicaid behavioral health care services. Two BHOs cover the entire state; each county works exclusively with one of the two. The Medicaid system began a concerted effort in 2017 to shift financing arrangements to VBPs, starting with physical health care and adding behavioral health care a year later.[54] The state established requirements for the counties that specify proportions of the total Medicaid health care cost expenditures to be paid to providers through VBP arrangements of different types. The requirements began with small percentages in low-risk VBP arrangements and have progressed to higher percentages at higher-risk VBP arrangements. The requirements apply to counties, which work with their MCPs and BHOs to develop and implement the financing arrangements with provider organizations.

> *We are a county-based system. People call our system a carve-out, but we call it a human services carve-in. Since most human services are managed at the county level, we also have behavioral health at the county level.*
>
> — Pennsylvania Interviewee

VBP financing for behavioral health care began in 2018, with a requirement that 5% of provider payments be through VBP contracts. By 2020, this requirement had risen to 20%, with at least half involving medium- or high-risk arrangements. (The state requirements are not specific about populations to be covered or measurement methods to be used.)

In the VBP arrangements, risk can be shared between the counties and the BHO, depending on the general contracting arrangements. In a minority of counties, the BHO serves only as an administrative service organization, and the county assumes all of the risk. In the other counties, the BHO takes on risk. Where BHOs do so, they also stand to gain from shared savings of up to 3% of expenditures, which accrue to the BHO as savings and can be used to reinvest in non–Medicaid-covered services such as infrastructure, integration with human services organizations, or training. Reinvestments can be included in future capitation rates. Savings above 3% of expenditures must be returned to the state.

The state requires that primary behavioral health contractors (counties and BHOs) adopt state-designed VBP models (or others newly developed by the contractors in collaboration with the state) to organize and deliver VBP-financed care. One model, illustrated in Figure 8, covers behavioral health care through the behavioral health carve-out and primary health care through MCPs. Another model, illustrated in Figure 9, combines outpatient mental health and substance use treatment. While the state developed the former model, the latter was initiated by a group of counties in northwestern Pennsylvania and developed with input from the BHO. The state also uses VBP models specific to behavioral health care. These include a model focused on posthospitalization transitions to community-based outpatient mental health care that ties payment for inpatient providers to standardized performance measures and requires standardized data collection for a continuum of ambulatory behavioral health programs.

Model 5: New York State Value-Based Payment Roadmap

Value-Based Payment Models and New York's Health and Recovery Plans

New York State has attempted to promote use of VBPs for SMI beneficiaries in the context of its carved-in Medicaid program. The state included behavioral health-related measures in its required measure list.

- Managed care plans did not develop VBP models to cover the SMI population, despite encouragement to do so.
- State officials suggested that managed care plans preferred to include SMI in comprehensive VBP models than to develop specialty VBP models.

In 2015, New York launched a five-year Delivery System Reform Incentive Payment (DSRIP) demonstration program that included requirements for value-based payments between MCPs and provider organizations known as performing provider systems. The program aimed to have a minimum of 80% of payments made through VBP models at HCPLAN Category 2 or higher by the end of the five-year demonstration period. To this end, New York modified its contracting with MCPs to incentivize the growing use of VBP in the plans' payments to providers, with bonuses, upside sharing, and downside risks tied to performance metrics.

Additionally, the state amended its Section 1115 waiver to enable qualified mainstream MCPs to comprehensively manage a more generous behavioral health benefit for Supplemental Security Income (SSI) enrollees, who had been excluded from a previously implemented carve-in of the Medicaid behavioral health benefit. This expanded behavioral health benefit was made available through MCPs to all adult enrollees not in Medicare through (1) an expanded behavioral health benefit and (2) special needs plans, known as Health and Recovery Plans (HARPs). The expanded benefit includes managed behavioral health care and primary care case management. The HARPs cover a broader range of specialty behavioral health services, including behavioral health home and community-based services (HCBS) such as employment and crisis respite services. The HARP program was rolled out in stages; by October 2016 it was fully operational statewide. HARP eligibility is based on age (21 and over), diagnosis of SMI and/or SUD, and HARP risk factor criteria largely determined by intensity of behavioral health utilization. HARP-eligible individuals are identified quarterly and are passively enrolled into HARPs.

Managed care organizations said, "How can we take highest-cost people into a risk arrangement? We need to spread out the risk." We had thought, "Oh, you can really focus by putting all people with severe mental illness into the same kind of contract." But plans said this didn't make sense. How do you do a VBP for high-cost, high-need people? Where is the opportunity to save?

— New York interviewee

The state has set clear expectations for MCPs to transition to VBPs to finance the care of Medicaid enrollees, encouraging the use of three types of contracts. These are (1) Total Care for the General Population (TCGP); (2) Total Care for Special Needs Populations (TC-SNP), which target special needs plans' members, including HARP enrollees; and (3) episodic care arrangements, which target subpopulations with higher primary care needs and associated higher costs.

The incentive measures that MCPs can use in their VBP arrangements include behavioral health quality measures, with more SMI-targeted measures included in TC-SNP contract arrangements that MCPs may use for their HARP-covered members. Plans' uptake of these arrangements for the HARP population has been minimal. Instead, MCPs have covered this population under the much more widely used TCGP contract arrangements. Moreover, the state has noted very limited implementation of VBP arrangements between MCPs and specialized behavioral health providers, including HCBS providers. Interviewees speculated that plans included patients who need high-cost services in contracts that pool total costs of care for larger populations to spread risk. However, this raised concerns that enrollees with behavioral health conditions covered under TCGP contracts might become targets for cost reduction strategies, resulting in reductions in needed care. Medicaid officials in New York have been disappointed and are searching for new mechanisms to promote development of VBPs despite this experience.

Implementing VBP Models in Medicaid Behavioral Health: Perspectives from the Field

While the published evidence of VBP models' impacts in Medicaid behavioral health care is scarce, the perspectives of experts in the design and analysis of payment mechanisms, and of state officials who have taken an active role in implementing Medicaid VBPs, can provide valuable lessons for California. Interviewees for this report highlighted concerns related to VBP implementation and sustainability, including quality measurement and the scope of services included in models.

Quality Measurement Is Critical to Preserving and Improving Quality and Enabling Accountability

All interviewees recognized the critical role of quality measurement in the move from FFS to VBP. Any payment mechanism that conditions payment on quality performance clearly requires methods for measuring quality. However, in VBP models that allow providers flexibility using bundling, quality measures are critical to ensuring that quality of care is not compromised and to ensuring accountability, as described previously. As one of the academic expert interviewees put it: "When you cut costs, you could be acting efficiently, or you could be shirking on quality. You want to give incentives for being efficient but not shirking on quality." All state interviewees recognized the need to define measures of quality for behavioral health; build the information technology and data analytics capacity to collect, analyze, and report the measures; and develop trust in the measures among stakeholders. This is reflected in how they planned for and moved toward implementation of VBP models. Each of these issues is described below.

- **Existing quality measures for behavioral health care are limited.** Nationally, behavioral health care has lagged behind other areas of medicine in capturing clinical data through electronic health records (EHRs), to a large extent due to its exclusion from large-scale EHR initiatives.[55] A recent report from the National Committee for Quality Assurance found that quality measurement in behavioral health lacks consistency in data collection and reporting methods, fails to cover important areas of care, and fails to measure integration of care.[56] Both academic experts and state officials who were interviewed indicated that measures currently in use are largely limited to the process, rather than the outcomes, of care. For example, of the quality measures required by the CCBHC demonstration project, only one was an outcome measure: symptom improvement in patients treated for depression. The lack of a broader range of outcome measures means that patients' improvement in functioning or recovery over time is not directly measured and thus is not directly incentivized by VBP models. Interviewees expressed concern about the lack of outcome measures while also recognizing that the complex factors influencing health outcomes make attributing outcomes to specific treatments problematic.

> *We developed homegrown measures with CMS approval where we needed measures to reflect our program's goals but where a National Quality Foundation measure didn't exist at the time.*
>
> — Massachusetts interviewee

Interviewees were also concerned that the process measures currently in use do not cover the full range of behavioral health services, and that this could lead to providers "gaming the system" — that is, focusing on the services linked to payment but cutting back on unmeasured services. Several states, including New York, have been developing measures of their own

to cover additional areas of behavioral health care to enable future implementation of VBPs. New York now includes a measure of housing status in its list of measures that can be used in VBP contracts; however, this measure is eligible for pay-for-reporting, not pay-for-performance, arrangements.[57]

- **Developing and introducing quality measures in payment models takes time and requires significant stakeholder input.** Given states' concerns about their behavioral health care providers' ability to collect and report quality measure data, states have tended to implement VBP models in stages over multiple years. For instance, following several years of stakeholder-informed policy development process, Vermont began its program in 2019 with a pay-for-reporting system. Providers were rewarded for successfully reporting quality information regardless of the quality of care their data indicated. The first year that Vermont used any quality information to disburse bonus payments was 2021.

Earning back the withhold started with data quality. In the beginning, people were excited. Then, we asked them to do encounter claims, timely and complete encounter data. Consumer satisfaction was the next piece. We used items they'd been doing for a couple years. The measures are not national, so they're self-administered. We're seeing very different sampling methods among providers right now. We're looking at creating a minimum standard.

— Vermont interviewee

Quality measures that involve surveys of patients or family members require attention to respondent sampling, since the method may affect the overall rating a provider receives. Stakeholder involvement in measure development is important for establishing trust that the process results in equitable assessment of quality across providers and regions. The fact that this concern was raised in small states suggests that this effort will be significantly more complex in California. Stakeholder input can also support selecting measures that help assess and address disparities in health access and quality experienced by diverse populations.

- **Health information technology in behavioral health is improving but has a long way to go.** States have made large investments over multiple years to build community mental health and substance use treatment providers' technology infrastructure. For instance, between 2017 and 2020, New York State implemented a Behavioral Health Value Based Payment Readiness Program specifically for this purpose.[58] Still, interviewees acknowledged that, despite these and other improvements, community behavioral health care providers continue to lag general health care providers in implementation of information technology, such as EHRs.[59] This lag has implications for VBP models because these models need consistent, automatic reporting of quality measures according to standard specifications using EHR systems. Even in the CCBHC demonstration program, which involved community mental health centers that were generally larger and more sophisticated than average, many programs collected quality measure information through ad hoc manual data entry systems because they lacked the needed EHR functionality. EHR reporting is particularly important for developing outcome measures since those measures are poorly captured in claims data.

We heard about challenges with information sharing—mental health and substance abuse data. No one will enter into VBP contracts without the ability to share these data.

— New York interviewee

- **Information sharing across provider organizations becomes more important when financial risk is shared.** Historically, federal and state regulations and established practices have limited sharing of mental health and substance use treatment–related information across provider organizations.[60] While some regulatory barriers have been lifted and some states have embraced health information exchanges for the secure sharing of clinical information,[61] interviewees raised concerns that barriers remain in information systems and clinical practice. Limitations in data sharing have implications for VBP. If providers cannot share patient information, they are unlikely to enter into financial arrangements where they share risk. This is an important consideration when a single VBP is designed to cover multiple types of care, such as MH and SUD care.

Specifying Scope of Covered Services Is Fundamental to Model Design

The VBP models described previously illustrate multiple ways that services can be bundled into a single payment mechanism. For example, the Baltimore City Capitation Project model includes inpatient as well as outpatient mental health and SUD non-pharmacy services, while the CCBHC model covers only outpatient mental health and SUD services. Given the extensive needs of Medicaid populations, there are many options for the scope of services that can be included in a VBP model and, conversely, excluded. Moreover, while Medicaid covers a broad set of services, some essential to supporting people in the community with SMI, SED, and/or SUDs fall outside the Medicaid benefit. Decisions about the scope of services in VBP models have consequences for the organization of services: A VBP model creates a financial incentive for the delivery system to reduce the costs of providing included services but may not affect, or may have negative consequences for, services that are excluded. Several important design principles related to the scope of services bundled into VBP models arose in the authors' review of the literature and key interviews. These principles are described below.

- **The scope of services should align with the plan or provider's scope of practice.** A basic but important design consideration is that the provider paid through a VBP should have influence over the full scope of services covered by that VBP. Poor alignment of VBPs with specialty mental health services in New York is one of the explanations interviewees offered for the lack of VBP models focusing on the SMI or SUD population. In New York, value-based payments were made by attributing patients to primary care providers, although these providers do not control behavioral health services for people with serious mental illness. In contrast, in the other examples that were examined, the provider of behavioral health care was also the direct recipient of the value-based payment. The VBP model should be designed such that the provider who receives the payment can influence the delivery of services and the quality of care received by patients covered by the VBP.
- **The scope of services should create incentives to improve the care system's efficiency.** VBP models create incentives for providing the covered services efficiently. VBP model designers should look for strategic opportunities where such incentives could improve the delivery system. For instance, if a VBP model were created to cover both mental health and substance use treatment, it might create incentives for county

behavioral health plans to begin integrating these relatively fragmented systems. Similarly, VBP models that include physical and mental health care in the covered scope of services would incentivize integration between county Mental Health Plans and MCPs for people with mental illness. In explaining this concept, one state official emphasized that VBP models should be designed to cross the boundaries dividing the current system: "There need to be incentives that cross the border." However, this principle should be tempered by the need described previously for the scope of services bundled into a VBP model to be within the range of services offered by the provider paid.

- **The scope of services may depend on local conditions.** In Pennsylvania, local providers, groups of providers, and counties identified collective strategies for integrating care, then worked with their contracted BHO to design VBP mechanisms that would enable and incentivize the desired changes. These "bottom-up" VBP models were encouraged, along with "top-down" models developed by the state or BHO and offered to the providers or counties. While the impact of these models has not been studied, the variety of designs implemented is notable, and stakeholders are largely supportive. Pennsylvania's experience suggests that local stakeholders have insight into the scope of services that can reasonably be combined and the measurement strategies that would work in the local context, and may be in a good position to inform the design of VBP models. The approach used by Pennsylvania and elsewhere, where targets for the proportion of spending that flows through VBP arrangements are set without specifying the models to be used, allows local stakeholders to play a role in model design.

> *Our state is a county-based system. Counties hold contracts with the state, then they hire MCOs like mine. One hundred percent of lives in any county are under one MCO. Each county needs to meet requirements for VBP spending... Requirements for VBP arrangements are very high-level: Counties determine what kind of VBP to use, and there are no specific populations required to target. Counties determine quality metrics to use, except for metrics that an MCO enforces across contracts. From the county perspective, the MCO offers a "menu" of VBP options to choose from.*
>
> — Pennsylvania interviewee

Additional Considerations Related to Value-Based Payment Model Implementation

Interviewees identified several additional issues requiring careful consideration that may apply at both the state-to-plan and plan-to-provider payment levels. These model design issues should be clearly delineated in contracts.

- **Larger organizations can take on more financial risk than smaller organizations.** VBPs involve financial risks for provider organizations. Rates are set on the basis of average costs, but the costs of care for individual patients may vary widely. Many provider organizations in the specialty behavioral health sector are quite small, and small organizations are less able to sustain themselves financially with fluctuating revenues. Imposing risk on small organizations can unfairly advantage larger organizations and drive these

small providers out of the market. One policy expert suggested that payment mechanisms could be tailored to organizations of different sizes. Small organizations could be paid through fixed fees. Medium ones, which have some ability to bear risk but may still be vulnerable to "outlier" patients whose needs result in high costs, could be paid through prospective payments with risk adjustments and upside risks (as are currently used in CCBHCs). Large providers could be held accountable on quality performance with significant upside and downside risks.

- **States can use contractual methods to hold plans and providers accountable.** Methods for ensuring accountability suggested by interviewees include detailed reviews of plan-provider contracts, requirements for behavioral health expertise within plans, required contracting with existing provider organizations, and network adequacy requirements. New York interviewees emphasized that the state Medicaid office needs to develop the skill and capacity to carry out these reviews with specific attention to and expertise in behavioral health issues.
- **Contractual mechanisms are also needed to protect providers and plans.** Payments held in reserve to cover potential losses, known as risk corridors, can protect plans from unexpected expenses, particularly during the early years of implementation when historical data are lacking. A variety of other mechanisms, including outlier payments and soft capitation, were also mentioned. Outlier payments are amounts added on to cover patients at the extreme high end of service utilization. Such payments could be particularly important for smaller county plans or providers, where a small number of patients who need very high-cost services can have a disproportionate effect on resources. Soft capitation refers to capitation models where risk is shared between the payer and the payee. One of the mechanisms used to finance CCBHCs is a prospective monthly payment: The clinic receives a fixed payment for each month in which a patient receives a service. This mechanism uses two structural features to address the wide variation across patients in the services they might use over an entire month: stratification by severity and outlier payments.

We did a ton of workshopping with entities on what makes sense to track. We feel good about it, and it incentivizes alignment. We've played a facilitator role...Alignment has been very helpful aside from financial incentives. We're spending a lot of time and effort on contract management. This has made a huge difference, and we learned so much.

— Massachusetts interviewee

Summary of Challenges

A thorough search for VBP models implemented in Medicaid programs for the care of enrollees with serious mental illness or substance use disorders found few examples, and almost no empirical studies investigating their effects. The lack is striking given the enthusiastic embrace of value-based arrangements to finance Medicaid services in recent years. Although some states have made significant efforts, overall, financing care with VBPs for enrollees with significant behavioral health needs remains far behind other areas of Medicaid-financed health care. Moreover, among the models that are being implemented and tested, the value-based components tend to involve no or low risk to the provider organizations. The field has moved very slowly toward more advanced models that involve risk for providers.

Next Steps Toward Payment Reform in Medi-Cal Specialty Behavioral Health

Despite the attention given to VBP in recent years, very little evidence exists regarding its use in Medicaid behavioral health services. A body of research based on rigorous empirical evidence to clearly guide policy does not exist. Moreover, only a few examples of implemented VBP models exist, and many of the examples are in early, exploratory stages. Officials and experts in states that have implemented VBP models did not have specific evidence of their impacts on outcomes such as total costs of care or quality of care, but they were optimistic about anticipated future benefits. The authors did not identify any cases where states had experimented with VBP models and then decided not to move forward with implementation. Based on these findings, there is not sufficient evidence to recommend that California pursue VBP models, let alone evidence to support a recommendation for a specific model. However, lessons from other states point to steps that California can take now to help inform future decisions on VBP models.

This section draws on findings from other states and from interviews conducted with county and state officials in California to present recommendations regarding the future of VBP for financing Medi-Cal's behavioral health system. In considering potential VBP models, the authors cast a wide net, including models between a state and the specialty behavioral health plans and models that plans may enter into with providers. In addition, the authors considered VBP models limited to specialty behavioral health services, as well as those that would cover physical and behavioral health services.

This report provides two sets of recommendations. The first is for actions that California can take immediately, as behavioral health payment reform occurs under CalAIM, that will improve the state's capacity to make future decisions about VBP. The second concerns issues that the state should anticipate will arise in the process of designing and implementing a specific VBP model for specialty behavioral health, should the state decide to pursue one.

Recommendations for the Near Term: Immediate Actions

California could take two immediate actions to improve its ability to implement VBP models in the future:

Action 1. Develop a Comprehensive Behavioral Health Quality Strategy

DHCS's 2022 Comprehensive Quality Strategy (CQS) includes significant steps to overhaul the approach to quality measurement in Medi-Cal by identifying areas for quality improvement, metrics to assess improvement drawn from the CMS Core Set, and performance targets for MCPs, MHPs, and Drug Medi-Cal Organized Delivery Systems (DMC-ODS).[62] However, respondents in California and other states emphasized the limitations of existing behavioral health quality measures and highlighted the wide variation across counties in the sophistication of their quality reporting systems.

Yet, as highlighted by the CQS, a robust quality measurement infrastructure is critical to the design and implementation of any VBP model. Therefore, the authors recommend that the state begin a strategic-planning initiative focused on improving quality measurement in behavioral health, to build on the momentum of the CQS and provide the additional focus, infrastructure development, and stakeholder engagement to address concerns specific to the state. The initiative should focus

on quality measurement within county behavioral health plans, considering the complexity of the population served, the plans' unique structural characteristics (e.g., diversity of providers and workforce, variable EHR adoption), and budgetary constraints.

In addition, the initiative should study alignment of quality measurement across county behavioral health plans, to ensure consistency in assessment of quality; across MCPs, to ensure consistency in measurement of care for mild-to-moderate conditions; and between behavioral health plans and MCPs, to ensure monitoring of physical health treatment for people with behavioral health conditions, and vice versa. In each domain, measures that incorporate patient-reported outcomes and that assess equitable delivery of care should also be prioritized.

Finally, the initiative could include investment in improving county behavioral health health information technology (HIT) systems to support quality measurement and quality improvement efforts, ideally resulting in a single electronic health record system that will support efficient, low-burden capture of information on quality of care. This initiative would lay critical groundwork for a future VBP model should policymakers decide to move forward. It would also offer early benefits by improving quality measurement for people receiving specialty behavioral health services.

We don't have great indicators of quality in the behavioral health system. We have lots of process indicators, but we don't have great outcomes indicators for substance use disorder—is it a good thing if a person came back to treatment after three months?

— California county interviewee

The current transition to an FFS system for health plan payment under CalAIM is an opportune time to consider a comprehensive strategy for behavioral health quality measurement. The FFS system will require development and implementation of data systems with more fine-grained information on service provision than has been available in the past on a statewide basis. These new systems will provide new opportunities to assess quality, potentially using both claims and EHR data. In particular, it will be valuable to develop a track record of quality performance prior to introduction of any VBP models.

There are five key components of a behavioral health quality strategy initiative.

1. **The strategy should develop an accurate baseline of performance on behavioral health quality measures by county behavioral health plans and providers.** Setting quality performance expectations in a VBP model requires an empirical basis for realistic projections of future performance or improvement in performance over time that considers baseline conditions, case mix, and access to resources.[63] If standards are too high, providers have no reasonable expectation of benefiting from incentive payments and therefore no real incentive to invest in quality improvement. Setting benchmarks that are just right can be challenging, but national and regional benchmarking initiatives for Medicaid populations can be a valuable resource.[64]
2. **The strategy should focus on developing clear and transparent standards for the process of collecting, reporting, and evaluating information on quality of care.** These should include measures based on Medi-Cal claims data as well as additional measures based on data from EHRs or other data systems. Several county officials, who highlighted concerns about fundamental differences in systems of care between

California's small rural and large urban counties, emphasized the need for transparency. In order for counties to trust that they are being held to a common standard, they must first trust that data are being collected in the same way across the state. Documenting the data collection process across the state will help build trust in future VBP models.

Laying the Groundwork for Value-Based Payment in Behavioral Health in New York State

New York State's Behavioral Health Value Based Payment Readiness Program provided funding to help behavioral health care providers participate in VBP arrangements.[65] The program operated for three state fiscal years, from 2017–2018 to 2019–2020, allowing all providers to access up to $60 million over the program period. To participate, providers were required to form behavioral health care collaboratives (BHCCs), networks of providers able to deliver the full spectrum of services needed to meet the behavioral health needs of their regions. BHCCs were required to include community rehabilitation providers, smaller specialty agencies, and providers addressing the social determinants of health. Funds supported BHCC organization, data analysis, quality oversight, and clinical integration of behavioral and physical health care. Final deliverables included participation in a VBP model with at least one payer. Toward the end of the program, stakeholders reported that the program had spurred development of important VBP capabilities, such as information technology (IT) and analytic infrastructure, and that participants had made progress on governance structures needed for VBP arrangements.

3. **The strategy should assess for systematic differences in quality performance across county behavioral health plans possibly related to differences in local delivery system characteristics or populations served.** These should include differences between plans (e.g., between rural and urban counties) as well as within plans (e.g., differences in performance by race/ethnicity or by provider size). Understanding these patterns of quality performance will be essential for designing VBP models that do not unfairly punish or reward counties for factors beyond their immediate control. Making performance data public can also contribute to the goal of transparency discussed in the previous paragraph.[66]

   A relevant model might be the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) program administered by the New York State Office of Mental Health. PSYCKES uses Medicaid claims and other data sources to systematically assess quality performance of the licensed mental health provider agencies that provide the bulk of care to enrollees with SMI.[67] The program can generate performance reports and identify patients with high levels of utilization for all licensed providers in the state. With consistent assessment of quality measures across the state, a similar approach could be developed for California.

4. **The strategy should expand the breadth of behavioral health quality measures.** Quality measures currently recommended or required by Medicaid, Medicare, or other payers provide a starting point for a behavioral health quality measure strategy. CMS has identified a core set of 20 such measures currently recommended for voluntary reporting by state Medicaid agencies, with reporting to become mandatory in 2024.[68] However, the measures leave large domains of behavioral health practice unexamined.[69] If the quality measures to which Medi-Cal payment is

tied are restricted to certain services (e.g., pharmacological treatment), there will be financial incentives to focus on those services and not others, even though services such as supported employment or housing subsidies may more powerfully affect enrollees' quality of life and recovery outcomes. Measures that cover these services, developed with stakeholder input, will help ensure that payment models value important outcomes beyond adherence to treatment and symptom control.

Another area for measures development is where behavioral health and general health care meet.[70] For instance, developing measures on management of physical health conditions among people with mental health conditions will require alignment of the multiple organizations involved in coordinating this care, including general health care providers, MCPs, and behavioral health providers and plans. Policymakers and advocates have expressed interest in including measures that draw on patient-reported outcomes, although development of these measures and their use in payment models have been challenging. While patient perspectives are valuable, the utility of patient-reported outcomes for SMI populations, particularly those with schizophrenia and psychotic disorders, may be reduced by cognitive and other symptoms.[71] Moreover, no widely accepted methods for designing VBP models that use patient-reported outcome measures exist.[72]

5. **The strategy should include investments in EHRs and other health information technology that will enable consistent quality reporting.** Academic commentators have highlighted the importance of direct investment in information technology and noted the difficulty of supporting extensive information technology investment through FFS payments.[73] To help current providers collect the source data and report quality measures without undue administrative burden, other states have invested extensively in multiyear technical assistance programs and electronic health record systems and upgrades. For instance, states participating in the CCBHC demonstration program created extensive training programs for clinic financial and administrative staff and supported the development of online learning communities, so that staff at different clinics could learn from each other's experiences. New York State supported a Behavioral Health Readiness Network to develop quality measurement capabilities among community behavioral health providers. The most effective way to achieve consistent quality reporting statewide would be to move to a single EHR system. The California Mental Health Services Authority is currently pursuing this strategy through its Semi-Statewide EHR project.[74]

Action 2. Build Analytic Capacity and Expertise in Contracting at the State Level

Another area of shorter-term system development that will inform future decisions is the capacity to analyze data, including claims and other secondary data as well as EHR data, and to develop and manage contracts between behavioral health plans and providers. The authors recommend adding individuals with specialized behavioral health services expertise to DHCS's new Quality and Population Health Management (QPHM) Program.[75] A theme emerging from interviews with state officials was that VBP models require a higher level of oversight by the state than other payment arrangements. While the current burden on the state of auditing specialty behavioral health cost reports will be removed with the FFS payment system, a VBP model would place a different set of responsibilities for oversight and analytic capacity on state agencies and county behavioral health plans. While monitoring FFS systems requires review of claims and maintenance of fee schedules, a VBP model would require greater

capacity to develop, implement, and maintain quality measurement procedures, analyze and compile quality measures, and monitor performance over time. The state would need to help select measures for incentives, risk adjustment model development, and quality benchmarking, among other technical tasks. The state would also need to develop capacity to create robust contract language and analyze and review VBP contracts between MCPs or county behavioral health plans and providers to ensure that they meet regulatory standards. Experience from other states suggests that behavioral health experts should be in the room when these issues are discussed.

Recommendations for a Future with Value-Based Payment Models: Design and Implementation Considerations

In the longer term, California could take four actions to develop VBP models suited for its unique context. First, the state could ensure that models incentivize services for patients with complex needs. Second, it could establish models that give local systems the flexibility to best serve their populations and respond to local conditions. Third, the state could design its models to improve equity and population health and reduce health disparities. And fourth, it could use VBP models to promote delivery system integration. Details on ways to approach each of these actions are provided in the following sections.

Action 1. Incentivize Services for Patients with Complex Needs

VBP models can create incentives for payers and providers to avoid patients who need high-cost services, or to skimp on their care. States where behavioral health services are carved into general medical care have developed financing mechanisms, such as New York's special needs plans, to ensure that such patients receive adequate services. In California, the Medi-Cal specialty behavioral health carve-out provides structural protection for behavioral health financing overall. Within that carve-out, however, VBP models could still create financial incentives for county behavioral health plans to avoid patients with the highest need. Given the role of Medi-Cal MCPs in providing physical health care and non-specialty mental health services to this population, the same could be true for MCPs. The authors recommend several strategies for addressing these issues.

1. **Include high-cost acute services in VBPs while monitoring utilization.** VBPs that include high-cost acute services — that is, emergency department visits and inpatient hospitalizations — create incentives to improve the quality of outpatient care for patients who need high-cost services. At present, for example, inpatient services in institutions for mental disease (IMDs) cannot be reimbursed through Medicaid and therefore cannot be covered through Medicaid VBP models. California plans to propose a waiver of the IMD exclusion, which, if granted, would enable inclusion of a larger share of inpatient psychiatric services within Medi-Cal. The contours of the waiver have, however, yet to be firmed. Moreover, even if it is granted as a statewide mandatory model, the waiver is unlikely to cover IMD facilities that typically have longer lengths of stay, given the likely CMS requirement to maintain a statewide average length of stay of 30 days. Hence, an IMD waiver's effect on the state's ability to include IMD stays in VBP models is difficult to predict.
2. **Monitor for potential signs of cherry-picking.** A main concern raised by interviewees and in the literature is that VBP models can create incentives for plans to cherry-pick their patients — that is, attempt to selectively treat patients for whom they can achieve higher performance at lower cost.[76] Unlike adverse selection, which

disadvantages the payer when higher-need individuals select only certain plans, cherry-picking describes plans' deliberate exclusion of patients with higher needs as a cost-containment strategy. California's behavioral health carve-out limits cherry-picking and adverse selection because responsibility for meeting the behavioral health care needs of the eligible population (enrollees with SMI/SED/SUDs) lies primarily with geographically exclusive behavioral health plans that do not financially compete. The policy of "No Wrong Door," implemented as part of CalAIM, may also remove some of the incentive for MCPs to avoid patients with behavioral health problems by ensuring payment prior to diagnosis and allowing reimbursement for behavioral health services by both MHPs and MCPs, when appropriate.[77] However, cherry-picking could become a concern in ensuring treatment of patients with mild-to-moderate behavioral health conditions by MCPs, as they would have an incentive to shift patients to MHPs or to other MCPs operating in the same county. Explicit criteria for eligibility for behavioral health plan services, as recently specified by DHCS, can help prevent this shifting, but these criteria may leave room for interpretation.

3. **Implement risk mitigation provisions to protect behavioral health plans and providers.** California county officials raised concerns about imposing significant downside risk on county behavioral health plans through VBP models that target payers. Their argument is that behavioral health plans are public institutions with limited budgets to address their policy responsibilities. Financial losses would harm the patients the system is intended to serve. VBP models that incorporate risk mitigation strategies can allay some of these concerns. Strategies that may be used alongside future VBP models in California include partial capitation (payments are a combination of risk-adjusted capitated amounts for specified services and FFS payments for non-specified services), risk corridors (arrangement that limits losses and also profits if actual spending per enrollee falls outside a prespecified corridor around the target amount), variable capitation rates based on enrollee complexity or costs of producing health care, and subcapitation (agreed-upon payments paid by health plans to provider organizations for each person assigned to the provider organization). In addition, *reimbursements that exceed costs* should be considered when VBP models include enrollees who need high-cost services. Providers may need additional financial incentives to enroll people with serious mental illness, especially those with histories of multiple hospitalizations, incarcerations, and episodes of homelessness.

Action 2. Allow for Flexibility in Tailoring Value-Based Payment Models to Local Circumstances

The local delivery system should inform the design of VBP models. States took a variety of approaches to tailor VBP models to local circumstances and to provide time and resources for local systems to prepare. In Pennsylvania, for instance, targets for the proportion of total spending to be paid through VBP models were specified, but many design and implementation details were left to counties. Vermont is taking preliminary steps toward implementation of VBP models, considering system capabilities along the way. Allowing flexibility in the design and implementation of VBP models for behavioral health will be particularly important for California with the wide variation in size and resources across county MHPs. The authors recommend the following approaches to facilitate this process.

1. **Stage implementation of VBPs over time.** A clear timeline for incremental implementation has been important in other states. Unanticipated consequences have required introduction of additional contracting requirements and plan guidance. Starting with upside-only models can

ensure that new payment systems do not disrupt the treatment system during the transition period. The proportion of expenditures expected to flow through VBPs can be increased over time. A staged process starting with pay for reporting of quality measures, like that used in the Vermont Mental Health Case Rate example, was also used in California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program.[78]

2. **Promote development of a "menu" of VBP models.** California should promote development of a variety of VBP models with input from local stakeholders, including SUD and MH provider agencies, MCPs, county behavioral health plans, and other county or regional organizations, to provide flexibility and ensure best fit with local conditions. This strategy could be adapted from that used in Pennsylvania, where BHOs work with counties or groups of counties to develop VBP models; some models could be developed by the state and offered as options to counties, while others could be initiated at the local level and developed in collaboration with the state. The approach would be appropriate for California given its geographic and population diversity. Such an approach would also require considerable investment at the state level in reviewing and monitoring expertise for VBP contracting.

3. **Adjust levels of risk to the size of the covered population.** All providers are not equally able to bear financial risk. The high variability in costs across patients with complex behavioral health needs means that a small number of patients could have a large effect on costs if the treatment population is small. To reduce the likelihood of unintended financial consequences, the degree of risk should be determined mainly on the basis of provider size — that is, size of the active patient population — although payer mix/safety-net status and availability of additional resources may also be considered. A potential initial approach suggested by one interviewee is for small providers to be paid flat fees, medium providers to be paid prospectively with upside risk, and large providers to assume significant downside risk.

Action 3. Address Equity and Population Health Issues in Value-Based Payment Model Designs

VBP models offer opportunities to build accountability for equity and population health into financing systems, but they also involve potential pitfalls. VBP models can be designed with explicit requirements for advancing health equity, through community-based services, tracking of social risk factors in the patient population, and achieving benchmarks related to disparities in access to and quality of care.[79] Quality measures, which tend to be defined for narrow clinical populations, can be defined at the population level.

Potential pitfalls stem from the incentives created by accountability for quality measures when different population groups require more or less effort to achieve equivalent measure performance. This is a particular concern in behavioral health, where disparities in quality of care related to race/ethnicity and other social factors are well documented.[80] VBP models can financially incentivize plans or providers to avoid patients with complex needs rather than seek them out as the most in need. A countervailing concern is that having lower standards for populations most in need creates an inequitable double standard. VBP models can equitably address disparities by stratifying performance by group within the plans or providers being evaluated, or by adjusting for within-provider associations between patient characteristics and quality measure performance.[81] Additional strategies for ensuring adequate payment to providers who care for structurally disadvantaged patients are being examined for use in the Medicare program and could have applications in Medicaid as well.[82]

Action 4. Use Value-Based Payment Models to Promote Delivery System Integration

Interviewees from Massachusetts and Pennsylvania emphasized the opportunity that VBP models present for integrating the delivery system through integration of payment. In California, this may mean creating service bundles that include services provided by different financing systems, such as bundling mental health and primary care services for adults with serious mental illness, or bundling mental health and substance use treatment for adults with co-occurring disorders. Such payment models will require administrative structures for shared accountability for quality of care between MCPs and county MHPs, or between mental health and substance use treatment systems. Efforts to promote integration through payment can also be overly broad, as shown by the lack of uptake of such models by Medicare accountable care organizations.[83]

Conclusion

Under CalAIM, California is undertaking financial reforms of its Medicaid program that will have far-reaching effects on behavioral health care systems in the state. The CalAIM goals of promoting prevention, care integration, patient-centered care, and disparity reduction are at least as important for behavioral health care as they are in general medical care. VBP models may be part of this future and offer the potential to address these goals by allowing MCPs, behavioral health plans, and providers greater flexibility to respond to patients' individual needs and address population health. However, development and implementation of VBP models for Medicaid behavioral health care remains limited, and a strong evidence base to guide policy development and model design does not exist. Consequently, the recommendations in this report focus not on whether VBP models should be adopted in California, but on steps that California policymakers can take in the short and medium term that will improve behavioral health services while also preparing the state for possible future introduction of VBP models. The expertise and experience that California gains over the next few years can put the state in a strong position to make informed decisions.

Appendix A. Methods

This appendix presents details about RAND's research methodology. It includes details on the literature review; selection of the value-based payment (VBP) sample; key interviews with academic experts, state experts, and California stakeholders; and the advisory panel.

Literature Review

The authors reviewed public-facing documents describing the characteristics and impacts of VBPs for specialty mental health care. The review had two goals:

1. Identify evidence about the effects of VBPs for specialty mental health care on quality of care, integration of physical and behavioral health care, health outcomes, and costs.
2. Select a sample of VBPs for in-depth data collection using key-informant interviews.

The authors aimed to capture a broad set of documents, including peer-reviewed scholarly literature, non–peer-reviewed literature (such as white papers by nongovernmental expert organizations), and government documents describing state VBP initiatives. The authors used the following search terms:

> mental health or behavioral health or mental illness or substance use disorder or addiction
>
> *and*
>
> payment reform or alternative payment or value-based payment or pay for performance or shared saving or shared risk or bundled payment or episode-based payment or capitation or global budget
>
> *and*
>
> Medicaid

To identify up-to-date information about the effects of VBPs in states with current VBP initiatives, results were restricted to the last 10 years. To supplement the broader search, the authors also conducted a search in the Cochrane Reviews database, which compiles high-quality systematic reviews that capture results from multiple individual studies, using the same terms and time frame. To results from these searches, the authors added key documents known to behavioral health and VBP experts on the RAND team and academic experts who were interviewed.

Documents were retained that met at least one of the following criteria:

- Provides specific examples of alternative payment models for behavioral health care, with a focus on models that target behavioral health care provider organizations (not primary care clinics, hospitals, or other kinds of provider organizations more broadly).
- Describes evidence about the effect of VBPs for behavioral health care on clinical integration, access, quality, spending, or health outcomes.
- Provides important background or contextual information about VBPs for behavioral health care that would help with the authors' deliverables.

Payment Model Sample Selection

The authors selected payment models for case studies by conducting a literature review to identify VBP initiatives that cover behavioral health treatment in Medicaid and by accepting the recommendations of experts. The authors considered payment models that met two criteria: (1) cover services for people with serious mental illness and/or serious emotional disturbance (SMI/SED) within either specialty mental health systems or systems that provide

care for all types of mental health problems, and that (2) meet the Health Care Payment Learning & Action Network (HCPLAN or LAN) definition of a VBP model. Seven such initiatives were identified. For each initiative, the authors collected descriptive information from published literature and policy documents on the state's Medicaid system prior to the VBP reform, the structure of the VBP model, performance metrics used by the model, barriers and facilitators to the model's implementation, and evidence of impacts. Interviews were then conducted with state officials and other experts familiar with each of the models. Table A1 lists the models and the number of interviewees for each.

Of the seven VBP initiatives, two, in Massachusetts and Oregon, had not yet progressed to implementing the payment models. For each of the five VBP models that had been implemented, the authors conducted more detailed case studies, which are described in the text.

Table A1. State Interviewees

VBP MODEL	INTERVIEWEE TYPE	NUMBER OF INTERVIEWEES
CCBHC	Policy experts*	2
Maryland	Health care provider	1
Massachusetts	State agency	2
New York	State agency	3
Oregon	Expert organization	1
Pennsylvania	BH MCO	1
Vermont	State agency	1
Total		**11**

Source: Author-generated list of interviewees; interviews conducted 2022.

Notes: *BH* is behavioral health. *CCBHC* is Certified Community Behavioral Health Clinic. *MCO* is managed care organization.

* One of the experts on the CCBHC model is the first author of this report, who is a leader of the national evaluation of the CCBHC demonstration project.

Interviews

Interviews were conducted with three groups of key informants: academic experts on VBPs for specialty mental health care, state experts with detailed knowledge of VBP models used in the sample states that were selected, and California stakeholders with expert knowledge of California's specialty mental health care system.

Academic Experts

The authors identified scholarly experts who were known to the RAND team for outstanding research on VBPs. The final sample consisted of five interviewees, including four from research universities and one from a national organization with expertise on mental health and substance use treatment. Topics for the interviews included the state of evidence about specific VBP models, the potential effects of different VBP design choices, and options for preventing possible adverse consequences of VBP.

State Experts

The authors identified experts with detailed knowledge of the VBP models in the sample states based on review of public documents and websites. The final sample consisted of four from state Medicaid agencies and one each from a Medicaid managed care organization (MCO) and a behavioral health care provider. Topics for the interviews included goals and design process for the VBP model; design of the VBP model, including payment mechanisms, services covered, and metrics; experience with implementation, including perceived successes and challenges; and potential lessons for California.

California Stakeholders

The authors identified interviewees with expert knowledge of California's specialty mental health care system based on review of public documents and websites as well as the RAND team's knowledge of California stakeholders. The final sample included nine employees of county behavioral health systems, two employees of the state's Department of Health Care Services (DHCS), one representative from a county association, and one representative from a health plan association (Table A2). Topics for these interviews included the characteristics of local behavioral health systems, such as their relationships with behavioral health care providers and the mix of services they provide; capacity of the behavioral health system to participate in VBP and perceived benefits or drawbacks; and anticipated effects of VBP models on the behavioral health care system.

Table A2. California Interviewees

ORGANIZATION INTERVIEWEES	NUMBER OF INTERVIEWEES
County agency	9
State agency	2
County association	1
Health plan association	1
Total	**13**

Source: Author-generated list of interviewees; interviews conducted 2022.

Analysis of Key Interviews

All interviews were conducted by telephone by at least two researchers, with one person leading the interview and the other taking notes. Interviews were also audio-recorded when interviewees provided consent. The audio recordings were used to enhance the interview notes to ensure fidelity to the original. The entire research team reviewed the notes for each interview and identified themes related to the design and implementation of each VBP model, drawing also on accompanying technical documentation where available. Team members drafted descriptions of the VBP models that were shared across the entire team to ensure accuracy. Themes related to implementation of VBP in other states and in California were identified through group discussion of the interviews. The themes were then described in written form and shared with the group for refinement. Quotations from interviews illustrating the themes were then abstracted from the interview notes and recordings.

Advisory Panel

The authors convened an advisory panel to review preliminary findings from the literature review and key interviews, and to provide feedback to help improve the presentation of findings and recommendations in the final report. The panel consisted of six members, including four representatives of county behavioral health systems, one representative from DHCS, and one representative from a national nongovernmental organization with health care expertise. The authors facilitated two one-hour, virtual advisory panel meetings on July 29 and 30, 2022, each with different members attending, to accommodate their schedules. Two members participated in the first meeting, and four participated in the second.

Endnotes

1. "CalAIM: Our Journey to a Healthier California for All," California Department of Health Care Services, accessed January 16, 2023.
2. Michael E. Porter, "What Is Value in Health Care?," *New England Journal of Medicine* 363, no. 26 (Dec. 2010): 2477–81.
3. *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* (PDF), California Department of Health Care Services, January 2021.
4. "CalAIM: Our Journey," DHCS.
5. Joe Parks et al., eds., *Morbidity and Mortality in People with Serious Mental Illness* (PDF), National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006; and Laura Weiss Roberts et al., "Premature Mortality Among People with Mental Illness: Advocacy in Academic Psychiatry," *Academic Psychiatry* 41, no. 4 (Aug. 2017): 441–46.
6. Elizabeth Reisinger Walker, Robin E. McGee, and Benjamin G. Druss, "Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-Analysis," *JAMA Psychiatry* 72, no. 4 (Apr. 2015): 334–41.
7. Benjamin Lê Cook et al., "A Review of Mental Health and Mental Health Care Disparities Research: 2011-2014," *Medical Care Research and Review* 76, no. 6 (Dec. 2019): 683–710.
8. *Comprehensive Quality Strategy: 2022* (PDF), California Department of Health Care Services, February 4, 2022.
9. "CalAIM: Our Journey," DHCS.
10. *California Advancing and Innovating Medi-Cal (CalAIM): Our Journey to a Healthier California for All* (PDF), California Department of Health Care Services, accessed January 16, 2023.
11. *CalAIM Initiatives Launch Timeline as of February 2022* (PDF), California Department of Health Care Services, updated February 2022.
12. Thomas G. McGuire, "New Financing Models in Behavioral Health: A Recipe for Efficiency or Under-Provision?," in *The Palgrave Handbook of American Mental Health Policy*, ed. Howard H. Goldman, Richard G. Frank, and Joseph P. Morrissey (Cham, Switzerland: Palgrave Macmillan, 2020), 639–57.
13. Megan Dormond and Sara Afayee, *Understanding Billing Restrictions for Behavioral Health Providers* (PDF), Behavioral Health Workforce Research Center, November 2016.
14. Daniëlle Cattel and Frank Eijkenaar, "Value-Based Provider Payment Initiatives Combining Global Payments with Explicit Quality Incentives: A Systematic Review," *Medical Care Research and Review* 77, no. 6 (Dec. 2020): 511–37.
15. Rachel M. Werner et al., *The Future of Value-Based Payment: A Road Map to 2030*, Leonard Davis Institute of Health Economics, February 17, 2021.
16. Werner et al., *The Future of Value-Based Payment*.
17. McGuire, "New Financing Models in Behavioral Health."
18. McGuire, "New Financing Models in Behavioral Health."
19. Donald M. Steinwachs, Kathleen Stratton, and Leslie Y. Kwan, eds., *Accounting for Social Risk Factors in Medicare Payment* (Washington, DC: National Academies Press, 2017).
20. Joshua Breslau et al., "Racial and Ethnic Differences in the Attainment of Behavioral Health Quality Measures in Medicare Advantage Plans," *Health Affairs (Millwood)* 37, no. 10 (Oct. 2018): 1685–92; and Marcela Horvitz Lennon et al., "Where You Live Matters: Quality and Racial/Ethnic Disparities in Schizophrenia Care in Four State Medicaid Programs," *Health Services Research* 50, no. 5 (Oct. 2015): 1710–29.
21. Haekyung Jeon-Slaughter, "Economic Factors in of Patients' Nonadherence to Antidepressant Treatment," *Social Psychiatry and Psychiatric Epidemiology* 47, no. 12 (Dec. 2012): 1985–98.
22. Marcella Horvitz-Lennon, Joshua Breslau, and K. John McConnell, "Association Between the Merit-Based Incentive Payment System and Access to Specialized Behavioral Health Care for Medicare Beneficiaries," *JAMA Health Forum* 3, no. 3 (Mar. 2022): e220219; Karen E. Joynt Maddox et al., "Adjusting for Social Risk Factors Impacts Performance and Penalties in the Hospital Readmissions Reduction Program," *Health Services Research* 54, no. 2 (Apr. 2019): 327–36; and Eric T. Roberts et al., "Assessment of the Effect of Adjustment for Patient Characteristics on Hospital Readmission Rates: Implications for Pay for Performance," *JAMA Internal Medicine* 178, no. 11 (Nov. 2018): 1498–507.
23. Cheryl L. Damberg and Marc N. Elliott, "Opportunities to Address Health Disparities in Performance-Based Accountability and Payment Programs," *JAMA Health Forum* 2, no. 6 (June 2021): e211143.
24. Kathleen Gifford et al., *A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020*, KFF (Kaiser Family Foundation), October 18, 2019.
25. Tricia Leddy, Tricia McGinnis, and Greg Howe, *Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches*, Center for Health Care Strategies, February 2016.
26. "Shared Savings Program: About the Program," CMS.gov, last modified December 15, 2022.
27. "Comprehensive Primary Care Plus," CMS.gov, last updated August 5, 2022.

28. *Comprehensive Primary Care Plus* (CPC+) Round 2 (PDF), CMS.gov, July 10, 2017.

29. Sylvia M. Burwell, "Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care," *New England Journal of Medicine* 372, no. 10 (Mar. 5, 2015): 897–99.

30. Gifford et al., *A View from the States*.

31. Margaret Tatar and Richard Chambers, *Medi-Cal and Behavioral Health Services* (PDF), California Health Care Foundation, February 2019.

32. *Medi-Cal at a Glance: Most Recent Reported Month, April 2022 (Date Represented: January 2022)* (PDF), California Department of Health Care Services, April 2022; and "Medi-Cal Enrollment," California Department of Health Care Services, last modified November 30, 2022.

33. Margaret Tatar and Athena Chapman, *The Medi-Cal Program: An Overview* (PDF), California Health Care Foundation, February 2019.

34. Don Kingdon, Molly Brassil, and Erynne Jones, *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions* (PDF), California Health Care Foundation, August 2016.

35. Tatar and Chapman, *The Medi-Cal Program*.

36. Darren Urada et al., *Drug Medi-Cal Organized Delivery System: FY 2020 Evaluation Report* (PDF), UCLA Integrated Substance Abuse Programs, revised July 9, 2021.

37. Molly Brassil, Carol Backstrom, and Erynne Jones, *Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots* (PDF), California Health Care Foundation, August 2018.

38. "Institution for Mental Diseases List," California Department of Health Care Services, last modified January 6, 2023.

39. Amy Clary and Trish Riley, Braiding & *Blending Funding Streams to Meet the Health-Related Social Needs of Low Income Persons: Considerations for State Health Policymakers*, National Academy for State Health Policy, February 2016; and Don Novo et al., *Maximizing County Behavioral Health Programs in California: A Dollar and Sense Road Map to Meeting State and Federal Requirements* (PDF), Health Management Associates, December 4, 2019.

40. Sarah Arnquist and Peter Harbage, *A Complex Case: Public Mental Health Delivery and Financing in California* (PDF), California HealthCare Foundation, July 2013.

41. Arnquist and Harbage, *A Complex Case*; and Carolyn L. Yocom (director, Health Care, US Government Accountability Office) to Ron Johnson (chair, Committee on Homeland Security and Governmental Affairs, US Senate), Medicaid: Primer on Financing Arrangements (PDF), July 14, 2020.

42. *CalAIM Proposal*, DHCS.

43. A "carve-out" refers to a system where behavioral health financing is separated from financing for general health care. A "carve-in" is a system where financing for behavioral and general health care are integrated.

44. Andrew D. Carlo et al., "Association of Alternative Payment and Delivery Models with Outcomes for Mental Health and Substance Use Disorders: A Systematic Review," *JAMA Network Open* 3, no. 7 (July 2020): e207401.

45. Heather Beil et al., "Behavioral Health Integration with Primary Care: Implementation Experience and Impacts from the State Innovation Model Round 1 States," *Milbank Quarterly* 97, no. 2 (June 2019): 543–82.

46. Beil et al., "Behavioral Health Integration with Primary Care."

47. Melissa Bailey, Rachael Matulis, and Kelsey Brykman, *Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations* (PDF), Center for Health Care Strategies, September 2019; Joshua Barrett et al., "Value-Based Payment as Part of a Broader Strategy to Address Opioid Addiction Crisis," *Health Affairs Forefront*, December 1, 2017; Robert Belfort and Adam Striar, *Paying for Value in Behavioral Health: What California Can Learn from Other States' Medicaid Programs* (PDF), California Health Care Foundation, February 2020; and Amanda Mauri et al., *Payment Reform and Opportunities for Behavioral Health: Alternative Payment Model Examples* (PDF), The Kennedy Forum, September 2017.

48. J. Brown et al., "Implementation and Costs of the Certified Community Behavioral Health Clinic Demonstration," *Health Services Research* 55, suppl. 1 (Aug. 2020): 100–101; and Yuanyuan Hu et al., "A Brief Report on Certified Community Behavioral Health Clinics Demonstration Program," *Social Work in Mental Health* 19, no. 6 (2021): 534–41.

49. Joshua Breslau et al., "Evaluation Design Recommendations for the Certified Community Behavioral Health Clinic Demonstration Program," *RAND Health Quarterly* 6, no. 3 (June 2017): 7.

50. Brown et al., "Implementation and Costs of the CCBHC Demonstration."

51. Joshua Breslau et al., *Preliminary Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration*, Mathematica, September 2020; and Allison Wishon Siegwarth et al., *Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration*, Office of the Assistant Secretary for Planning and Evaluation (ASPE), US Department of Health and Human Services, September 11, 2020.

52. Breslau et al., *Preliminary Cost and Quality Findings*.

53. Robert R. Neall (secretary, Maryland Department of Health) to Nancy J. King (chair, Senate Budget and

Taxation Committee) and Maggie McIntosh (chair, House Appropriations Committee), Report on the Baltimore City Capitation Project (PDF), November 26, 2019.

54. "Value Based Purchasing," Pennsylvania Department of Human Services, accessed January 17, 2023.
55. Piper A. Ranallo et al., "Behavioral Health Information Technology: From Chaos to Clarity," *Health Affairs (Millwood)* 35, no. 6 (June 2016): 1106–13.
56. Lauren Niles and Serene Olin, *Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care* (PDF), National Committee for Quality Assurance (NCQA), May 2021.
57. "Behavioral Health/Health and Recovery Plan (HARP): Value Based Payment Quality Measure Set, Measurement Year 2020," New York State Department of Health, revised February 2020.
58. *Behavioral Health Value Based Payment Readiness Program Deliverables* (PDF), New York State Department of Health, Office of Mental Health, September 15, 2017.
59. Deborah Cohen, "Effect of the Exclusion of Behavioral Health from Health Information Technology (HIT) Legislation on the Future of Integrated Health Care," *Journal of Behavioral Health Services & Research* 42, no. 4 (Oct. 2015): 534–39; and Ranallo et al., "Behavioral Health Information Technology."
60. Timothy Stoltzfus Jost, "Appendix B: Constraints on Sharing Mental Health and Substance-Use Treatment Information Imposed by Federal and State Medical Records Privacy Laws," in *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series* (Washington, DC: National Academies Press, 2006); and Jane Hyatt Thorpe and Elizabeth Alexandra Gray, "Big Data and Ambulatory Care: Breaking Down Legal Barriers to Support Effective Use," *Journal of Ambulatory Care Management* 38, no. 1 (Jan. 2015): 29–38.
61. *2022–2026 Arizona Health Care Cost Containment System: Health IT Strategy – History and Future* (PDF), Arizona Health Care Cost Containment System (AHCCCS), accessed January 17, 2023; and "Health Information Exchange - Providers," Pennsylvania Department of Human Services, accessed January 17, 2023.
62. *Comprehensive Quality Strategy*, DHCS; and "Adult Health Care Quality Measures," Medicaid.gov, accessed January 16, 2023.
63. Sherri Rose, Alan M. Zaslavsky, and J. Michael McWilliams, "Variation in Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking," *Health Affairs (Millwood)* 35, no. 3 (Mar. 2016): 440–48.
64. "Appendix C: MCO Comparison Results" (PDF), in *2020 Comparative and Regional Analysis Report*, Washington Health Care Authority, 2020; "Quality Compass®: Benchmark and Compare Quality Data," National Committee for Quality Assurance, accessed January17, 2023; So O'Neil and Ella Douglas-Durham, Determining Performance Benchmarks for a Medicaid Value-Based Payment Program (PDF), Medicaid.gov, January 31, 2018; and Karen Onstad et al., *Benchmarks for Medicaid Adult Health Care Quality Measures* (PDF), Medicaid.gov, November 2014.
65. *New York State Behavioral Health Value Based Payment Readiness Program Overview* (PDF), New York State Department of Health, Office of Mental Health, September 15, 2017.
66. Damberg and Elliott, "Opportunities to Address Health Disparities."
67. Thomas Uttaro et al., "Reduction of Concurrent Antipsychotic Prescribing Practices Through the Use of PSYCKES," *Administration and Policy in Mental Health and Mental Health Services Research* 34, no. 1 (Jan. 2007): 57–61.
68. *June 2020 Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission (MACPAC), June 2020; and Bonnie T. Zima, "U.S. Child Behavioral Health Quality Measures: Advancing a National Research Agenda," *Journal of Abnormal Child Psychology* 48, no. 6 (June 2020): 745–56.
69. Harold Alan Pincus et al., "Quality Measures for Mental Health and Substance Use: Gaps, Opportunities, and Challenges," *Health Affairs (Millwood)* 35, no. 6 (June 2016): 1000–1008; and Milesh M. Patel et al., "The Current State of Behavioral Health Quality Measures: Where Are the Gaps?," *Psychiatric Services* 66, no. 8 (Aug. 2015): 865–71.
70. Matthew L. Goldman et al., "Quality Measures at the Interface of Behavioral Health and Primary Care," *Current Psychiatry Reports* 18, no. 4 (Apr. 2016): 39; and Matthew L. Goldman, Brigitta Spaeth-Rublee, and Harold Alan Pincus, "Quality Indicators for Physical and Behavioral Health Care Integration," *JAMA* 314, no. 8 (Aug. 2015): 769–70.
71. Hiroyoshi Takeuchi, Gagan Fervaha, and Gary Remington, "Reliability of a Patient-Reported Outcome Measure in Schizophrenia: Results from Back-to-Back Self-Ratings," *Psychiatry Research* 244 (Oct. 2016): 415–19.
72. Dana Gelb Safran, "Feasibility and Value of Patient-Reported Outcome Measures for Value-Based Payment," *Medical Care* 57, no. 3 (Mar. 2019): 177–79; and Lee Squitieri, Kevin J. Bozic, and Andrea L. Pusic, "The Role of Patient-Reported Outcome Measures in Value-Based Payment Reform," *Value in Health* 20, no. 6 (June 2017): 834–36.
73. Douglas A. Conrad, "The Theory of Value-Based Payment Incentives and Their Application to Health Care," *Health Services Research* 50, no. S2 (Dec. 2015): 2057–89.
74. "Semi-Statewide EHR," California Mental Health Services Authority, accessed January 16, 2023.
75. *Comprehensive Quality Strategy*, DHCS.
76. McGuire, "New Financing Models in Behavioral Health."

77. Shaina Zurlin (chief, Medi-Cal Behavioral Health Division, California Department of Health Care Services) to California behavioral health associations, opioid maintenance providers, county behavioral health directors, and county drug and alcohol administrators, Behavioral Health Information Notice No. 22-011: No Wrong Door for Mental Health Services Policy (PDF), March 31, 2022.

78. Nadereh Pourat et al., *Preliminary Summative Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program* (PDF), UCLA Center for Health Policy Research, February 2021.

79. Werner et al., *The Future of Value-Based Payment*.

80. Andrea Acevedo et al., "Disparities in the Treatment of Substance Use Disorders: Does Where You Live Matter?," *Journal of Behavioral Health Services & Research* 45, no. 4 (Oct. 2018): 533–49; Breslau et al., "Racial and Ethnic Differences"; and Marcela Horvitz Lennon et al., "Disparities in Quality of Care Among Publicly Insured Adults with Schizophrenia in Four Large U.S. States, 2002–2008," *Health Services Research 49*, no. 4 (Aug. 2014): 1121–44.

81. "Stratified Reporting," CMS.gov, last modified December 22, 2022; Damberg and Elliott, "Opportunities to Address Health Disparities"; and Roberts et al., "Assessment of the Effect of Adjustment."

82. Steven Sheingold et al., "Should Medicare's Value-Based Pricing Be Adjusted for Social Risk Factors? The Role of Research Evidence in Policy Deliberations," *Journal of Health Politics, Policy and Law* 43, no. 3 (June 2018): 401–25.

83. Valerie A. Lewis et al., "Few ACOs Pursue Innovative Models That Integrate Care for Mental Illness and Substance Abuse with Primary Care," *Health Affairs (Millwood)* 33, no. 10 (Oct. 2014): 1808–16.