



# Carpe Diem: Behavioral Health Transformation for 2020 and Beyond

Prepared for CaIMHSA by:

John Freeman and Karen Linkins, PhD

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## Overview

In recognition of the need for county behavioral health to be part of preparation for California's next Medicaid waivers, as well as other initiatives, CalMHSA contracted with John Freeman and Karen Linkins, with Integrated Behavioral Health Partners (IBHP), to draft the attached road map of potential transformation strategies. The topics in the paper are all framed as part of an overall effort to transform treatment and prevention services and better meet the needs of individuals living with behavioral health disorders. We are hoping you can review this document and provide feedback to us by August 6<sup>th</sup>.

With the upcoming 1115 and 1915 waivers, California should take the opportunity to make infrastructure and service delivery investments to achieve better care, better health, and better costs for people experiencing behavioral health disorders. The following transformation efforts should all be considered as part of these waivers, as well as potential state plan amendments and other initiatives. Each of these should be available for all 58 of California's counties, with consideration of regional and small county conditions.

1. **Integrated Managed Care Contracting:** Establish county options to move to integrated managed care contracting for health and behavioral health care services, including multi-county arrangements
2. **Value-Based Purchasing:** Establish and support behavioral health payment models, such as case rates, that support provider excellence and payment for value
3. **Infrastructure for Behavioral Health Promotion:** Establish the infrastructure to promote behavioral health to address the financial and human costs of under-reporting and undertreatment of illness
4. **Peers/Non-Licensed Providers:** Establish statewide certification and billing standards for peers and other non-licensed providers in health and behavioral health service settings, and require that these providers be part of any waiver-funded services
5. **Workforce Retention:** Establish statewide workforce retention reporting standards and require waiver-funded projects to explicitly include retention efforts
6. **Supported Employment:** Establish opportunities for providing evidence-based supported employment services as behavioral health services
7. **IMD Exclusion:** Establish budget-neutral opportunities for a waiver of the IMD payment exclusion for mental health services
8. **Reporting and Documentation Burden:** Establish contracting and payment models that align provider payment and incentives with reporting and documenting the delivery of better care, better health, better costs, and better provider satisfaction

By design, this document is intended to initiate a conversation among key stakeholders (such as you!) to elicit critical feedback on the proposed approaches in terms of feasibility, priority, and the overall will to pursue them. The intent is to continue to support the transformation of care to better meet the needs of individuals living with behavioral health disorders. Please read on and then provide feedback by email to [Wayne.Clark@calmhsa.org](mailto:Wayne.Clark@calmhsa.org) and [john@ibhpartners.org](mailto:john@ibhpartners.org).

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## Introduction

California's county-based behavioral health systems are at a crossroads. Today, more than ever, the central importance of behavioral health is broadly recognized as a vital component of achieving and maintaining health and wellness and managing the total cost of care. CMS administrators, health plans, hospitals, employers, county supervisors, city council members, law enforcement -- frankly all community members and stakeholders --are looking with eager expectation to the behavioral health community.

It has been more than a decade since it was established that people with behavioral health disorders die 25 years earlier than the general population. While there have been many changes in physical and behavioral health care since that time, little progress has been made to reduce this disparity. Efforts to change care delivery, while laudable, continue to miss the mark in terms of improved health and behavioral health outcomes:

- Nearly two thirds of California adults experiencing a mental illness did not receive treatment in the last year
- One in three California adults who report a major depressive episode did not receive treatment
- One in five adults experiences a mental health issue in any given year and one in 25 live with a serious mental illness
- One in 10 young people experience a major episode of depression in any given year but less than a third of them received treatment in California
- California's suicide rate in 2016 was 12.1 per 100,000 and more than 50% had no known mental health condition
- 12.7% of adults live with substance dependence or abuse
- 18% of adults live with anxiety disorders
- 7% of adults live with major depression
- 25% of homeless adults staying in shelters live with serious mental illness
- Risks to mental health impact individuals at every stage of the life course, from the early years, through adolescence, as young adults and adults, and as parents and older adults

To better advance the transformation efforts needed to meet the ever-increasing expectations of behavioral health services, the behavioral health field needs to clearly delineate key problems and unmet needs as well as the program, service, and/or infrastructure developments that will address those obstacles. To simplify matters, it makes sense to look to the Institute for Healthcare Improvement's "Triple Aim" (Better care, better health, better costs) and to the emerging Quadruple Aim which adds the critical goal of improving the work life of health care providers. As California explores the way forward in health services with an eye toward 2020 and beyond (including behavioral health!), it seems reasonable to ensure that activities actively promote the quadruple aim, or at least address barriers to accomplishing it.

## Quick Note on Waivers and State Plan Amendments

Medicaid waivers are a way for states to customize their Medicaid programs. Waivers give States the option to waive Federal requirements, such as for eligibility, comparability of services; and statewideness. Waivers can address single narrow issues, broad and expansive issues, and/or multiple issues and goals. Getting a waiver approved requires negotiation with the Centers for Medicare and Medicaid Services (CMS) – and much more. State plan amendments are generally more administrative modifications, offering the simplest way for states to change programs, but they cannot go beyond what is explicitly authorized in statute. There are a range of authorities that waivers can be requested under, but the most applicable for purposes here are:

- Section 1115 Medicaid Research & Demonstration Waivers – such as California’s current Medi-Cal 2020 Demonstration waiver, which includes Whole Person Care and Drug Medi-Cal Organized Delivery System (DMC-ODS). These waivers can be statewide, and they may include a menu of options for portions of a state to pursue or not (like Whole Person Care or DMC-ODS). The idea behind 1115 waivers is to pilot and test things, with requirements to achieve certain targets and deliver outcomes.
- Section 1915(b) Managed Care Waivers – such as the Medi-Cal Specialty Mental Health Services Waiver, which allows California to mandate enrollment into County Mental Health Plans.
- 1915(c) Home and Community-Based Services Waivers – which allows the state to offer services not otherwise available through Medi-Cal to serve people (including individuals with developmental disabilities) in their homes and communities.
- 1915(c), 1915(i), and 1915(k) are other waivers related to Home and Community-Based Services that may also be relevant for the topics discussed below.

The following table, adapted from MACPAC, shows a comparison of the approval process and requirements for state plan amendments and key Medicaid waivers. MACPAC has much more detail and information at: <https://www.macpac.gov/subtopic/waivers>

	Typical State Plan Amendment (SPA)	§1115	§1915(b)	§1915(c)
<b>Public review</b>	Public notice for certain changes in reimbursement	Robust public process required, additional requirements added by the ACA	Public process encouraged; tribal input required	Public process encouraged; tribal input required
<b>Federal budget requirements</b>	No budget neutrality requirement; report expected fiscal impact	Budget neutrality required	Cost effectiveness required	Cost neutrality required
<b>Approval Time</b>	90-day clock	No required timeframe	90-day clock	90-day clock
<b>Monitoring and Evaluation</b>	Standard Medicaid requirements for CMS to ensure state plan compliance	Annual state reports required; evaluations required	Must monitor access; independent assessment required	Annual state reports required
<b>Approval period</b>	Indefinite	Initially approved for five years	Initially approved for 2 years (up to 5 years if dual eligibles included)	Initially approved for 3 years (up to 5 years if dual eligibles included)
<b>Renewal</b>	Not required	Customarily up to three years (up to five years if dual eligibles included)	Customarily up to two years (up to five years if dual eligibles included)	Customarily up to five years

# 1. Integrated Managed Care Contracting

*Establish county options to move to integrated managed care contracting for health and behavioral health care services, including multi-county arrangements*

California should follow national trends and pursue integrated managed care contracting. Across the United States, there has been a proliferation of initiatives integrating health and behavioral health using 1115 Medicaid waivers, as well as new opportunities created through the Affordable Care Act (ACA). California's current 1115 waiver, Medi-Call 2020, demonstrates the state's commitment to ensuring that counties interested in advancing integration have access to the federal resources to support these efforts. To make further progress in advancing integration, California should look very closely at other states, particularly Washington, for models of integrated managed care contracting. The state should explore providing counties with a flexible and accountable range of options and timing, the most transformative of which would be immediately moving toward fully "carving in" behavioral health funding with managed care health contracting by county or region. Counties could also be given the option to consolidate their behavioral health contracting with the state, moving to Behavioral Health Organizations (BHOs), even if not moving to integrated managed care contracting. For those counties where the above two options don't make sense for various reasons, they could opt to continue to expand the integration and coordination of health and behavioral health services.

In general, county options could be as follows:

1. Full Integration: Opt in to one-county or multi-county integrated health and behavioral health managed care plans.
2. Behavioral Health Integration: Opt in to one-county or multi-county Behavioral Health Organization (BHO) with combined mental health and substance use disorder funding that is separate from health care funding to Managed Care Organizations.
3. Expand Integration: Opt to maintain current progress on integrating and coordinating health and behavioral health care with more robust requirements for MCOs and counties to coordinate care and achieve outcomes.

Obviously, there are many federal, state, regional, county, and local hoops that would need to be identified and jumped through, but this is meant to offer one path forward to fostering better coordination of care for all Californians, particularly the most vulnerable. The most critical next steps for this are for county behavioral health directors to review this concept and provide their feedback as to whether they are supportive, neutral, or opposed, as well as which approach and timing might be sought by their county. With that information in hand, the MCOs could be approached to review this concept and seek alignment for an approach to be used in communicating with DHCS.

## Context

In many ways, California's system for safety-net health care is simple: the state contracts with managed care plans for Medi-Cal health services – including services for mild to moderate behavioral health disorders, with county mental health plans for services for people experiencing serious to severe mental health disorders, and with counties and selected providers for Drug Medi-Cal substance use disorder treatment services. This approach to contracting for behavioral health is a clear example of a "carve out" where services are funded separately from physical health services.

The current system presents several challenges, particularly when it comes to coordinating care for people with the most complex health care needs, including for behavioral health services. Even if every administrative barrier and challenge was removed, and infinite funding made available, serving these individuals would remain daunting. But, as is well known, there are plenty of administrative complications and funding is far from infinite.

How the state purchases safety-net health care services has evolved over time and continues to change based on state and federal initiatives, with various pilot programs always providing statewide and local exceptions. Whole Person Care, Health Homes, Drug Medi-Cal Organized Delivery System, and others each take a slightly different approach to addressing the challenges of care coordination (and funding) for slices of the systems and populations. All pilots, as well as overall changes (and non-changes) depend on a complex interplay of collaboration and tension between CMS, the state, counties, MCOs, providers and many other stakeholders. For now, we will leave the issues of service delivery and dollar amounts for others and focus here on the contracting mechanisms in place to purchase services.

## National Landscape

Nationally, there is a steady move toward integrated managed care where physical health, mental health, and drug and alcohol treatment are coordinated to help provide whole-person care under one health plan. Twenty-six states have already integrated financing of behavioral health in Medicaid health plans and another nine states are in the process of moving in this direction including Arkansas, Arizona, Colorado, Florida, Maryland, North Carolina, Ohio, Virginia and Washington.

This tendency toward “carving in” behavioral health funding with health care funding looks a bit different in each state working on it, but generally involves some version of integrated managed care contracting with plans. It is important to recognize, as is pointed out in an integration FAQ document from Washington:

*Integrated managed care is necessary but not sufficient to achieve clinical integration. By integrating the way the state purchases and administers medical and behavioral health services, this sets a foundation for managed care plans and providers to work towards integration at the delivery system level.<sup>1</sup>*

Reviewing a few of the various models being implemented to achieve integrated managed care reveals the range of differences across states.

## Arizona

Arizona’s Health Care Cost Containment System (AHCCCS –pronounced 'access'), the state Medicaid program, is moving toward a hybrid model of integrated funding for those without a Serious Mental Illness and a Medicare-like integrated Special Needs Plan for those with Serious Mental Illness. In this system, most AHCCCS members will be in regional integrated AHCCCS Complete Care (ACC) health plans and receive all health and behavioral health services through these plans. However, for those determined to have a Serious Mental Illness (and a few other populations) Regional Behavioral Health Authorities (RBHAs) will be contracted to manage both physical and behavioral health services – in other words, health services are carved in to a special program for those with Serious Mental Illness. RBHAs

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<sup>1</sup> <https://www.hca.wa.gov/assets/program/faqs-why-change-apple-health.pdf>

will also continue to provide crisis, grant funded and state-only funded services. Historically, behavioral health has been carved out and separately managed by the RBHAs, with an AHCCCS acute health plan responsible for physical health services.

## Oregon

In Oregon, the state has pursued a relatively radical integration approach, using an 1115 waiver to move to 15 coordinated care organizations (CCOs) covering regions of the state. CCOs represent a full carve in, with one budget for mental, physical and ultimately dental care. Each CCO is accountable for health outcomes of the population they serve and is governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.<sup>2</sup> Under this model, high standards have been set for meeting the needs those with a Serious Mental Illness to ensure that the elimination of the carve out doesn't adversely affect care to this population. Five years into this project, Oregon is recognized as having what some consider the best Medicaid system in the country, regularly hitting their cost curve bending targets and a large set of quality metrics.

## Washington

Washington is in the midst of a stepped approach toward integrated managed care and a fully carved in behavioral health benefit and is particularly relevant because of its similarity and potential applicability for California. Washington has historically contracted separately for managed health care, mental health, and SUD services on a regional basis, but with different regional definitions for each service type, and some regions comprising single counties. Each region has had a different mix of managed care plans. As the state moves toward integrated managed care contracting, the major milestones in this process can be summarized as follows:<sup>3</sup>

1. Bringing together state agencies responsible for health, mental health and substance use disorder services under one agency.
2. Aligning state agencies' geographical boundaries into Regional Service Areas (RSAs) for purchasing behavioral and physical health care through managed care contracts.<sup>4</sup>
3. Regionally integrating mental health and SUD services under Behavioral Health Organizations (BHOs) in preparation for full integration.
4. Integrating managed care for physical health, mental health, and drug and alcohol treatment to provide clients with whole-person care under one health plan, with clients choosing their plan based on those available in their region.

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<sup>2</sup> See: <https://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx>

<sup>3</sup> See the following for additional information.

- Overview: [https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO/BHO\\_Overview.pdf](https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO/BHO_Overview.pdf)
- Current Information: <https://www.hca.wa.gov/about-hca/healthier-washington/regional-resources>
- BH-ASO Details: <https://www.hca.wa.gov/assets/program/bhaso-fact-sheet.pdf>
- Continuum of County Options: <https://www.hca.wa.gov/assets/program/integrated-care-continuum-of-county-responsibility.pdf>

<sup>4</sup> RSAs join and include contiguous counties, contain at least 60,000 people on Medicaid, possess an adequate number of health care providers, and reflect natural physical and behavioral health service referral patterns.

To address the complexities of Washington’s environment, the state has had to develop intermediary steps to full integration, such as BHOs, BH-ASOs, and BHSOs, each described below.

- **Behavioral Health Organizations (BHOs)** “simply” brought together mental health and SUD services for the regions, transforming two service delivery systems into one region wide system, paid through a per member per month (PMPM) capitation model.
- **Behavioral Health – Administrative Services Organizations (BH-ASOs)** have been developed because, even with integrated managed care, certain services must be available to anyone regardless of their insurance status or income level. For these, residents and clients also have access to a BH-ASO contracted by the state to cover mental health crisis services and short-term substance use disorder (SUD) crisis services. Within their available funding, the BH-ASO also has the discretion to provide outpatient mental health services or voluntary psychiatric inpatient hospital admissions for state citizens who are not eligible for or enrolled in Medicaid. The BH-ASO may also provide various administrative functions, such as a behavioral health ombudsman, managing the block grant based on locally approved block grant plans, or managing Criminal Justice Treatment Account (CJTA) funds and Juvenile Drug Court funds.
- **Behavioral Health Services Only (BHSO)** plans have been established for clients who are eligible for Medicaid, but not eligible for managed care enrollment. These fee-for-service clients receive their behavioral health services from one of the BHSO plans in the region they live in, offered by the same health plans administering integrated managed care in that region.

Additionally, the state is providing a range of schedules to move into fully integrated managed care, with early-, mid- and late-adopting regions. The one early adopter region (Southwest Washington) skipped the BHO step and moved directly to fully integrated managed care in 2016. Middle adopter regions are going live in January 2019, and the entire state will be operating under the integrated managed care financing model in 2020.

### Current California Contracting for Care

Keeping in mind the Washington model described above, it’s worth reviewing how things work in California. For health care services, the state contracts with different managed care plans in different models depending on the county, as described below and illustrated in the following map:

- **County Organized Health Systems (COHS):** In COHS counties, the Department of Health Care Services (DHCS) contracts with a single health plan created by the County Board of Supervisors and run by the county.
- **Geographic Managed Care (GMC):** In GMC counties, DHCS contracts with several commercial plans, with beneficiaries choosing their plan.
- **Two-Plan:** In these counties, DHCS contracts with two plans, a Local Initiative (county organized) and a Commercial Plan.
- **Regional:** 18 counties have come together as region to offer the same two plans contracted with DHCS.
- Imperial county has two commercial plans contracted with DHCS and San Benito has one.

## Managed Care Contracting Models in California Counties



## Actual Managed Care Contracting Arrangements in California



It is important to note that 14 of the 58 counties have “unique” county-specific managed care contracting.<sup>5</sup> As mentioned above, 18 counties have an explicitly regional approach, offering two plans across the 18 counties.<sup>6</sup> Another 14 counties use the COHS model, but all use the same plan.<sup>7</sup> Five other counties also use a COHS model but with one plan for two of the counties<sup>8</sup> and another for the other

<sup>5</sup> Alameda, Contra Costa, Imperial, Kern, Los Angeles, Orange, Sacramento, San Benito, San Diego, San Francisco, San Mateo, Santa Clara, Tulare, and Ventura

<sup>6</sup> Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba

<sup>7</sup> Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo

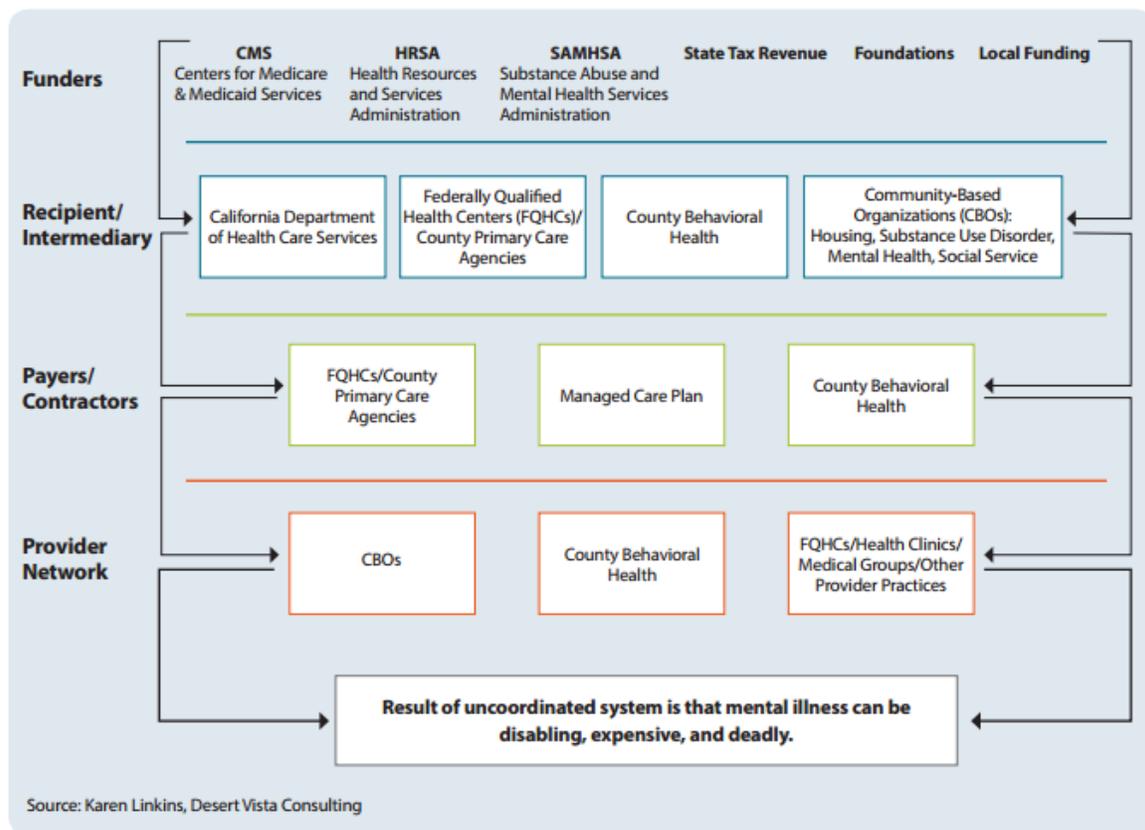
<sup>8</sup> San Luis Obispo and Santa Barbara

three.<sup>9</sup> Finally, there are seven counties that use a two-plan model (three use the same two plans<sup>10</sup> while the other four have the same two plan arrangements for two counties each.<sup>11</sup> The end result is that 44 of California's 58 counties are operating de facto regionalized multi-county managed care for health services, with just seven different managed care contracting relationships across them.

Meanwhile, the state contracts for behavioral health through a carve out where services for people experiencing serious to severe behavioral health disorders are funded separately from their physical health services. For those individuals, the state contracts with 56 separate county mental health plans (Sutter and Yuba counties operate one plan, as do Sierra and Placer) and has 57 different county Drug Med-Cal contracts for substance use disorder treatment services (Sutter and Yuba are combined while Sierra and Placer are separate for SUD treatment services). With Medi-Cal expansion under the Affordable Care Act (ACA) as well as parity requirements, the managed care plans took on responsibility for covering services for mild to moderate behavioral health disorders.

The tangled mess of financing for behavioral health services is captured by the following graphic:

### Financing Behavioral Health Care in California: Uncoordinated Care from Unaligned Funding



<sup>9</sup> Merced, Monterey, and Santa Cruz

<sup>10</sup> Fresno, Kings, and Madera

<sup>11</sup> Riverside and San Bernardino; and San Joaquin and Stanislaus

## What California Could Do

California could be well-served by looking to Washington's approach. As mentioned at the outset, the state could explore providing counties with a flexible and accountable range of options and timing, the most transformative of which would be immediately moving toward fully "carving in" behavioral health funding with managed care health contracting by county or region. Counties could also be given the option to consolidate their behavioral health contracting with the state, moving to Behavioral Health Organizations (BHOs), even if not moving to integrated managed care contracting. For those counties where the above two options don't make sense for various reasons, they could opt to continue to expand the integration and coordination of health and behavioral health services.

In general, county options could be as follows:

1. Full Integration: Opt in to one-county or multi-county integrated health and behavioral health managed care plans.
2. Behavioral Health Integration: Opt in to one-county or multi-county Behavioral Health Organization (BHO) with combined mental health and substance use disorder funding that is separate from health care funding to Managed Care Organizations.
3. Expand Integration: Opt to maintain current progress on integrating and coordinating health and behavioral health care with more robust requirements for MCOs and counties to coordinate care and achieve outcomes.

California has already made progress on integration, with gains in clinical practice, and by bringing together state agencies responsible for health, mental health and substance use disorder services under one agency. These gains could be sustained and expanded by providing counties and MCOs with opportunities for further improving integration and care coordination, including requirements that they collectively meet process and outcome goals to benefit clients. It is important to note that any additional requirements will need to be developed in collaboration with clients, clinicians and other stakeholders to ensure they advance better care, better health, better costs, as well as improving the work life of health care providers.

Currently, while the state may contract for mental health and SUD services with county "Behavioral Health" agencies, these remain segregated contracts and often represent bringing together mental health and SUD services and funding in name only. Just bringing together mental health and SUD contracting for individual counties could foster greater alignment and coordination of these services. That said, it is important to not let financing models drive clinical practice, but rather to have clinical design be supported by appropriate financial arrangements.

As many initiatives have shown, most recently the Whole Person Care pilots, while California consists of 58 counties, many issues do not stop at county borders and require an explicitly regional approach. Regionally integrating multi-county Behavioral Health Organization (BHO) with combined mental health and substance use disorder funding that is separate from health care funding to Managed Care Organizations would have the potential for administrative simplification and budget advantages at the local, state, and even federal levels. Depending on the legal structure of the BHO arrangement, counties could see significant reductions in their direct exposure to risk of all kinds.

Integrating managed care for physical health, mental health, and drug and alcohol prevention and treatment would have the potential to realize the goals outlined above, and to provide clients with truly whole-person care under one health plan.

Learning from what Washington has already developed, California could consider the following:

- **Behavioral Health Organizations (BHOs)** could bring together single- or multi-county contracting for mental health and SUD services, transforming two service delivery systems into one county- or region-wide system with funding separate from that to Managed Care Organizations.
- **Behavioral Health – Administrative Services Organizations (BH-ASOs)** could be developed to ensure that those services that must be available to anyone regardless of their insurance status or income level are maintained. For these, residents and clients could also have access to a BH-ASO contracted by the state to cover mental health crisis services and short-term substance use disorder (SUD) crisis services. Within their available funding, the BH-ASO could also have the discretion to provide outpatient mental health services or voluntary psychiatric inpatient hospital admissions for state citizens who are not eligible for or enrolled in Medicaid. The BH-ASO could also provide various administrative functions, such as a behavioral health ombudsman, or other state or locally determined functions.
- **Behavioral Health Services Only (BHSO)** plans could be established for clients who are eligible for Medi-Cal, but not eligible or participating in managed care. These fee-for-service clients could their behavioral health services from one of the BHSO plans in the county or region they live in, offered by the same health plans administering integrated managed care in that region or the BHO.

In light of the array of existing county contracting arrangements described above, clearly one size and schedule will not fit all. However, it seems plausible that the 18 counties currently contracting for managed care on a regional basis might be interested in moving rapidly toward an integrated contracting model. Likewise, the 14 counties sharing a single COHS would also seem like potential prime candidates to be early adopters, as would the others with multi-county COHS and two-plan arrangements. Even if not moving directly into an integrated contracting model, these counties and the state could achieve significant administrative efficiencies as well as better care coordination by moving toward multi-county BHOs. The 14 counties with county-specific contracting arrangements could benefit from these same efficiencies through BHOs and some would likely see an opportunity in exploring an integrated contracting model. For counties where these approaches were not appropriate, they could opt to maintain current progress on integrating and coordinating health and behavioral health care with more robust requirements for MCOs and counties to coordinate care and achieve outcomes.

## Next Steps

County behavioral health directors need to review these concepts and provide feedback regarding their support and ranking of each in terms of feasibility, importance, and general will. With that information in hand, the MCOs could be approached to review this concept and seek alignment for an approach to be used in communicating with DHCS.

California is trailing a national trend toward integrated managed care aimed at providing whole-person care under one health plan. The state needs to look at other states, particularly Washington, for how

this is being accomplished, including what challenges are being encountered and overcome. Making this happen hinges on federal, state, regional, county, and local issues, stakeholders, and processes that need to be identified and addressed, but doing so would foster better coordination of care for all Californians, particularly the most vulnerable.

## 2. Value-Based Purchasing

*Establish and support behavioral health payment models, such as case rates, that support provider excellence and payment for value*

At its heart, payment reform is quite simple: it supports moving from a system that pays for volume (units) to one that pays for value (outcomes). Accomplishing this requires coming to agreement on the desired outcomes, the indicators that will document progress and success, and the protections that need to be in place to ensure clients are receiving quality care. Payment reform opportunities for California's behavioral health services are many and complicated, primarily due to current state contracting arrangements for services, and the cost-based reimbursement model for payment using fee-for-service.

The key steps in moving toward payment reform in a fee-for-service environment are to:

1. Identify avoidable spending and barriers
2. Reduce avoidable spending and barriers
3. Use the resulting savings to reduce spending and adequately compensate providers, through an alternative payment model (such as a case rate)

### Case Rates

Irrespective of what the state does regarding contracting arrangements, the time is ripe to revise payment rules to allow for case rates and other alternative payment methodologies that are not based solely on the cost of a service provided but rather on the value delivered. But what is a case rate? The following definition was provided by Dale Jarvis and John Freeman in a 2014 paper<sup>12</sup> for the National Council:

**Bundled Payments/ Case Rates:** a predetermined amount paid to a provider organization to cover the cost of all of the services required for a given episode of care.

In that same paper, the authors go on to make the case for case rates (which may also be called "bundled payments):

*A Case Rate is a single payment to cover the costs of a "case". Let's make this definition a bit longer: A Case Rate represents a predetermined amount of money paid to a provider organization to cover the average costs of all services needed to achieve a successful outcome for a given defined episode of care for an individual over an agreed upon time period.*

**Example:** *We will pay you \$3,500 for providing six months of community-based, recovery-oriented services for an adult mental health consumer who requires LOCUS Level 3 services. Your part of the bargain is to work with the consumer to develop a recovery-oriented professional*

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<sup>12</sup> [https://www.thenationalcouncil.org/wp-content/uploads/2014/09/14\\_Creeping-and-leaping.pdf](https://www.thenationalcouncil.org/wp-content/uploads/2014/09/14_Creeping-and-leaping.pdf)

*care plan and self-care plan, identify at least one clinical goal and one personal goal, use a validated measurement tool to track progress on the clinical goal, work toward the agreed upon outcomes, change the care plan as needed, and get high marks on your customer satisfaction survey. Simple, right?*

*Case Rates are Important for Two Main Reasons:*

- 1) Case Rates provide much greater flexibility to the provider and consumer regarding who provides services, what can be provided, and where services can be provided – the consumer and provider decide and can be more agile about what’s needed.*
- 2) Case Rates have a two-part value equation built into the process. First, if a care team selects a package of services for a consumer that is more cost-effective than other alternatives for achieving the desired outcome, the episode’s actual cost may be lower than the case rate payment, allowing the provider to earn what some describe as a ‘value bonus’. The second ‘value lever’ is to remove waste (excess cost) through lean process improvement activities, achieving a lower unit cost than what was built into the case rate.*

*This agility and value is possible because Case Rate amounts are generally developed and set after determining an average rate per unit and the average number of units of service required to achieve a positive outcome. If you can achieve good outcomes with fewer units at a lower cost, you earn a value bonus.*

*Note that Case Rates can also result in a reduction in administrative costs, when compared to fee for service. Although payors will require the submission of encounters under a Case Rate system, providers do not have to manage the intricacies of primary and secondary billing cycles for services provided to enrollees of a payor that pays Case Rates.*

## **Other Options**

While case rates seem the most promising way to advance payment reform for behavioral health services in California, a toolkit developed to support Arizona and its providers as they moved toward value-based purchasing can be helpful for reviewing the many other possible options available:

<http://azpaymentreform.weebly.com>.

If the state moves forward with alternative payment methodology (APM) pilots for FQHCs, behavioral health providers partnered with those centers may be able to be part of **global payments** for the total cost of care for assigned clients. The state could also develop a **prospective-payment system** for behavioral health, similar to how FQHCs are paid, and based on what has been implemented in Certified Community Behavioral Health Center (CCBHC) pilots around the country.

Many of these options, or combinations of them, would resolve (or at least get around) California’s prohibition of **same-day reimbursement for primary care and behavioral health visits** for FQHCs and Rural Health Centers. If the path forward does not resolve this same-day billing issue, the state should consider removing this prohibition so that providers may appropriately serve their clients.

## Next Steps

County behavioral health directors need to review these concepts and provide feedback regarding their support and ranking of each in terms of feasibility, importance, and general will:

1. Case rates
2. Allowances for behavioral health services to be included as part of global budgets for FQHCs using APMs
3. Allowing same-day reimbursement for primary care and behavioral health visits in health centers
4. Development of a prospective-payment system for behavioral health

With that information in hand, the MCOs could be approached to review these concepts and seek alignment for an approach to be used in communicating with DHCS.

## 3. Infrastructure for Behavioral Health Promotion

*Establish the infrastructure to promote behavioral health to address the financial and human costs of under-reporting and undertreatment of illness*

Mental health promotion is an infrastructure investment, needed because behavioral health disorders are massively under-reported and undertreated. California should take the opportunity of the next 1115 and 1915 waiver renewals to make infrastructure and service delivery investments to achieve better care, better health, and better costs for residents experiencing behavioral health disorders. CMS has consistently recognized that infrastructure investments are reasonable and necessary to support health care transformation in 1115 demonstration waivers, including in the current Whole Person Care pilots. By recognizing that behavioral health promotion represents infrastructure needed to prevent and treat behavioral health disorders, the state can draw on federal financial participation that would not otherwise be available for funding this vital function.

### Context

In order to reduce the incidence and prevalence of mental illness and other behavioral disorders, there needs to be a comprehensive effort to promote mental wellness, prevent mental health challenges and intervene early before individuals develop a chronic if not fatal condition. Behavioral health, like physical health, is not just the absence of disease or disorders, but rather a whole way of living. Treating disorders and diseases will always be necessary, but actively promoting health and wellness is central to avoiding poor health and identifying it when it happens.

Generally, waiver projects need to have the potential for showing budget neutrality or a relatively rapid return on investment. Achieving those returns typically requires funding significant administrative and service delivery infrastructure components, such as program staffing data, IT systems, and even things like new physical hospital beds for expanded respite care services. Mental health promotion is just such an infrastructure investment that will allow, support, and foster other service delivery transformations to address the issues summarized in the introduction to this paper, including:

- Nearly two thirds of California adults experiencing a mental illness did not receive treatment in the last year
- One in three California adults who report a major depressive episode did not receive treatment

- One in 10 young people experience a major episode of depression in any given year but less than a third of them received treatment in California

If the state can successfully get CMS to agree that mental health promotion represents an infrastructure investment, then statewide, regional, and county pilots could be used to demonstrate how it can allow, support, and foster other service delivery transformations. In turn, these service delivery transformations could be statewide or part of a menu for that a region, county, or other local entity would choose from. The framing for these efforts would be on the potential improvement in outcomes for beneficiaries and financial or administrative efficiency and improved cost effectiveness for federal, state, county, and other funders.

To allow these services to work, however, the new waiver plan should contain a strong emphasis on mental health promotion that seeks to normalize the conversation about mental health, no longer treating it as a stigma that hides the illness but bringing mental health challenges out into the open of every day conversations at home, in the workplace, in schools, community gatherings, in religious institutions, and in the media. Everybody has problems, everybody has a bad day, everybody has had trauma, everybody gets lonely, but we live in a society that does not promote or encourage talking about these emotional issues. The norm is to not talk about mental health challenges or emotions until they reach a crisis state, no other health condition hides the illness from everyday conversation. Break an arm and people sign your cast, have depression and you can't even mention it.

California policy makers can learn from other health conditions where a health and wellbeing public health approach has been employed, and demonstrated that, while changing social norms does not occur over night, with a long-term commitment, it works. For instance, tobacco use dropped from 60-75% of California adults smoking 30 years ago to less than 11% today. The public health approach was to challenge public policies, create media messages, target educational awareness, cultivate grassroots activism, and research the change in knowledge, attitudes and behavior about tobacco use. The combination of strategies changed the social norms about tobacco use in our society and significantly reduced the risk of cancers, pulmonary, coronary and other health conditions.

California has embarked on a similar path through a statewide prevention campaign for behavioral health that has changed knowledge, attitudes, and behaviors, resulting in significant projected financial savings and countless improvements in quality of life. California needs to continue to invest in the long-term impact of changing the norms about mental health, reducing stigma and promoting emotional wellbeing.

Pushing the envelope a bit, California has an opportunity to work way up stream in the prevention of behavioral health problems and the recurrence of behavioral health conditions. Internationally known for technological innovation, for the past 10-15 years California's technology industry has been applying its ideas and tools to health problems from cardiac monitoring apps, to pulmonary symptom recognition, to diabetes management, and more recently to behavioral health conditions. Approaches range from geo mapping behavioral health trigger sites, to phenotype analysis, to Artificial Intelligence, to virtual reality, to smart phone apps, and other approaches in gene mapping etc. The technology companies are working on innovative ways to use data and algorithms that can guide, assist, and connect people through their smart phones, bringing them out of isolation, alienation, stigma, and

loneliness. These tools are all part of the current trend in health care to use technology for preventing health consequences and better managing illness.

Prevention efforts such as these (a population health approach and innovative technologies) can assist those with diagnosed behavioral health challenges but also reach those that need a conversation about their depression, anxiety, stress, alienation, loneliness, and trauma.

### Next Steps

To advance these concepts, it will be necessary to define a narrow scope of evidence-based promotion and prevention activities that could be put forward.

## 4. Peers/Non-Licensed Providers

*Establish statewide certification and billing standards for peers and other non-licensed providers in health and behavioral health service settings, and require that these providers be part of any waiver-funded services*

California should pursue a first in the nation state plan amendment (SPA) for reimbursing preventive services delivered by non-licensed providers in both behavioral health and primary care. The state should also continue to vigorously leverage the potential of non-licensed providers within future 1115 waiver requests for all practice settings. This strategy aligns with the California Future Health Workforce Commission subcommittee recommendation for creating a standardized Peer Support Specialist certification and training process statewide.

### Context

While there is an array of workforce challenges confronting behavioral health services in California, all worthy of attention, the time has come for the state to find its way forward to thoroughly integrate services from non-licensed providers into the full range of settings and across all models of care.

Non-licensed providers are vital players in helping meet the health and wellness needs of people who are especially challenged by the health care system. The non-licensed workforce is uniquely positioned to support achievement of the Quadruple Aim. It is now broadly understood that we need to go beyond traditional services to address the social and environmental conditions that contribute to poor health. Providers of these services have multiple names such as Community Health Workers (CHWs) or Care Navigators in health and human service settings and Peers in behavioral health. In the interest of focusing on the coordination needed for the systems working to improve health and well-being for the most vulnerable among us, we will use the term non-licensed provider to encompass the full range of individuals working across various sectors.

The non-licensed workforce is exceptionally qualified to assist others and encourage resiliency, wellness and self-management of health and behavioral health. Non-licensed providers often have the shared experience of stigma and discrimination, the impact of behavioral health challenges on all life domains, and the knowledge of how these issues affect healthcare access and engagement. Non-licensed workers support patient health and wellness in ways that are typically outside the role of clinical providers, including:

**Assistance in daily management of chronic disease:** Non-licensed service providers use their own experiences with diet, physical activity and treatment adherence in helping people manage chronic conditions.

**Linkages to clinical care and community resources:** Non-licensed service providers can help bridge the gap between the patients and health professionals and encourage individuals to seek out clinical and community resources when appropriate – even accompanying the patient to appointments or providing transportation.

**Social and emotional support:** Through empathetic listening and encouragement, Non-licensed service providers are an integral part of helping patients to cope with social or emotional barriers and to stay motivated to reach their goals.

Non-licensed service providers have a unique dynamic with patients where the trust and relationship they foster is paramount to empowering positive change. They offer and receive help, based on shared responsibility and mutual agreement of what is helpful for individuals with lived experience from a diversity of backgrounds and cultures.

## Scope of Services

Non-licensed service providers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also develop support or educational groups, plan services or activities, supervise other non-licensed workers, provide training, gather information on community resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness on various clinical, policy or community issues.

## Promoting Health & Wellness

Non-licensed providers working in behavioral health settings have a long history of fostering hope and promoting a belief in the possibility of recovery. With increasing attention focused on improving access to health care, chronic disease management and population health, the role for non-licensed providers has expanded to promote greater health and wellness. Potential duties for non-licensed providers include:

- Models wellness
- Assists the individual to develop their own definition of wellness
- Asks about physical wellness (e.g., physical activity, nutrition, smoking)
- Explores substituting healthy for unhealthy behaviors
- Offers support for healthy behaviors
- Develops health improvement goals and person-centered support plan
- Provides on-going support to achieve client self-identified goals
- Addresses fear of doctors, appointments, procedures, etc.
- Provides information and education about health care options
- Provides education to and acts as an example for health care providers to address stigma that affects access to services as well as types of services offered.
- Conducts referral and linkage activities
- Facilitates warm hand-offs to other services

- Assists the client to advocate for themselves in order to get their needs met from other providers

The state should establish statewide certification and billing standards for peers and other non-licensed providers in health and behavioral health service settings, and require that these providers be part of any waiver-funded services.

### Next Steps

County behavioral health directors need to review these concepts and provide feedback regarding their support and perception of feasibility, importance, and general will. Assuming there is director support, it will be necessary to secure support from CASRA and identify who the best lead will be for the effort. It will also be important to review this concept with behavioral health and other providers in each county for their feedback and buy-in, as well as statewide associations such as CPCA and the Nurses Association.

## 5. Workforce Retention

*Establish statewide workforce retention reporting standards and require waiver-funded projects to explicitly include retention efforts*

The state must take immediate action to address the costs and service quality issues brought on by poor retention and turnover rates within the behavioral health workforce. California should establish statewide workforce retention reporting standards and require waiver-funded projects to explicitly include retention efforts, including building staff resilience. Retention is directly related to recruitment, as higher turnover rates drive ever-greater needs for recruitment, while simultaneously serving as a red flag for candidates. Behavioral health treatment and prevention services can be very high stress, which means that recruitment and retention efforts must also include supporting and building staff resiliency in the face of the challenges they face through their work.

### Behavioral Health Workforce Turnover May be Costing California \$650 million per year

California has a mental health workforce of about 156,000 (See [this OSHPD report](#)). The mean salary for those working in "Community and Social Service Occupations" in California is \$55,000 per year. If we estimate turnover is currently about 33%, but should be closer to 10%, and that replacing an employee costs a third of their salary, turnover is costing California \$653 million dollars per year.

There are many issues confronting the behavioral health workforce, with a concomitant array of efforts underway to address them. A February 2018 report on "California's Current and Future Behavioral Health Workforce" from the Healthforce Center at UCSF recommended four key actions:<sup>13</sup>

1. Increase Supply

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<sup>13</sup> See <https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf>

2. Improve Geographic Distribution
3. Increase Racial/Ethnic Diversity and
4. Improve and Expand Collection and Dissemination of Workforce Data

These are all important activities, but a key area is omitted: retention.

The Healthforce recommendation regarding the need for workforce data collection and dissemination points to the possibility that retention data may simply be lacking. SAMHSA's 2013 "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues" backs up this hypothesis, where it noted that information was mostly limited to addiction services workforce retention, but that data pointed to turnover rates ranging from 18.5% to 50%.<sup>14</sup>

Given that the cost of replacing an employee is estimated to be between one third and two thirds of the first year's salary, California could realize significant cost savings by identifying and addressing retention issues. California has a mental health workforce of about 156,000 (See [this OSHPD report](#)), and the mean salary for those working in "Community and Social Service Occupations" in California is \$55,000 per year. If we estimate turnover is currently about 33%, but should be closer to 10%, and that replacing an employee costs a third of their salary, it seems conservative to estimate that turnover is costing California \$653 million dollars per year for its behavioral health workforce. \$653 million dollars every single year that could be invested in retention efforts without adding a penny of additional cost.

Of course, increasing the workforce supply is an important effort, but this needs to be coupled with a focus on retention. to the greatest extent possible.

The importance of all of these efforts was noted in the Med-Cal Specialty Mental Health External Quality Review FY16-17 Statewide Report:<sup>15</sup>

*The issues emerging from the reviews call out for new and innovative approaches to developing and stabilizing this workforce. Removing debt barriers and flexible use of other health professionals have been recommended. New approaches to this ongoing set of challenges could include subsidized training, retention bonuses when staff are licensed, and early recruitment into these fields through career ladders from high school and college. As noted above, these are particularly crucial to expand the peer and family-led workforce.*

## Next Steps

County behavioral health directors need to review these concepts and provide feedback regarding their support and perception of feasibility, importance, and general will. It will be helpful to get even a general sense of the turnover rates for providers in each county, as well as any information that counties may have gathered regarding the costs of turnover, and any efforts they have underway to address retention.

While those results may be adequate to prompt further action, particularly with the more than half-billion dollars in annual costs, to best quantify the need and potential for retention strategies,

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<sup>14</sup> See <https://store.samhsa.gov/shin/content//PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>

<sup>15</sup> See <http://caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202016-2017%20Reports/CalEQRO%20Statewide%20Annual%20Report%20FY16-17.pdf>

stakeholders should develop a survey to gather data on retention and turnover rates and costs, as well as what the causes are. With that data in hand, a relatively simple cost benefit exercise could help identify statewide, regional, and county-level strategies for improving retention.

## 6. Supported Employment

*Establish opportunities for providing evidence-based supported employment services as behavioral health services*

The state should pursue a Medicaid 1915(i) State Plan Amendment (SPA) to secure funding for supported employment services. As Jackie Pogue explained in an earlier paper about this topic,<sup>16</sup> stable funding is needed for evidence-based supported employment services to be more widely implemented and sustained for individuals with behavioral health disorders. Adults with psychiatric disabilities who maintain competitive employment rely less on the behavioral health system, and utilize fewer public resources, including behavioral health services and public entitlements. One funding option available for employment services is a Medicaid 1915(i) State Plan Amendment (SPA). Using the SPA option, as well as including supported employment as part of an 1115 waiver would have the potential to significantly expand the availability and benefit of supported employment services.

Nationally, 85% of adults with psychiatric disabilities do not work, while research shows that 60-70% of these people would like a job. In California, more than 90% of adults in the public mental health system were not working competitively in 2013. County and community behavioral health providers recognize the need for employment services for people who want to work as part of their recovery, but struggle to secure adequate funding for these services.

While Medi-Cal funds employment services that relate to a person's mental health treatment, particularly case management and individual rehabilitation, employment programs must also utilize funding from the California Department of Rehabilitation for job development and placement. Most programs struggle to manage this braiding of Department of Rehabilitation and Medi-Cal revenue. Worse still, reimbursement rates for these services, do not cover the average cost of providing the service.

If California developed and received approval for a 1915(i) SPA focused on funding evidence-based supported employment services, agencies would have a stable, viable way to fund these services that have a major positive impact on people with behavioral health disorders. A 1915(i) SPA would generate federal funds for services that are recovery-oriented and help people live more integrated lives in their communities. The state and counties would save money by funding quality evidence-based practices that support a more complete system of care.

A 1915(i) SPA has similar features to a Medicaid waiver, allowing states to provide home and community-based services (HCBS) to individuals who require less than institutional levels of care. States establish needs-based criteria to determine eligibility and can target services to a specific population. One key feature is that a 1915(i) SPA does not require states to demonstrate budget neutrality, which

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<sup>16</sup> Special thanks to Jackie Pogue, IPS Trainer at Alameda County Behavioral Health Care Services who previously developed much of the background information for this section in her paper, "1915(i) State Plan Amendment- A Good Option for Funding Employment Services for Adults with Serious Mental Illnesses in California."

can allow states to expand access to HCBS to more people, and offer funding from the federal government to help offset the cost.

## Next Steps

To advance these concepts, it will be necessary to define a narrow scope of evidence-based supported employment services that could be put forward.

## 7. IMD Exclusion

*Establish budget-neutral opportunities for a waiver of the IMD payment exclusion for mental health services*

California counties are interested in requesting a waiver of the IMD payment exclusion for mental health services in California's next 1115 waiver.

### Context

Currently, states can use federal Medicaid funds for inpatient hospital and nursing facility services in IMDs for people age 65 and older and inpatient psychiatric hospital services for those under age 21. States can also cover IMD stays of 15 days or less in a month, under authority for managed care plans to cover services "in lieu of" of those available under the Medicaid state plan. In addition to these exceptions to the IMD exclusion, states can use some disproportionate share hospital payments (DSH) to cover IMD services. California's Drug Medi-Cal Organized Delivery System Demonstration provides a limited waiver of the IMD exclusion for SUD services, but not for mental health services.

While CMS has previously granted waivers of the IMD exclusion for mental health services, those waivers have all lapsed or are being phased out. Several states have pending waiver applications including IMD mental health services, but CMS currently seems to be limiting IMD exclusion waivers to SUD services. Congress is considering action to further limit these waivers to only cover opioid use disorder.

In this environment, California will likely be best served to build the business case for a potential future waiver of the IMD exclusion for mental health services. If California can show that the IMD exclusion waiver in its Drug Medi-Cal Organized Delivery System demonstration allows the state to maintain or reduce SUD and/or mental health spending in comparison to what would have been spent absent the demonstration, the state may be able to use this information to support a case for a waiver of the mental health exclusion in a subsequent waiver.

It is worth noting that Illinois' waiver request included a rationale and limited scope that could have proven compelling, but was ultimately rejected by CMS:<sup>17</sup>

*The federal IMD exclusion represents a significant barrier to ensuring availability of a full spectrum of behavioral health services. In Illinois today the IMD exclusion undermines access to appropriate services for individuals in crisis and vulnerable populations with mental illness diagnoses.*

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<sup>17</sup> See

[https://www.illinois.gov/hfs/SiteCollectionDocuments/1115%20Waiver%20for%20CMS%20Submission\\_final.pdf](https://www.illinois.gov/hfs/SiteCollectionDocuments/1115%20Waiver%20for%20CMS%20Submission_final.pdf)

*While Medicaid beneficiaries can receive physical health services in a wide range of inpatient facilities, individuals with mental health conditions may encounter barriers to accessing inpatient mental health services, even when inpatient treatment is most appropriate. Therefore, the IMD exclusion unnecessarily restricts and complicates care for individuals with mental health needs. In addition, the IMD exclusion drives up otherwise avoidable system costs such as inappropriate use of expensive emergency room services. CMS' recent managed care rule acknowledges this in part by allowing capitation payments to managed care organizations (MCOs) for enrollees who are patients in an IMD for 15 days or less, lending credence to the argument that IMD services can be paid in lieu of more costly hospital based services – a rationale Illinois supports.*

*Through the 1115 waiver, Illinois seeks to test provision of crisis intervention and acute stabilization services within IMD facilities for stays of up to 30 days for all Medicaid members including those deemed unfit to stand trial (UST) (four of Illinois' state psychiatric hospitals serve this UST population). Illinois intends to ensure that individuals who are admitted to IMDs for shorter stays are admitted as part of a seamless and appropriate continuum of care, fully coordinated with that individual's IHH.*

*Illinois believes that the addition of this IMD benefit, within the context of a transformation to a system of IHHs that take accountability for providing whole-person care and are complemented by new community-based behavioral health and supportive services, will increase rates of longterm recovery and maintenance of behavioral health members in the community while improving outcomes and lowering costs.*

California will need to keep this in mind and bring clear cost, access and quality data to any future IMD exclusion waiver requests.

A March 2018 California Health Care Foundation publication, "Mental Health in California: For Too Many, Care Not There," offers compelling data on the lack of acute psychiatric beds in California (available at <https://www.chcf.org/publication/mental-health-in-california-for-too-many-care-not-there/>). According to that publication, acute psychiatric beds per 100,000 population decreased 42% from 1995 through 2014 and California would now need an additional 1,158 beds to reach the national average of 20 beds per 100,000 population. (Note: the national average bed availability may well not be adequate.) Additionally, the publication points to geographic disparities within California:

There was significant geographic variation in the availability of acute psychiatric inpatient beds in California: 25 counties had no adult acute psychiatric beds, and 46 counties had no psychiatric beds for children, in 2015. When inpatient facilities are far from where people live, it is more difficult for families to participate in treatment and for facilities to plan post-discharge care.

## Adult and Child/Adolescent Acute Psychiatric Inpatient Beds by California County, 2015



Notes: Acute psychiatric inpatient beds excludes beds in California state hospitals. It includes psychiatric units in general acute care hospitals (including city and county hospitals), beds in acute psychiatric hospitals, and beds in psychiatric health facilities. Source: California's Acute Psychiatric Bed Loss, California Hospital Association, October 25, 2016.

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Given that current IMD exclusion provisions do not apply to children, even without waiver authority, California could make investments to address the 46 counties that lack beds for children.

For additional information, see Key Questions about Medicaid Payment for Services in “Institutions for Mental Disease” at <https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/> and the GAO report "States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies" at <https://www.gao.gov/assets/690/686456.pdf>. For up to the minute information, KFF's "Medicaid Waiver Tracker: Which States Have Approved and Pending Section 1115 Medicaid Waivers?" is available at <https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/>

### Next Steps

County behavioral health directors need to review these concepts and provide feedback regarding their support and perception of feasibility, importance, and general will. Feedback should also include information about specific barriers to inpatient psychiatric beds for child/adolescent residents, as well as any county or regional opportunities to add beds. With that information in hand, it will be important to

develop a work plan to identify specific services and populations that might lend themselves to revenue-neutral waiver projects, including supporting data that can be gathered from California's and other states' waivers for IMD SUD services.

## 8. Reporting and Documentation Burden

*Establish contracting and payment models that align provider payment and incentives with reporting and documenting the delivery of better care, better health, better costs, and better provider satisfaction*

Health care's administrative burdens are making their way into popular consciousness. A recent New York Times article brought the discussion out of Health Affairs and delved into "The Astonishingly High Administrative Costs of U.S. Health Care" for the reading public.<sup>18</sup> The details of that article won't shock any active health care provider, but point to the growing understanding that health care financing, like health care, is in fact, complicated.

The Trump administration, through CMS, is clearly seeing the need to address the administrative burdens on health care providers, and the associated costs, putting forth a radical restructuring of Medicare payment rates that they hope will simplify reporting and documentation for providers.<sup>19</sup> In this proposal, there would be one rate for any type of office visit, rather than the current five levels of payment for different visit complexities, eliminating the need for providers to document certain details to earn the current differential rates. This means that highly paid specialists would see their rates cut. How this proposal fares in the wilds of public comment will be very interesting to watch. What it reflects, however, is that CMS is ready to pay attention to how the current financing system burdens providers with documentation and reporting requirements, as well as the associated costs to the federal government. That said, they may need some additional guidance on how to put this concern into practice.

As the above information illustrates, the last several years have seen a marked increase in documentation and reporting requirements for health care providers, and for behavioral health providers in particular. Much of this increase is due to a broad and ongoing shift to data-driven care and achieving measurable client and clinical outcomes. These are good things.

More onerous, but equally important to keep in mind, is that much of the increase in reporting and documentation can be attributed to a perception that providers need to be held to higher standards of ensuring program integrity and compliance. This was explicitly stated by CMS when they approved California's 1915(b) waiver renewal in 2015, noting that, "After working closely with the Department of Health Care Services (DHCS) during the previous renewal period, an overarching concern continues to be program integrity monitoring and compliance. Because of this, adherence to the attached Special Terms and Conditions is required as a condition of approval."<sup>20</sup> The STCs then go on to enumerate the newly required reporting requirements.

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<sup>18</sup> <https://www.nytimes.com/2018/07/16/upshot/costs-health-care-us.html>

<sup>19</sup> <https://www.nytimes.com/2018/07/22/us/politics/medicare-payments-trump.html>

<sup>20</sup> [http://www.dhcs.ca.gov/services/MH/Documents/Ltr\\_1915-b\\_Waiver\\_Amend\\_01\\_10\\_14.pdf](http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf)

The challenge is that many of these increased requirements have not been adequately factored in to contracting, payment, and reimbursement arrangements or rates. Thus, contracts include cascading requirements that organizations document and report things they have little, if any, control over, and often continue to lack requirements to track critical client outcomes data. Payment terms remain disconnected from actual performance or achievement of what is being reported and documented – and certainly from what is not being reported or documented. Reimbursement rates have not been adjusted to reflect the additional burden. Where changes have occurred, with provider workflows and (hopefully) staff-time allocations, there has been little to no movement on provider compensation.

According to The California Council of Community Behavioral Health Agencies (CBHA):

*Varying county-mandated documentation requirements results in California having an average of 20 minutes needed to document each therapy/treatment visit, which is four times the national average. Not only does this reduce the amount of time for professionals to provide services, the frustration associated with excessive documentation encourages trained and licensed staff to seek jobs outside of this field. Statewide standards must be established to increase treatment capacity and retain a qualified work force.<sup>21</sup>*

The challenging reality is that none of these reporting and documentation requirements are going to lighten without changing contracting arrangements and/or payment models (like integrated managed care contracting and case rates, discussed above). There is good news for providers though!

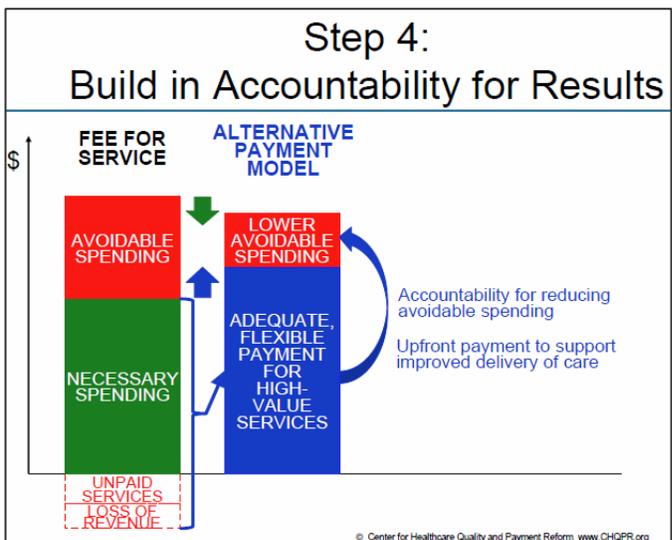
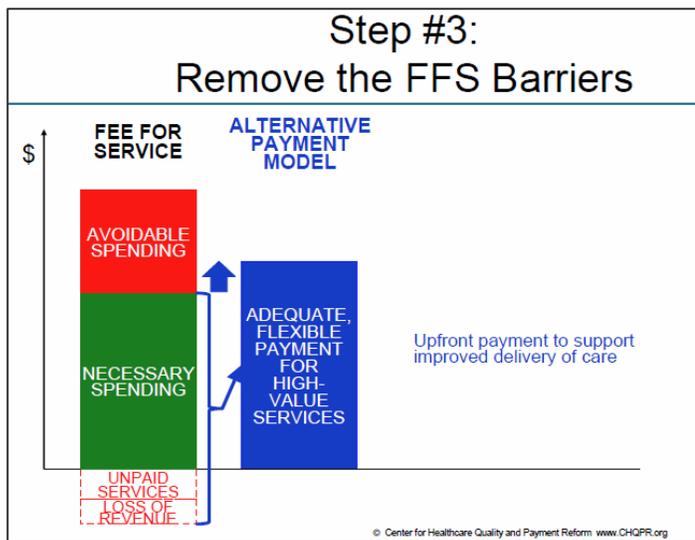
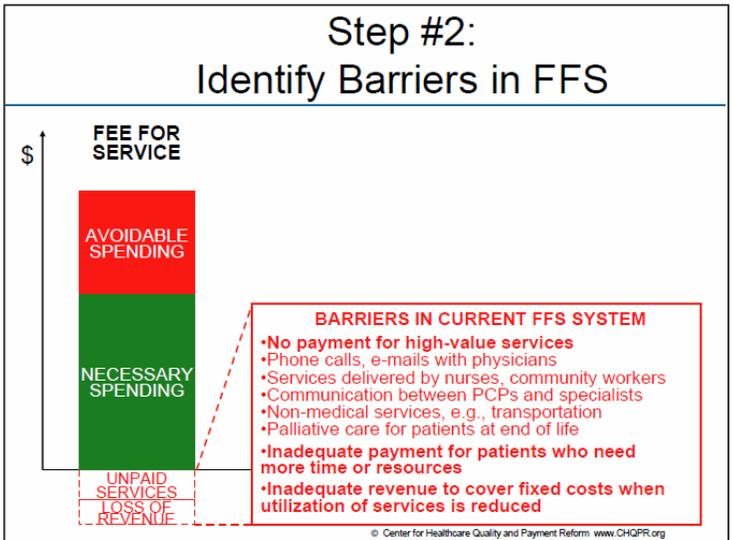
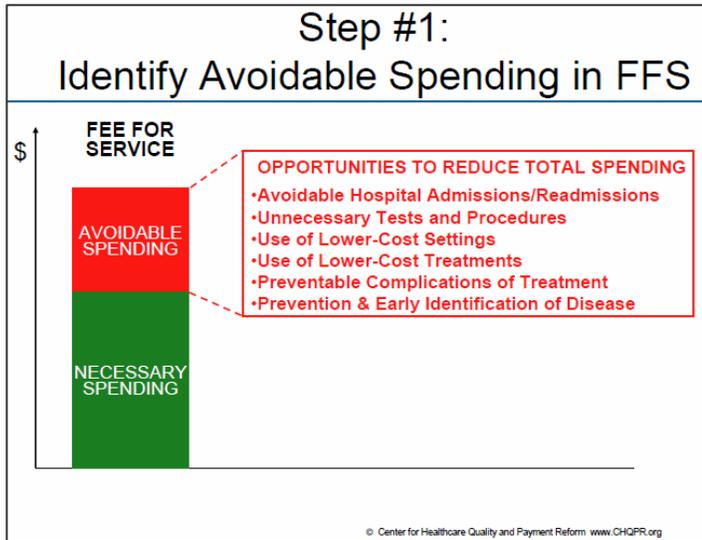
It is possible to address onerous administrative burdens and achieve value-based payments for what have traditionally been volume-based fee-for-service arrangements by following these steps:

1. Identify avoidable spending and barriers (like unnecessary reporting and documentation burdens)
2. Reduce avoidable spending and barriers
3. Use the resulting savings to reduce spending and adequately compensate providers, through an alternative payment model (such as a case rate)

These steps are further illustrated by the following graphics, presented by Harold D. Miller, President and CEO of the Center for Healthcare Quality and Payment Reform, during the National Value-Based Payment and Pay for Performance Summit in San Francisco in March 2017.

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<sup>21</sup> <https://www.cccbha.org/page/PolicyAdvocacy>



In other words, if you establish contracting and payment models that align with reporting and documenting the delivery of quality care that achieves health outcomes, for rates that cover the cost of care and support provider satisfaction, you should have enough money to cover the cost of care and the associated reporting.

### Next Steps

Of course, all of this is easier said than done, but in other parts of this paper we discuss contracting arrangements, payment models, and other strategies that will support the delivery of high quality behavioral health care for all Californians served by the safety net. Even if California does not move forward with integrated managed care or changes that allow for value-based purchasing of behavioral health services, there are still changes that could address the reporting burden for providers.

The state could work to establish criteria to quantify the staffing burden of future reporting and documentation changes and ensure this burden was reflected in reimbursement rates. Within the current contracting arrangements, providers could undertake a study of documentation requirements,

where they originated, what their intent is, and whether they are in fact required by federal, state, or county policy, using the results to re-negotiate the requirements and associated rates. Providers could also review current compliance-oriented reporting requirements and their performance, negotiating a threshold of success, where after a series of acceptable reports, compliance was established as being achieved and the reporting requirement lifted.

All of that said, in the current environment, the path toward addressing documentation and reporting burden is most likely going to be through changing payment models and contracting arrangements, allowing for a challenging mix of provider flexibility and accountability.

## Conclusion and Suggested Next Steps

It needs to be acknowledged up front that what gets included and addressed in Medi-Cal waivers, programs, other system transformation efforts is political. By virtue of having significant funding available, via MHSA and other sources, the behavioral health community has the foundation of a compelling case to be part of discussions related to the next waivers and other initiatives. However, having money is only part of the equation.

The next steps for each goal outlined above is for county behavioral health directors to review the concepts and provide feedback and ranking regarding feasibility, priority, and will to move forward. Then each concept needs vetting and further development in collaboration with clients, clinicians and other stakeholders to ensure they advance the Quadruple Aim through better care, better health, better costs, and improved work life of health care providers. In addition, it is critical that the behavioral health community engages in earnest in the waiver conversations already underway among managed care plans and hospitals to develop a more aligned approach for system transformations in California. Once the county behavioral health directors provide their feedback and prioritization, the MCOs and hospitals would need to be approached for their input, seeking alignment for an approach to be used in communicating with DHCS, and to develop a work plan to identify and address the policy and political issues, including:

- a. Federal legislative authority
- b. CMS authority, including what would need to be part of the following:
  - i. State Plan Amendment
  - ii. 1115 waiver
  - iii. 1915 waiver
  - iv. Other
- c. State legislative authority
- d. DHCS authority
- e. County-specific authority

By design, this document is intended to initiate a conversation among key stakeholders (such as you!) to elicit critical feedback on the proposed approaches in terms of feasibility, priority, and the overall will to pursue them. The intent is to continue to support the transformation of care to better meet the needs of individuals living with behavioral health disorders. Please [provide feedback using the tool we have developed](#) for this purpose, accessible [at this link](#), or by email to [Wayne.Clark@calmhsa.org](mailto:Wayne.Clark@calmhsa.org) and [john@ibhpartners.org](mailto:john@ibhpartners.org).