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Joint Informational Hearing –
Senate Health Committee and Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services

Progress Reforming Medi-Cal's Behavioral Health Services Through the CalAIM Behavioral Health Initiative

March 13, 2024 – 1:30 p.m.
1021 O Street, Room 1200

This hearing of the Senate Health Committee and Senate Budget Subcommittee No. 3 on Health and Human Services will provide an overview of the California Advancing and Innovating in Medi-Cal (CalAIM) Behavioral Health Initiative. According to the Department of Health Care Services (DHCS), the behavioral health components of CalAIM are designed to support whole-person, integrated care; move the administration of Medi-Cal behavioral health to a more consistent and seamless system by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through improvements to behavioral health policies and the launch of behavioral health payment reform. The majority of these policy changes launched in 2022, with behavioral health payment reform going live July 1, 2023, and implementation of other CalAIM components continuing through 2027. This hearing will include representatives from DHCS who will provide updates as to how the initiative is progressing, focusing on efforts to simplify the administration of the Medi-Cal behavioral health system and payment reform. This hearing will also include the perspectives of counties, providers, and health care consumers to evaluate the successes and challenges of this initiative to determine the impacts on access to Medi-Cal behavioral health services.

Background

I. Provision of Behavioral Health Services in Medi-Cal

SBX1 1 (Hernandez), Chapter 4, Statutes of 2013, First Extraordinary Session, requires Medi-Cal managed care (MCMC) plans to provide services for mild-to-moderate impairment of mental, emotional, or behavioral health functioning. As a result, Medi-Cal mental health benefits are now delivered through two separate systems and under a separate statutory framework from the drug Medi-Cal benefit. County mental health (MH) plans provide a broad range of specialty services to individuals with more severe mental illnesses, while MCMC plans provide nonspecialty services (generally known as mental health services for those with mild-to-moderate mental illness). The delivery of specialty services through county mental health plans is commonly referred to as a "carve out," which is when

services covered by the Medi-Cal program are delivered outside of an MCMC plan. Specialty services are provided under a federal 1915(b) waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. MCMC plans provide individual and group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated and medically necessary to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; outpatient laboratory, drugs, supplies and supplements; and psychiatric consultation. In addition, for the small number of individuals on Medi-Cal not enrolled in a MCMC plan, the same services that are provided by MCMC plans are available through the fee-for-service delivery system.

Similar to specialty mental health services, the Drug Medi-Cal (DMC) program is also carved out of MCMC plan coverage. The scope of DMC services varies by county depending upon whether the county opted-in to the state's DMC Organized Delivery System (DMC-ODS). In August 2015, DHCS received approval from the Centers for Medicare and Medicaid Services to implement the DMC-ODS waiver, and counties could opt into participating. The DMC-ODS is a pilot project authorized originally under California's Section 1115 Bridge to Reform Demonstration Waiver, continued in the Medi-Cal 2020 Waiver, and was renewed again with the CalAIM waiver. The purpose of the pilot program is to test a new paradigm for organized delivery of health care services for Medicaid beneficiaries with a substance use disorder. DMC-ODS waiver services include the four existing Drug Medi-Cal treatment modalities (Narcotic Treatment Program, Residential Treatment Services, Outpatient Drug-Free Treatment Services, and Intensive Outpatient Treatment Services), and additional new and expanded county optional services. Counties that opted into the DMC-ODS waiver are required to provide a continuum of care to all eligible beneficiaries modeled after criteria developed by the American Society of Addiction Medicine.

Through reforms implemented in the 1991 and 2011 Realignments, counties are responsible for the non-federal share of specialty mental health and DMC services provided to most Medi-Cal beneficiaries. Until July 2023, counties provided for the delivery of services and submitted expenditure reports to DHCS to receive federal matching funds. Claims were paid to counties on an interim basis, pending cost reporting after the end of the fiscal year. DHCS reconciled the interim payments made to counties with the submitted cost reports and recouped from counties that received excess interim payments or made additional payments to counties that received insufficient interim payments. In addition, DHCS audited each cost report, which could result in additional adjustments. Counties were permitted to appeal audit findings, which could lead to still more adjustments to reimbursements. The cost-based reimbursement structure for behavioral health services often took several years to resolve, leading to uncertainty for county behavioral health system financing.

Medi-Cal beneficiaries must demonstrate medical necessity to be eligible to receive specialty mental health services or substance use disorder services from county service delivery systems. State law defines a service as medically necessary for individuals 21 years of age and older when it is reasonable and necessary to protect life, to prevent significant illness or significant disability. For individuals under 21 years of age, state and federal law mandate that a service is medically necessary if the service is necessary to correct or ameliorate mental illnesses and conditions.

II. *Behavioral Health Needs of Medi-Cal Beneficiaries*

According to DHCS's most recently published statewide aggregate behavioral health services report regarding the receipt of specialty mental health services, the rates of use by both adults and children declined in 2019-2021 to lower than the rates in fiscal year 2017-2018.[1] According to a November 2020 report by the California Health Care Foundation, *Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal*[2], only 3.3% of adults enrolled in MCMC plans in 2017-2018 received mental health services from the plan – up from just 2% when the benefit was first introduced in 2014. Even when combined with the 3.8% of adult Medi-Cal beneficiaries receiving specialty mental health services, the total percentage is still far less than the estimated prevalence of adults having any mental illness in California at 17.9%. Furthermore, Medi-Cal mental health access rates vary significantly by race and ethnicity, with some groups accessing services at much higher rates than others. Black Medi-Cal enrollees use specialty mental health services at the highest rate of all racial and ethnic groups (7.4%) but use MCMC plan mental health services at a much lower rate than white enrollees, which suggests they may not be getting treatment until conditions have worsened. Latinx and Asian/Pacific Islander Medi-Cal enrollees access mental health services at the lowest rates of all racial and ethnic groups in both MCMC plans and county MH plans, despite high reported prevalence rates for certain subpopulations, particularly among refugee populations who have high trauma incidence. In addition, looking at the number of mental health services per 1000 enrollees, white enrollee are receiving more than double the services of any other racial/ethnic group from the MCMC plans.
A 2021 report by the California Pan Ethnic Health Network[3] reviewing DHCS data found that Medi-Cal members whose preferred written language is not English are less likely to receive mental health services from the MCMC plans. Finally, communities of color also do not receive follow up care from MCMC plans; with Asian/Pacific Islander and Latinx members being the least likely to receive five or more non-specialty mental health services from their MCMC plans, even though treatment for depression typically requires more than five sessions.

More recently, the California State Auditor released an audit report in November 2023 finding that both the MCMC plans and the county MH plans were failing to provide timely access to behavioral health services for children enrolled in Medi-Cal.[4] The report found inadequate monitoring and enforcement of both timely access and network adequacy standards resulting in long delays for children needing services.

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[1] DHCS's mental health dashboard data is available here: https://www.dhcs.ca.gov/services/MH/Pages/MHS-Performance-Dashboard-Reports-and-Data.aspx, with additional data sets available here: https://behavioralhealth-data.dhcs.ca.gov/ The most recent statewide children's report is https://www.dhcs.ca.gov/services/MH/Documents/CYOUTH-Statewide-Aggregate-Report-April-2022.pdf and the most recent adult report is https://www.dhcs.ca.gov/services/MH/Documents/ADULT-Statewide-Aggregate-Report-April-2022.pdf.

[2] https://www.chcf.org/publication/mental-health-disparities-race-ethnicity-adults-medi-cal/

[3] *Medi-Cal Managed Care Plan Mental Health Services: An Unfulfilled Promise for Communities of Color.* Available at https://cpehn.org/assets/uploads/2021/09/Medi-Cal-Managed-Care-Plan-Mental-Health-Services_September-2021-1.pdf.

[4] *Department of Health Care Services and Department of Managed Health Care: Children Enrolled in Medi-Cal Face Challenges in Accessing Behavioral Health Care,* audit report number 2023-115, available at https://auditor.ca.gov/reports/2023-115/index.html#section3

III. CalAIM

During the fall of 2019, the Administration released a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, known as the CalAIM initiative. Due to the pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. CalAIM was funded through the 2021 Budget Act and statutory language developed via Senate and Assembly bills was added to the 2021 health trailer bill AB 133 (Committee on Budget, Chapter 143, Statutes of 2021). CalAIM is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, Medi-Cal 2020, and CalAIM incorporates many of these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for MCMC plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity. CalAIM transitioned many of Medi-Cal's existing programs into managed care benefits under a new 1915(b) waiver, maintained some programs under the previous 1115 waiver authority, and made other changes through amendments to the State Plan. The federal Centers for Medicare and Medicaid Services approved California's 1115 waiver and 1915(b) waiver applications implementing CalAIM reforms on December 29, 2021. Both waivers were approved until December 31, 2026.

IV. The CalAIM Behavioral Health Initiative

The CalAIM Behavioral Health Initiative seeks to address several challenges the Medi-Cal behavioral health services system was facing due to its overly complicated structure. In addition to the payment challenges the counties faced described above, providers also reported excessive documentation requirements and consumers reported not being able to access either the nonspecialty services available through the MCMC plans or the specialty services available through the counties, often due to lack of clarity as to which delivery system to turn to.

A. Payment reform and changes to coding system

As mentioned above, the cost-based reimbursement utilized by the counties and DHCS to reimburse county MH plans for specialty mental health services was administratively burdensome for DHCS, counties, and subcontracted behavioral health providers. The complexity of the cost settlement process created significant audit risk and audit timelines created budget challenges for counties by requiring them to carry financial risk over multiple years. As of July 1, 2023, the county MH plans have shifted to a fee-for-service reimbursement structure to create more certainty around reimbursement rates to counties and ultimately providers. The following chart illustrates the key differences between the

previous cost-based reimbursement methodology and the current fee-for-service reimbursement methodology[5]:

Cost-Based Reimbursement	Fee-for-Service Reimbursement
County MH plans claim federal reimbursement on an interim basis foreach service rendered.	County MH plans claim reimbursement at rates established in MH plan fee schedule.
Counties and their contracted providers submit annual cost reports subject to audit, reconciliation, and cost settlement.	MH plans negotiate payment terms and rates with subcontracted providers.
MH plan reimbursement is limited to cost. Provider payments are negotiated with MH plans.	MH plans reimbursement for each service is final, with no additional settlement to cost for MH plans.
MH plans purchase specialty services and attest to expenditures of non-federal share under a Certified Public Expenditure (CPE) protocol.	Reimbursement is claimed via the fee schedule with the county share transferred by the county to the State.
CPE-based financing is based on actual costs incurred and requires cost reporting, audit, and settlement to finalize federal reimbursement to MH plans.	Sources of non-federal share available to county MH plans and eligible for use as IGTs (including Realignment and MHSA funds) do not change.

In addition to the payment system, the medical coding system also changed at the same time. Previously, DHCS and counties were using Healthcare Common Procedure Coding System (HCPCS) level II codes. With the implementation of payment reform they transitioned to using Current Procedural Terminology (CPT) coding where such codes exist. This transition moves counties from a system with dozens of billable codes that could capture a variety of activities to a system with hundreds of codes with more detailed and standardized definitions. Thisallows counties and DHCS to have more granular data on delivery of care. This change also aligns the Medi-Cal behavioral health delivery systems billing done by MCMC plans and commercial payers and complies with federal requirements for all state Medicaid programs to adopt CPT codes where appropriate.

The timing of these payment and coding transitions was not without friction. The rates were not all finalized by DHCS until the month prior to the July 1, 2023 implementation date leaving little time for counties to negotiate provider rates. Providers in some counties have stated that the rates offered by the counties are too low for them to stay in business, while counties maintain that the new system promotes efficiency and serving more Medi-Cal patients. Both counties and DHCS indicate that they are monitoring the impact of payment reform.[6]

B. No wrong door and updates to medical necessity criteria

On July 1, 2022, DHCS implemented the “no wrong door" policy to ensure Medi-Cal beneficiaries receive mental health services regardless of the delivery system where they seek care (via county behavioral health, MCMC plan, or the fee-for-service delivery system). This policy allows members who directly access a treatment provider to receive an assessment and mental health services, and to have that

[5] Adopted from DHCS’s FAQ available at https://www.dhcs.ca.gov/Documents/CalAIM-BH-Payment-Reform-Fact-Sheet.pdf

[6] *See e.g. CalMatters December 2021, 2023 article,* Mental Health Programs that Served Hundreds of Kids to Close After California Payment Changes, *available at* https://calmatters.org/health/2023/12/mental-health-programs-cuts/ .

provider reimbursed for those services by their contracted plan, even if the member is ultimately transferred to the other delivery system due to their level mental health needs. In certain situations, Medi-Cal beneficiaries may receive coordinated, non-duplicative services in multiple delivery systems, such as when a member has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other. DHCS also clarified that patients with co-occurring mental health and substance use disorder conditions may be treated by providers in each of the behavioral health delivery systems, as long as the covered services are not duplicative and meet specified requirements for contracting and claiming.

In a related effort, DHCS also updated and clarified the responsibilities of county MH plans, including updates to the medical necessity criteria for access to specialty services, both for adults and members under age 21 through BHIN 21-073[7] as of January 1, 2022. These criteria were developed based on feedback from stakeholders in order to improve members' access to services and reduce provider administrative burdens. Such clarity around when services met the medical necessity standard for specialty services should reduce the experience some Medi-Cal beneficiaries had in being turned away by both their MCMC plans and the county specialty services.

C. Documentation redesign and Screening and Transition of Care tools

In April 2022, DHCS published streamlined behavioral health documentation requirements for substance use disorder and specialty mental health services to align more closely with the Centers for Medicare and Medicaid Services' national coding standards and physical health care documentation practices. These standards were updated in November 2023 via BHIN 23-068[8] and are effective as of January 1, 2024. These standards do not apply to behavioral health services in Fee-for-Service and Medi-Cal managed care delivery systems. The standards also do not apply to some subsets of substance use disorder and specialty mental health services, primarily inpatient and residential services and methadone services.

The updated policy aims to do the following: standardize assessment requirements; standardize the categories of information that are captured in an assessment; standardize the problems identified in the assessment (e.g. symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters); standardize the treatment progress note format; standardize the requirements for care planning; and standardize the documentation of telehealth services. Such standardization is intended to both reduce the amount of documentation required by providers of specialty mental health and substance use disorder services, and to ensure that providers working in more than one county are asked to provide the same type of documentation for the same services. Prior to the implementation of this policy, county standards could vary considerably as counties themselves did not have clarity as to what was required by DHCS and interpreted the existing documentation requirements differently.

In a related effort, DHCS also created standardized screening tools for adults and youth in order to determine the most appropriate Medi-Cal mental health delivery system (e.g., county MH plan or

[7] https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf

[8] https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf

MCMC plan) for members who are not currently receiving mental health services when they contact the MH or MCMC plan seeking mental health services, as well as a transition of care tool for the transition of services between delivery systems or when adding a service from the other delivery system to their existing mental health treatment. The guidance regarding these tools is available in APL 22-028[9] for the MCMC plans and BHIN 22-065[10] for the county MH plans. According to DHCS, the purpose of these tools is to guide referrals of adult and youth beneficiaries to the appropriate Medi-Cal mental health delivery system and ensure that beneficiaries requiring transition between delivery systems receive timely coordinated care.

D. Administrative integration

In addition to the abovementioned efforts that have already been implemented, the CalAIM Behavioral Health Initiative also includes plans to require counties to combine the administration of specialty mental health and substance abuse disorder services into one, integrated specialty behavioral health program by January 1, 2027, with a voluntary early integration scheduled for January 1, 2025. While this hearing will not focus this ongoing planning process, DHCS did release a concept paper in January 2023[11] and an early integration workgroup is in progress.

Issues for Consideration

1. With regards to payment reform, how are DHCS and the counties monitoring the impact of reform on Medi-Cal beneficiaries' access to care? In other words, is access to providers and services increasing or decreasing? Does DHCS anticipate making further changes to the rates?
2. Are the various efforts to simplify payment and documentation increasing the amount of time that providers can spend on patient care? Are there further efforts that could decrease the documentation burden?
3. Are the efforts around "no wrong door" and the streamlining of assessment and treatment helping Medi-Cal beneficiaries access behavioral health services in a more timely fashion? Are there further efforts that could decrease wait times?

[9] https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-028.pdf
[10] https://www.dhcs.ca.gov/Documents/BHIN-22-065Adult-and-Youth-Screening-and-Transition-of-Care-Tools-for-Medi-Cal-MHS.pdf
[11] https://www.dhcs.ca.gov/Documents/Concept-Paper-for-Behavioral-Health-Administrative-Integration-January.pdf