

## Carpe Diem Redux:

# Behavioral Health Transformation for 2020 and Beyond

### Overview

California's county-based behavioral health systems are at a crossroads. Behavioral health is now broadly recognized as a vital component of achieving and maintaining health and wellness and managing the total cost of care for individuals and populations. While stakeholders are looking with eager expectation to the behavioral health community for answers and results, many obstacles remain. Several program, service, and infrastructure transformation efforts are needed to address these obstacles.

Below are several improvements that can support meeting the behavioral health needs of all Californians. While each of these could be pursued in isolation, there are important opportunities for synergy that need to be explored and prioritized.

To make these improvements as effective as possible, stakeholders need to first establish general timelines for three overarching system transformations:

#### System Transformation Changes

- **Integrated Contracting:** When will California establish options to integrate contracting for health and behavioral health care services?
- **Regional Contracting:** When will California establish options to regionalize behavioral health contracting across multiple counties?
- **Value-Based Purchasing:** When will California establish behavioral health payment models that support provider excellence and payment for value?

Regardless of the answers to these timing questions, with the upcoming 1115 and 1915 waivers and other system changes, 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 system improvements should be considered as part of these waivers, potential state plan amendments, and other initiatives:

#### • System Improvements for Capacity and Outcomes

- **Promoting Emotional Health and Wellbeing:** Establish infrastructure that supports prevention of the occurrence and recurrence of behavioral health challenges.
- **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
- **Workforce Recruitment, Retention, and Resilience:** Establish statewide workforce retention reporting standards and require waiver-funded projects to explicitly include retention efforts
- **Supported Employment:** Establish opportunities for providing evidence-based supported employment services as billable behavioral health services
- **IMD Exclusion:** Establish budget-neutral opportunities for a waiver of the IMD payment exclusion for mental health services
- **Reporting and Documentation Reform:** 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

## Three Overarching System Transformation Questions

Transformations toward regionalization, integration, and value-based purchasing are closely linked, but do not need to be pursued simultaneously. Our analysis of national trends and the California context leads us to recommend that stakeholders explore and prioritize the options below, identifying state and individual county timelines for each effort.

### Integration and Regionalization

**Integrated Contracting:** *When will California establish options to integrate contracting for health and behavioral health care services?*

**Regional Contracting:** *When will California establish options to regionalize behavioral health contracting across multiple counties?*

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). Under these integrated managed care arrangements 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. For California, options could include the following.

- **Full Integration:** The state would contract with integrated health and behavioral health managed care plans, similar to current health care contracting. (no carve out / no regions)
- **Regionalization:** Counties would have the option to come together as regions for contracting with the state for behavioral health services, potentially following geography similar to current health care contracting. (keep carve out / add regions)
- **Regionalization and Integration:** Combining the two concepts above, the state would contract with one-county or regionally integrated health and behavioral health managed care plans, with explicit multi-county regional options. (no carve out / add regions)

In the absence of integration or regionalization, counties will be expected 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.

### Value-Based Purchasing

**Value-Based Purchasing:** *When will California establish behavioral health payment models 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. Irrespective of what the state does regarding integration or regionalization, the time is ripe to revise payment rules to allow for alternative payment methodologies that are not based solely on the cost of a service provided but rather on the value delivered. In concert with regional and integrated contracting or on their own, the following options should be considered.

- Development of a **prospective-payment system** for behavioral health, similar to that for FQHCs and for the Certified Community Behavioral Health Center (CCBHC) pilots around the country.
- Allowing behavioral health services to be included as part of **global budgets** for FQHCs using alternative payment methodology (APM), if the state moves forward with that.
- Allowing **same-day reimbursement for primary care and behavioral health visits** in health centers

Each of these payment reforms would support the system improvements for capacity and outcomes discussed below.

## System Improvements for Capacity and Outcomes

### **Promoting Emotional Health and Wellbeing:** *Establish infrastructure that supports prevention of the occurrence and recurrence of behavioral health challenges*

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. 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, identifying it when it happens, and minimizing the social, legal, health and economic consequences of untreated behavioral health challenges.

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.

Promotion and prevention efforts using 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.

### **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. 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.

The state should establish 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-funded services.

### **Workforce Recruitment, Retention, and Resilience:** *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 funded activities 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 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.

**Supported Employment: *Establish opportunities for providing evidence-based supported employment services as billable behavioral health services***

The state should pursue a 1915(i) State Plan Amendment (SPA) to secure funding for supported employment services. 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. As Jackie Pogue from Alameda County Behavioral Health Care Services explained in an earlier paper about this topic, 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).

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

California needs to build the business case for a waiver of the IMD exclusion for mental health services, allowing for equitable long-term care of mental illness as a chronic disease, when appropriate. While CMS has previously granted waivers of the IMD exclusion for mental health services, those waivers have all lapsed or are being phased out and CMS seems to be limiting IMD exclusion waivers to SUD services. The Drug Medi-Cal Organized Delivery System Demonstration (ODS) provides a limited waiver of the IMD exclusion for SUD services, but not

for mental health services. If California can show that the IMD exclusion waiver in its ODS 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 can use this information to support a case for a waiver of the mental health exclusion.

**Reporting and Documentation Reform: *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***

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 shift to data-driven care and achieving measurable client and clinical outcomes, but some is based on a perception that providers need to be held to higher standards of ensuring program integrity and compliance.

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.

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 value-based purchasing, above). 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. Moving to value-based purchasing would support data-driven care and achieving measurable client and clinical outcomes, easing the reporting burden and aligning documentation with clinical care and improved client outcomes.