California Advancing and Innovating Medi-Cal (CalAIM)
OVERVIEW: Behavioral Health Payment Reform
December 2022

How are Medi-Cal specialty behavioral health services reimbursed today?

In California, counties provide the majority of the state share of funding for Medi-Cal specialty mental health and substance use disorder services using dedicated revenue streams allocated by the State, including vehicle license fees and sales tax (1991 and 2011 Realignment funds) and Mental Health Services Act (MHSA) millionaire's tax dollars. As managed care plans, counties are responsible for administering covered Specialty Mental Health, Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System services throughout the state. County behavioral health (BH) plans may provide these services directly or contract with community-based behavioral health providers. Unlike other Medi-Cal managed care plans, counties do not receive per-member-per-month capitated payments. Federal reimbursement for specialty behavioral health services is limited to the cost incurred by counties. Counties claim payment for each service on an interim fee-for-service payment basis and are later subject to a cost reconciliation process.

What are the goals of behavioral health payment reform?

The CalAIM Behavioral Health Payment Reform initiative seeks to move counties away from cost-based reimbursement to better enable counties and providers to deliver value-based care that improves quality of life for Medi-Cal beneficiaries. The existing cost-based reimbursement model is administratively burdensome for the State, counties, and subcontracted behavioral health providers. The complexity of the cost settlement process creates significant audit risk. Long delays caused by statutory requirements in audit timelines create budget challenges for counties by requiring them to carry financial risk over multiple years. Opportunities for system reinvestment or value-based payments at the plan or provider levels are limited. Ending cost-based reimbursement and simplifying payments to county BH plans are foundational first steps toward future development of more innovative value-based payment models.

What will change, and when?

Beginning July 1, 2023, the CalAIM Behavioral Health Payment Reform initiative will change the way county BH plans claim federal reimbursement. As managed care plans,

counties will continue to contract with specialty behavioral health providers and negotiate provider payments under those contracts.

The CalAIM Behavioral Health Payment Reform initiative consists of three different transitions that will go live July 1, 2023:

I. Reimbursement Structure: End cost-based reimbursement and implement fee-for-service payments to county BH plans.

Goals: Simplify county BH plan payments and reduce administrative burden for the State, counties, and providers. Develop county BH plan rates sufficient for the plan to attract and maintain an adequate network of qualified specialty providers.

Present Cost-Based Reimbursement	Future Fee-for-service Reimbursement
• County BH plans claim federal reimbursement on an interim basis for each service rendered. • Counties and their contracted providers submit annual cost reports subject to audit, reconciliation, and cost settlement. • County BH plan reimbursement is limited to cost. Provider payments are negotiated with County BH plans.	• County BH plans claim fee-for-service reimbursement at rates established in a BH *plan* fee schedule. • County BH plans negotiate payment terms and rates with subcontracted providers. • County BH plan reimbursement for each service is final, with no additional settlement to cost for county BH plans.

II. Financing Mechanism: Transition to Intergovernmental Transfers (IGTs) to finance Medi-Cal county BH plan payments.

Goals: Enable county BH plans to continue providing the non-federal share of cost for Medi-Cal services without certified public expenditures and cost-based reimbursement.

Present Certified Public Expenditures (CPEs)	Future Intergovernmental Transfers (IGTs)
• County BH plans purchase specialty services and attest to expenditures of non-federal share under a Certified Public Expenditure (CPE) protocol. • CPE-based financing is based on actual costs incurred and requires cost reporting, audit, and settlement to finalize federal reimbursement to county BH plans.	• Reimbursement is claimed via the fee schedule with the county share transferred by the county to the State. • Sources of non-federal share available to county BH plans and eligible for use as IGTs (including Realignment and MHSA funds) do not change.

III. <u>Provider Billing:</u> Implement CPT Coding Transition.

Goals: Improve reporting and support data-driven decision making by disaggregating data on specialty behavioral health services. Align with other healthcare delivery systems and comply with Centers for Medicare & Medicaid Services (CMS) requirements for all state Medicaid programs to adopt CPT codes where appropriate.

Present **HCPCS Level II – All services**	**Future** **CPT/HCPCS Level I – Where applicable**
• HCPCS Level II codes are highly flexible; a variety of activities may be captured by the same code, making detailed analysis of services rendered a challenge. • HCPCS Level II codes can be used by any provider (licensed or non-licensed).	• CPT codes: more detailed and nationally standardized definitions for each code. • Some HCPCS Level II codes will be retained, for those behavioral health providers and services not captured by CPT codes.

**HCPCS: Health Care Common Procedure Coding System*
**CPT: Current Procedural Terminology*