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Research Report

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Carve-In Models for Specialty Behavioral Health Services in Medicaid

Lessons for the State of California

In Medi-Cal, California's Medicaid program, mental health (MH) and substance use disorder (SUD) services, collectively referred to as behavioral health (BH) services, are financed and managed separately from other services for enrollees with serious mental illnesses (SMI) and/or SUD. This arrangement, known as a *carve-out* because responsibility for financing and managing BH services is separated, or "carved-out," from general medical insurance, is not unique to California. Historically, many state Medicaid programs have used a carve-out model for BH services

KEY FINDINGS

- Despite significant momentum for the adoption of Medicaid behavioral health carve-ins as a strategy to promote greater clinical integration, evidence on the model's impacts is surprisingly limited and its significance for California is uncertain because of differences in policy contexts.
- However, qualitative evidence suggests that (1) carve-ins do not necessarily result in expected outcomes, (2) carve-in states have taken additional regulatory actions to promote expected outcomes, (3) carve-in states have used other approaches to mitigate the model's potential risks, and (4) carve-in implementation requires an incremental, stakeholder-engaged process.
- A major finding is that carve-in and carve-out models can have comparable performance if designed to both facilitate their expected benefits and minimize their potential risks. Given the limited evidence of benefits and the potential for risks from a carve-in transition, California may shift its attention to identifying those desirable design features while preserving what works well in the current system.
- Potentially effective strategies include (1) providing adequate and timely payment to payers and providers to enable the delivery of evidence- and need-based specialty behavioral health care, (2) strengthening contracting and data analytics expertise to monitor performance and conduct oversight, and (3) promoting clinical integration through investments in linking structures that enhance organizational integration.

(Busch, Frank, and Lehman, 2004). However, in recent years the pendulum has begun to swing in the opposite direction, with a growing number of state Medicaid programs opting for "carve-ins" that combine financing and management of the BH benefit with the larger pool of Medicaid-covered services. Under a unified carve-in arrangement, care is managed by a single organization, typically a Medicaid managed care organization (MCO). More than 20 states had BH carve-outs in 2004 (Busch, Frank, and Lehman, 2004), but as of 2019, only six of 39 Medicaid managed care (MMC) states and the District of Columbia maintained BH carve-out contracts for all BH services for enrollees with SMI and/or SUD (Gifford et al., 2019). In most carve-out states, these contracts are with MCOs that specialize in BH care, but in California, the carve-out contracts are with county BH departments.

In the context of this national trend toward carve-ins of BH financing in Medicaid, and as California's Department of Health Care Services (DHCS) renews the waiver authorizations that permit the use of managed care to deliver services (both the Section 1115 demonstration waiver and the Section 1915[b] specialty mental health services waiver), DHCS is pursuing a broad reform of California's Medi-Cal system that includes a proposal to pilot carve-in contracts for enrollees with SMI/SUD beginning in 2027. The goals of the reform, known as California Advancing and Innovating Medi-Cal (CalAIM), are to improve the quality of Medi-Cal-funded care and enrollees' quality of life and health outcomes (DHCS, 2021d). To achieve these goals, the state plans to undertake "broad delivery system, program, and payment reforms" in order to integrate delivery systems and align financing and quality targets (DHCS, 2021d).

As California stakeholders and policymakers consider a BH carve-in for Medi-Cal, it is important for them to have information on the experience of other states that have recently considered or implemented similar changes. To provide this information, the California Behavioral Health Directors Association (CBHDA) asked the RAND Corporation to conduct a literature review and environmental scan of recent Medicaid BH carve-ins. This report presents the results of that project.

Transitioning from a Carve-Out Model to a Carve-In Model

Carve-Out Model: Rationale and Outcomes

The push toward carving out BH services that held sway in the United States well into the late 2000s was propelled by two main motivations. First, there was a concern that the delivery of BH services requires specialized expertise and systems of care that mainstream organizations are not equipped to provide or manage (Frank and Garfield, 2007). People with SMI tend to have long-term chronic conditions that require diverse and well-integrated clinical and social supports. At the time Medicaid began, the specialty BH sector was dominated by large psychiatric hospitals. Since then, the BH specialty sector has evolved into a complex field with a multitude of provider types who work in a variety of community-based clinical settings. Because mainstream MCOs were thought to lack the expertise needed to manage these distinctive features of specialty BH care, management of these services by organizations with specialized expertise was preferred.

Second, there was a concern about adverse selection—that is, that MCOs would avoid enrolling beneficiaries with serious BH problems because of the associated excess costs and would shift resources away from those with the greatest need (Frank et al., 1996). Because of capitated financing mechanisms, MCOs stand to benefit by enrolling beneficiaries who are healthier or less likely to use costly services than the average beneficiary. Enrollees with comorbid SMI/SUD tend to be high utilizers not just of BH care but also of physical health (PH) care, thus providing MCOs with a financial incentive to avoid enrolling them. Risk adjustment is commonly used to counter incentives for adverse selection, but methods for risk adjustment for BH care had limited effectiveness (Ettner et al., 2000; Frank et al., 1996). By carving BH care out of Medicaid, states were able to mitigate the incentive for MCOs to avoid enrollees with SMI/SUD as a business strategy.

Two forms of carve-out arrangements can be distinguished. In *payer carve-out* arrangements, the state enters into separate contracts for the BH and

PH components of enrollees' health care. The BH contracts are typically with specialized BH MCOs but can also be with public payers, as in California. In *health plan carve-outs*, the state enters into a single contract for all health care with a mainstream MCO but allows for *subdelegation* of the BH component. Subdelegation is an arrangement whereby the MCO enters into a subcontract with a specialized BH MCO to manage BH services (Frank and Garfield, 2007). Although payer carve-outs might address adverse selection more effectively and state oversight might be more straightforward relative to health plan carve-outs (Frank and Garfield, 2007; McConnell et al., 2021), the research literature tends to presume that outcomes are comparable for both forms of carve-out arrangements (Frank and Garfield, 2007; Charlesworth et al., 2021). *In this report we focus on the potential transition from a payer carve-out model, i.e., the California model for enrollees with SMI/SUD, to a carve-in model.* Like Frank and Garfield (2007) and Charlesworth et al. (2021), we consider health plan carve-outs to be variations of the carve-out model, in which financial integration is less likely to be fully realized.

Frank and Garfield's (2007) exhaustive review of peer-reviewed studies of Medicaid and commercial payer and health plan carve-outs suggests mixed performance. Compared with pre-carve-out integrated fee-for-service (FFS) or managed care systems, Medicaid BH carve-outs were associated with lower utilization of psychiatric inpatient services and lower total costs for enrollees with SMI/SUD. However, Frank and Garfield were unable to draw firm conclusions regarding carve-out effects on BH outpatient utilization and quality of BH care.

Motivation for the Shift Toward Carve-Ins

A key driver of the current trend toward carving in BH services is the serious burden of disease associated with chronic medical comorbidities among adults with SMI, which may be partly caused by poor access to high-quality PH care, and evidence that strategies to enhance *clinical integration* of BH and PH care improve PH care outcomes (Scharf et al., 2014; Druss et al., 2010). *Clinical integration*—the sharing of information and coordination of activities between BH and PH providers in the service of care that is both comprehensive and continuous over time (Gittell et al., 2000; Minkoff, 2001)—may be affected by two other forms of integration—financial and organizational. *Financial integration* is achieved when financial incentives for the BH and PH care systems are well aligned through contractual arrangements; conversely, financial integration is thought to be undermined when services are financed separately, such as in states with BH carve-out arrangements. The lack of financial integration might be responsible for patients having only their BH (or PH) needs addressed when seen by their regular health care providers; as a result, enrollees with SMI or other chronic BH and PH comorbidities may need to manage several distinct systems of care. Likewise, clinical integration might be enabled by *organizational integration* achieved through the availability of well-functioning linking structures such as case management and integrated health information systems, and be undermined when these structures are absent or deficient (Horvitz-Lennon, Kilbourne, and Pincus, 2006; Shortell et al., 2000). MCOs may be more capable than publicly funded BH systems to invest in these linking structures as part of data-intensive population health management and other approaches. Because carve-in systems rely on primary care practices as the point of entry into all health care, these systems provide a significant fraction of BH care in primary care settings.

The final rule regarding compliance with the Mental Health Parity and Addiction Equity Act issued in 2016 by the Centers for Medicare & Medicaid Services (CMS) stands out among the federal policies that have contributed to turning the tide toward carve-ins (Ettner, Xu, and Azocar, 2019). Although the rule charged MCOs with responsibility for parity analysis and compliance, this burdensome responsibility is borne by the state in carve-out states.

Medicaid-Financed Care in California: Challenges and Opportunities

California, a State with a Relatively High Public Behavioral Health Spending and a High Cost of Living

California has had a relatively high per capita public BH spending in recent years, but its high cost of living—the amount of money needed to afford basic needs such as housing, food, transportation, health care and others—might be eroding the purchasing power of this spending. In fiscal year 2014, California ranked 14th among states in per capita public BH spending (Substance Abuse and Mental Health Services Administration, 2015). However, in 2019, it had the second-highest price level for consumption goods and services, including housing rents (U.S. Department of Commerce, Bureau of Economic Analysis, 2020). Even after accounting for public benefits and social spending, California had the highest poverty rate in the nation in 2017–2019 (Fox, 2020). Housing represents a particularly challenging problem for California. An average California home costs two and a half times the national average, and the average monthly rent is about 50 percent higher than in the rest of the country (California Legislative Analyst's Office, 2019a). Based on counts of people experiencing homelessness in 2020, California accounted for more than half of all unsheltered people in the United States, with nearly nine times the number of unsheltered people as Texas, the state with the next-highest number (Henry et al., 2021). Poverty, homelessness, and other social ills are likely to be far more widespread among Medi-Cal enrollees with SMI/SUD.

The Medi-Cal Health Care System

As described in detail below (also see Figure 1), California's Medicaid-financed health care system involves several separate systems financed through different Medicaid authorities (Tatar and Chambers, 2019).

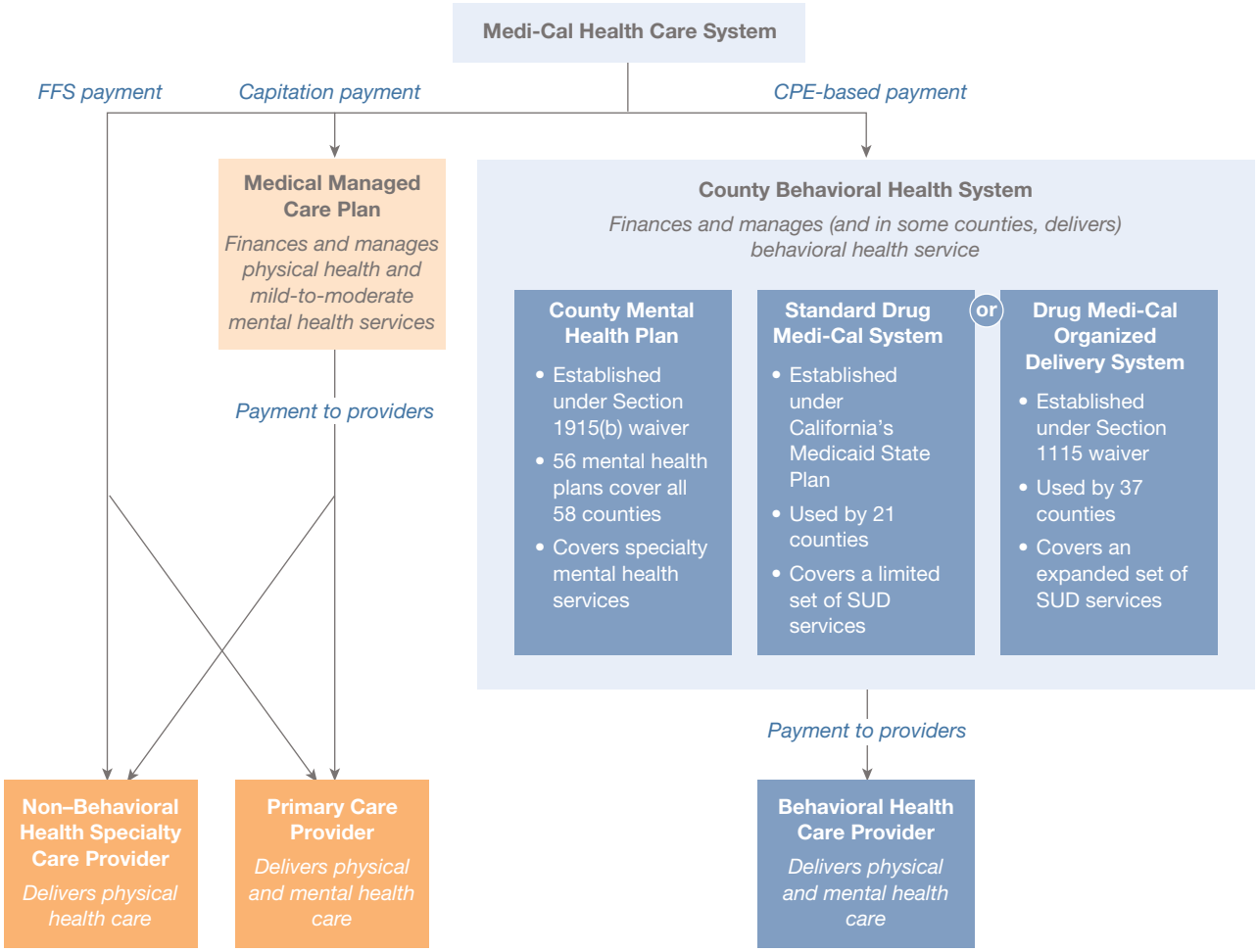
Counties and the County-Based Specialty Behavioral Health System

Consideration of a BH carve-in for California should take account of California's BH system, which is distinctive in its decentralization, with responsibility for organizing and managing specialty BH care for a high-need segment of the Medi-Cal enrollee population residing primarily with counties rather than the state. Counties are responsible for the financing and management of Medi-Cal specialty MH services for enrollees with SMI, including children with serious emotional disturbances (SED) (see Table 1 for age-specific eligibility criteria). Because counties operate under a managed care Medicaid authority—a Section 1915(b) specialty mental health services waiver first approved in 1995—they are considered prepaid inpatient health plans and are typically referred to as county mental health plans (MHPs). Currently, 56 county MHPs cover all 58 counties throughout the state (there are two multi-county MHPs: Sutter/Yuba and Placer/Sierra); MHPs provide services to approximately 615,000 Medi-Cal beneficiaries (DHCS, 2021e). County MHPs are responsible for a broad array of specialty MH services, ranging from psychiatric inpatient hospitalization to a variety of outpatient specialty MH services, including assessment, plan development, therapy, and rehabilitation; medication support services; intensive day treatment and rehabilitation; crisis services (intervention, stabilization, and residential treatment); adult residential treatment services; targeted case management; and, for enrollees younger than 21 years, therapeutic foster care services and intensive community-based services (Tatar and Chambers, 2019). Some of this care is delivered through institutions for mental disease (IMDs)—that is, psychiatric hospitals and residential treatment facilities with more than 16 beds (DHCS, 2021g); under federal law, counties cannot use Medi-Cal funds to finance IMD care for enrollees aged 21–64 (California Department of Mental Health, 2010). Emergency department (ED) care is largely covered separately by the MMC system when provided in general acute care hospital settings.

Counties are also responsible for Medi-Cal SUD services, which are managed separately from MH services (Brassil, Backstrom, and Jones, 2018).

FIGURE 1

Medi-Cal Health Care System



NOTE: CPE = certified public expenditures.

County SUD services are covered through one of two different authorities: Drug Medi-Cal, a program covered under the state plan, and the Drug Medi-Cal Organized Delivery System (DMC-ODS), a pilot program covered under a Section 1115 demonstration waiver. Drug Medi-Cal covers a limited set of SUD services on a FFS basis in 21 counties; the services include outpatient drug-free treatment, intensive outpatient treatment, residential SUD services for perinatal women (limited to facilities with 16 or fewer beds), and naltrexone and methadone treatment as part of the state's "narcotic treatment program" (Brassil, Backstrom, and Jones, 2018). The DMC-ODS program is administered by the remaining 37 counties as pre-paid inpatient health plans covering over 90 percent of the Medi-Cal population; the program stands as a trailblazer in the national trend to offer a more generous Medicaid-financed SUD benefit (Valentine, Violett, and Brassil, 2020). In addition to the services covered under Drug Medi-Cal, the DMC-ODS program covers a broader set of residential SUD services, including an expanded narcotic treatment program (e.g., buprenorphine treatment), withdrawal management, physician consultation, case management, recovery services, and two optional services: partial hospitalization and additional medication-assisted treatments (Brassil, Backstrom, and Jones, 2018).

Many counties deliver specialty BH services directly through county-operated programs and

TABLE 1

Eligibility Requirements for County MHP-Covered Services

Medi-Cal Enrollees 21 Years and Older (*both* requirements A and B must be met)		Medi-Cal Enrollees Younger Than 21 Years (*either* criterion 1 or criterion 2 must be met)	
Requirement A: Enrollee has one of the following: • significant impairment (*impairment* is defined as distress, disability or dysfunction in social, occupational, or other important activities) or • a reasonable probability of significant deterioration in an important area of life functioning.	**Requirement B:** The condition in A is due to: • a diagnosed MH disorder (according to official nosology) or • a suspected MH disorder that has not yet been diagnosed.	**Criterion 1:** Enrollee has a condition that puts them at high risk for a MH disorder due to experiencing trauma, evidenced by any of the following: • scoring in the high-risk range on a DHCS-approved trauma screening tool • involvement in the child welfare system • experience of homelessness.	**Criterion 2:** Enrollee must meet both A and B: • A. Enrollee must have at least one of the following: – a significant impairment (as defined in criterion 1) – a reasonable probability of significant deterioration in an important area of life functioning – a reasonable probability of not progressing developmentally as appropriate – a less than significant impairment but requires MH services that are not included within the MH benefits that MMC plans are required to provide. • B. The condition in A is due to: – a diagnosed MH disorder (according to official nosology) or – a suspected MH disorder that has not yet been diagnosed.

facilities. Counties also contract with local specialty BH providers, particularly larger counties that can more readily access a network of local specialty providers.

California currently uses a certified public expenditures (CPE) mechanism to pay for specialty Medi-Cal BH services, whereby counties draw from county funds to pay for services rendered to Medi-Cal enrollees; after a lengthy accounting process with the state, they receive the Federal Financial Participation (FFP) funds—that is, the federal match for Medi-Cal eligible services. For the 2017–2018 fiscal year period, federal funding available through Medi-Cal constituted over one-third of counties' total funding for BH services (California Legislative Analyst's Office, 2019b), an average that obscures important differences among counties.

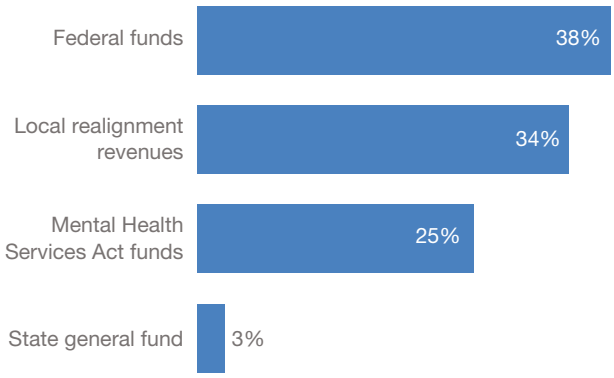
To the extent that resources are available, counties also fund and coordinate access to BH services beyond the scope of the Medi-Cal program, thus serving as the ultimate safety net for vulnerable residents. Beginning in the 1960s, a series of state laws shifted responsibility for administering and financing of public BH services and other services to counties. The 1968 Lanterman-Petris-Short Act required a judicial hearing to determine whether a person could be involuntarily hospitalized, thereby reducing state hospital commitments. In addition, it required counties with populations over 100,000 to establish MH programs and increased state funding for these programs (Semel Institute for Neuroscience and Human Behavior, undated). In response to state budget shortfalls in 1991 and 2011, two rounds of legislation known as "Realignment" transferred responsibility for administering and financing several BH, social service, and criminal justice programs to the counties. The 1991 Realignment legislation, known as the Bronzan-McCorquodale Act, provided counties with a portion of revenue from state sales taxes and vehicle license fees to fund several MH and social service programs. Subsequently, a series of bills in 2011 allocated a portion of state sales tax revenue to fund specific BH services and completed the transfer of responsibility for public MH services to counties.

The 1991 and 2011 Realignments represent distinct funding sources because they were authorized under different statutes and used to fund different county obligations (Arnquist and Harbage, 2013). Realignment revenues constitute approximately one-third of counties' total funding for BH services. In 2004, California voters approved the Mental Health Services Act (MHSA), which placed a state tax on incomes above $1 million and allocated the revenue to certain types of BH expenditures. MHSA funds constitute approximately one-quarter of total BH funds. Counties use 1991 and 2011 Realignment and MHSA funds as nonfederal funding to draw down FFP funds for Medi-Cal services. Additionally, counties use these funds and other local funding sources to finance a broad array of services not covered by Medi-Cal, as well as care for uninsured and commercially-insured individuals. Other sources include federal block grants, the State General Fund, and in some counties, county general funds (California Legislative Analyst's Office, 2019d). See Figure 2 for a description of funding sources for the fiscal year 2017–2018.

Counties braid their diverse funding sources to support a broad array of BH and other services needed by people with SMI/SUD, including BH services that are not covered by Medi-Cal and thus not eligible for FFP funds. Examples of the latter include community outreach and engagement, prevention and early intervention programs, selected crisis services, wraparound services, housing, residential care, IMD care, and jail-based treatment. In addition to this full spectrum of services, during emergencies and disasters, counties provide crisis counseling to affected communities, also investing in health promotion activities, such as MH public awareness campaigns. Counties address the complex social needs of Medi-Cal enrollees with SMI/SUD in partnership with various local agencies and nongovernmental organizations. For instance, counties' role in crisis stabilization requires strong relationships with hospitals, EDs, and other organizations on the crisis continuum. Many county BH departments manage and/or interact with programs addressing homelessness, often not funded through Medicaid or other payers. Further, counties often have relationships with agencies serving those with criminal justice involvement, including the public defender (to support diversion and reentry programs), probation, and special drug or mental health courts. To serve children, counties tend to have relationships with school districts and child and family services.

FIGURE 2

County Behavioral Health Services Funding by Source, 2017–2018



SOURCE: California Legislative Analyst's Office, 2019c.

The Role of Medi-Cal Managed Care in Physical Health and Mild-to-Moderate Mental Illness Care

General PH services in Medi-Cal are financed through the MMC system, which also has responsibility for the care of enrollees with mild-to-moderate mental illnesses. MMC-financed MH services include outpatient services delivered as part of the scope of practice of providers of primary care and include individual and group evaluation and treatment, medication management, diagnostics (psychological testing, laboratory), antidepressant drugs and other psychotropic drugs (except drugs considered specialty drugs, financed on FFS basis, see below), psychiatric consultation, and ED care provided in general acute care hospital settings.

Each county uses one of six MMC models: *County Organized Health System* (COHS), in which the MMC plan is a single plan option run by the county; *Two-Plan Model*, in which there is a commercial plan and a county-sponsored MMC plan (a local initiative plan) serving one or more counties; *Geographic Managed Care*, in which several commercial plans operate within a single county;

Regional, in which rural counties not participating in the COHS model or as a local initiative plan offer Medi-Cal managed care through commercial health plans; or one of two *Single-County Models* (in Imperial and San Benito Counties) that originated out of the regional model to serve rural expansion needs (DHCS, 2020a). Because California permits subdelegation (Mann et al., 2016), a fraction of the state's enrollees with mild-to-moderate mental illnesses have their BH services managed by specialized BH MCOs. We are not aware of research comparing their outcomes relative to those whose BH services remain carved in.

The Role of the Fee-for-Service System

Enrollees with mild-to-moderate mental illnesses receiving nonspecialty MH services through the same delivery system as that used by the MMC system may have their care financed on a FFS basis (Tatar and Chambers, 2019). Additionally, antipsychotic drugs and drugs used to treat SUD, including the opioid agonist buprenorphine, are currently financed on a FFS basis (DHCS, 2020b).

CalAIM as a Means to Address the Challenges

Because of the complex set of arrangements described above, the MH, SUD, and PH care of Medi-Cal enrollees are financed under different authorities and delivered through separate systems that typically lack linking structures or incentives for greater system integration. The state is attempting to address these challenges through the CalAIM proposal, which includes multiple reforms directly or indirectly affecting the care received by enrollees with SMI/SUD and that will be phased in and implemented no sooner than January 1, 2022 (DHCS, 2021a). Below, we describe some of the key reform initiatives.

1. Pilot Integration of Mental Health, Substance Use Disorder, and Physical Health Financing

As part of CalAIM, the state is pursuing approval for a single, comprehensive Section 1915(b) waiver to consolidate the existing managed care authorities. If approved, the state will combine each county's MHP and DMC-ODS plan into a single plan providing MH and SUD benefits. In addition, the state will undertake a pilot BH carve-in through MMC plans covering BH, PH, and oral health care in counties that agree to participate. These comprehensive plans would go live no sooner than 2027.

2. Payment Reform

The state would shift from employing the CPE approach to provide counties with the federal match for Medi-Cal-eligible services, as described above, to employing an intergovernmental transfer (IGT) approach. Under IGT, counties would transfer their share of Medi-Cal BH spending to the state to draw down federal matching funds rather than paying for the full cost of services up front and receiving reimbursement after a lengthy reconciliation process. Under the IGT approach, counties would receive a fixed payment for each type of service rendered based on a fee schedule—that is, FFS payments. Hence, payment reform requires an expansion of the use of Health Care Procedural Coding System (HCPCS) Level I codes, also referred to as Current Procedural Terminology (CPT) codes; currently, specialty BH service utilization is predominantly described with HCPCS Level II codes. Payment reform is slated to be implemented in July 2023 (DHCS, 2021a).

3. Behavioral Health Medical Necessity Criteria

The state will update and clarify the medical necessity criteria governing Medi-Cal eligibility for specialty BH services, in response to concerns that, as currently written, the criteria might limit Medi-Cal enrollees' access to needed services and pose an unnecessary burden on county MHPs and providers as a result of onerous documentation requirements and risk of payment disallowance. Proposed changes include allowing reimbursement of treatment before diagnosis and during the assessment period; development of standardized screening and transition tools to determine whether a Medi-Cal member should be served by the specialty BH system or an MCO; clarifying that treatment for co-occurring SUD is reim-

bursable if there is medical necessity; and an update of eligibility criteria for specialty MH services, including psychiatric inpatient level of care. Changes to BH medical necessity criteria will be implemented in January 2022.

4. Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

As already mentioned, under federal law, Medicaid funding cannot be used to pay for services provided in psychiatric hospitals or residential treatment facilities that qualify as an IMD, a policy commonly referred to as the IMD exclusion. The state will apply for a Section 1115 demonstration waiver, also referred to as an IMD exclusion waiver, which, if approved, will allow California to receive FFP funds for short-term, acute care stays by Medi-Cal enrollees with SMI in demonstration counties that opt into the opportunity. If the waiver is approved, it is expected that even participating counties will continue to pay for inpatient services without FFP funds, given federal requirements that the average length of stay not exceed 30 days. The goals of the demonstration are to reduce utilization and lengths of stay in EDs; reduce preventable readmissions; improve availability of crisis stabilization services; improve access to community-based BH services, including through increased integration of BH and PH care; and improve care coordination in the community following acute care utilization. The state expects to launch the SMI/SED demonstration opportunity in 2023–2024.

5. In Lieu of Services and Enhanced Care Management

To address social determinants of health, the state is planning to introduce a new menu of "in lieu of" services (ILOS) in its state plan. The ILOSs are described as flexible wraparound services allowed under federal law and delivered as part of population health strategies to prevent use of costlier services, such as ED utilization. Examples include housing tenancy and sustaining services, community transition services, and sobering centers. In addition, the state would replace the Health Homes program and Whole Person Care pilots with an enhanced care management (ECM) benefit to coordinate medical and social services for high-need Medi-Cal enrollees. As described by the state, ECM is "a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services" (DHCS, 2021d). Both the ILOS and ECM programs will be managed and administered by MMC plans; all plans will be required to cover ECM, whereas ILOS may be made available at the plans' discretion. These benefits will be available starting January 2022.

6. Integrating all Pharmacy Benefits Under the Medi-Cal Rx Program

The state will create the Medi-Cal Rx program, which will administer all drugs under a FFS arrangement; this will require carving the pharmacy benefit out of the MMC system. The state's rationale for this change is to "standardize the Medi-Cal pharmacy benefit statewide, under one delivery system; improve access to pharmacy services with a pharmacy network that includes approximately 94 percent of the state's licensed outpatient pharmacies; apply statewide utilization management protocols to all outpatient drugs; strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers, thereby creating additional costs-savings" (DHCS, 2020b). Under the new FFS arrangement, the state will contract with only one pharmacy benefit manager (PBM) to administer these benefits (DHCS, 2021b). The program's launch has been postponed, with a new launch date of January 1, 2022.

Objectives of This Study

In the context of CalAIM's BH reform initiatives, the CBHDA is interested in understanding the experience that other Medicaid state programs have had with BH carve-in arrangements. This project set out to examine the experience that other states and localities have had upon adopting a BH carve-in model to inform how this model might fare in the California context and identify key issues for the state to consider. This evidence will yield lessons that are of interest to California policymakers concerned with achieving the three aims of health care for Medi-Cal enrollees with SMI/SUD: improving the experience

of care, improving enrollees' health, and reducing costs of health care.

Specifically, we (1) evaluated the perceived or quantified effects that carve-ins have had in Medicaid systems that carved specialty BH services into MMC for enrollees with SMI/SUD and, prior to the transition, managed and delivered PH care through MMC and (2) identified the impacts of carve-in design features, such as robustness of contracting between states and MCOs, and implementation features, such as phased-in roll-out, on those outcomes.

We focused on the following outcomes:

- financial, organizational, and clinical integration
- access to, the quality of, and the value of BH and PH care
  - *access*, defined through utilization of outpatient and acute (inpatient and ED) care
  - *quality*, defined as adequate access to the continuum of outpatient BH services needed by enrollees with SMI/SUD, including evidence-based practices (EBPs) and access to preventive/primary care and specialty PH care for chronic medical comorbidities
  - *value*, defined as the cost of high-quality care
- patient outcomes, including BH and PH symptom changes, social functioning, and quality of life
- equity, or the absence of health and health care disparities by race/ethnicity, gender, sexual orientation, disability, or other population characteristics
- integrity of BH budgets following carve-in
- costs associated with BH care; acute care, including IMD care; and all health care.

We also evaluated whether there are differential carve-in effects for individuals with SMI/SUD relative to those with mild-to-moderate mental illnesses.

Methods

Our overall goal was to bring the experience of other state Medicaid programs that have recently carved in BH services to bear on discussions of carving in BH services in Medi-Cal. To this end, we used a three-part strategy that we describe in greater detail below. First, we identified states that have recently implemented carve-ins, drawing on the peer-reviewed and gray literature and interviews with experts in academia and advocacy organizations. Second, we systematically reviewed peer-reviewed studies to assess evidence of the impact that these carve-ins have had on integration and other study outcomes. Third, we identified important design and implementation issues relevant to the California context through interviews with three types of key informants: policy experts, informants from the states that have recently implemented carve-ins, and officials at the state and county levels in California's BH system.

Identification of States for Interviews

To identify states for key informant interviews, we conducted an environmental scan of state Medicaid programs that went through a similar transition to what California is considering. Specifically, we investigated whether each state Medicaid program experienced a policy change to cover BH services under a *comprehensive MCO*—that is, an MCO that covers all health services, including BH services. Our identification process began by reviewing CMS's managed care enrollment reports from 2010 through 2018 (the most recent timeframe available), classifying states based on the following: (1) whether the states experienced substantial increases in their percentage of Medicaid enrollment in comprehensive MCOs (i.e., a MMC carve-in plan)[1] and (2) whether states that experienced these increases previously had Medicaid enrollment in a comprehensive MCO that did not cover BH.

We then reviewed CMS profiles and program features of each state MMC program, as well as policy documents from state Medicaid websites, to determine which Medicaid subpopulations had undergone the transition to enrollment in a MMC BH carve-in plan. These subpopulations included enrollees with SMI/SUD, the non-Medicaid-expansion population,

[1] We considered "substantial increases" to be states that started below 30 percent enrollment in carve-in plans and increased to over 60 percent enrollment between 2010 and 2018.

and any/all of the states' Medicaid beneficiary populations (which can include SMI/SUD). Throughout this classification process, we also took note of other features of Medicaid programs that could be relevant to California, as policy context or for a future carve-in plan. These features included a pre-carve-in arrangement featuring a county-managed BH carve-out, geographic coverage (statewide versus regional), covered services, and carve-in design features such as the creation of *special needs plans* (SNPs) for enrollees with SMI/SUD or the use of subdelegation leading to health plan carve-outs.

Following this search, we selected state Medicaid programs for interviews where the BH carve-in entailed transitioning enrollees with SMI/SUD into a preexisting MMC system that was already managing their PH care. We also prioritized states that had experience with county management of BH services prior to the carve-in, SNPs for enrollees with SMI/SUD, or with subdelegation. Seven states fulfilled these criteria: Arizona, Florida, New York, New Mexico, Oregon, Texas, and Washington.

Review of the Literature on the Impacts of Carve-Ins

The purpose of our literature search was to identify articles that have examined Medicaid transitions to carving in BH services. In pursuit of this goal, we searched for peer-reviewed articles on PubMed from January 1, 2010, through June 30, 2021, using the following search string: ("mental health" OR "behavioral health" OR "mental illness" OR "substance use disorder" OR "addiction") AND ("financial integration" OR "budget integration" OR "integrated managed care" OR "carve-in" OR "carve-out") AND Medicaid. We then supplemented our search using Google Scholar to identify both peer-reviewed and gray literature from the same timeframe using the following string: ("mental health" OR "behavioral health" OR "mental illness" OR "substance use disorder" OR "addiction") AND "carve in" AND Medicaid.

This initial search yielded nine results in PubMed and 193 results in Google Scholar. After our initial search screen, we reviewed each of the articles' titles and abstracts to determine whether they were relevant to the overall purpose of our study. We assessed relevance based on whether the article either assessed outcomes of Medicaid programs that transition to carving in BH services or described the implementation process of the transition. We identified nine articles through this process: three peer-reviewed articles that employed quasi-experimental methods to assess the effects of Medicaid BH carve-ins and six articles, one of them peer-reviewed and five published in the gray literature, that employed qualitative methods to explore policymaker perspectives on Medicaid BH carve-ins. For each of the articles, we then reviewed their referenced literature to identify additional articles. This process, however, did not lead to the inclusion of more articles.

Following this identification, we abstracted key information from each article. For articles reporting on quasi-experimental research, we identified the datasets, study population, control groups, study period, study design, and outcomes assessed.

Assessment of Carve-In Design and Implementation Challenges

To identify and describe the key design and implementation issues that might impact a carve-in in California, we conducted interviews with three types of key informants: policy experts, a variety of informants in the states identified as having recently implemented a carve-in as described above, and a variety of officials based in California. Interviews were about 60 minutes long and were conducted by at least two RAND researchers, one leading the interview and one taking notes. Interviews were audio-recorded with consent of the interviewees for reference by the researchers during the analysis process.

Key Informant Selection and Interview Content

Policy experts: We identified as targets for interviews individuals who have led the field in studies of BH financing with specific expertise in carve-ins and carve-outs, Medicaid, services for adults with SMI, SUD treatment, and the Medi-Cal BH system. We conducted separate interviews with six policy

experts. The interviews, which were tailored to the expertise of the interviewee, covered theoretical issues in the designs of carve-ins, motivations for states to transition to carve-ins or maintain carve-outs, examples of carve-ins that could be instructive for California, and carve-in implementation issues.

Informants from recent carve-in states: We recruited informants within each of the seven states identified as having recently carved-in BH services in Medicaid. Where possible we requested referrals from colleagues or from other informants. We were successful in conducting interviews with informants from five of the seven states: New York (two interviews with three state officials), Oregon (one interview with an expert in Oregon policy), Texas (one interview with an expert in Texas policy), Washington (one interview with two state officials), and Arizona (one interview with two state officials). In most cases, experts were current state Medicaid officials with expertise in financing of care for enrollees with SMI/SUD. In two cases, we spoke with individuals with either experience as Medicaid officials directly involved in financing of BH care or expertise as Medicaid program evaluators. Officials within the state Medicaid office in Florida declined the interview. We reached out to state Medicaid officials in New Mexico but were unable to conduct an interview because of scheduling difficulties and personnel changes. Interviews with state informants followed a protocol described in Table 2. See the appendix for a systematic description of the study states, reflecting information elicited during our interviews supplemented by publicly available information.

California officials: We conducted interviews with California officials at the state and county levels with expertise in Medi-Cal, MMC, or BH who, because of to their position, would be among the stakeholders potentially involved in or affected by a carve-in transition. Our county-level informants were county BH directors and other officials directly involved in BH policy, and our state-level informants were officials directly involved in Medi-Cal BH policy. We selected the county officials to maximize the diversity of the counties in our sample with respect to geography, rurality, and delivery system characteristics. We worked with the CBHDA to identify informants within counties we chose to recruit into our sample, since the CBHDA has knowledge of county leaders with expertise in BH care financing and service delivery who could best contribute to the interviews. We included two counties (San Mateo and Shasta) that had a COHS as their PH care

TABLE 2
Interview Guide for Informants from Carve-In States

Questions
• What were the state's main goals in deciding to carve-in BH services? – Was there an interest in promoting clinical integration of BH and PH care? – Was there an explicit goal of lowering Medicaid costs?
• Was there concern among stakeholders and/or policymakers with potential risks associated with the carve-in? – Were there concerns about loss of access to BH care or quality of BH care? – Were there particular populations of concern? Based on diagnosis? Race/ethnicity or geographic location?
• When the carve-in was implemented, were there any arrangements, such as targeted plans for SMI/SUD enrollees, made to protect BH services? – Were there efforts focused on surveillance of the quality of care? BH provider networks? – Were financing mechanisms, including value-based payments, introduced to incentivize plans or providers? – Were there differences in how the carve-in was structured in different settings? Rural versus urban areas?
• What impacts have you observed since implementation? – How have provider networks transitioned to the new environment? – Is there evidence of the impact of the carve-in on access to care? Quality of care?

delivery model, as a COHS is a county-managed organization and may have different capabilities than a private MMC plan to integrate services with a county BH system. We included one predominantly rural county (Mono), defined as a county where at least half of residents live in rural areas (University of California, California Communities Program, undated). In addition, we included one county in the Northern California Regional Model Partnership for DMC-ODS, a group of seven northern California counties that collaborate with a MMC plan to operate a DMC-ODS pilot program. The interviews with our California informants, also tailored to the expertise of the informant, covered perceived advantages and disadvantages of a carve-in transition. Additionally, interviews with county officials covered descriptions of their county's Medicaid BH system, how that system is integrated with other county services, and how the county would be affected if BH financing was carved in. Specific follow-up questions explored how each county finances inpatient psychiatric hospitalizations and the possible impacts that an IMD exclusion waiver would have on their service system. A total of 13 interviews were conducted with California informants, including two state agency officials, officials from county agencies in nine counties, one representative of a county association, and one representative of a health plan association.

Analysis of Key Informant Interviews

We conducted analyses using the notes from the key informant interviews. We used the audio recordings to clarify points that were unclear in the notes and to confirm quotations. The entire research team reviewed the notes for each interview. The team developed brief case studies for each state by filling out a matrix of carve-in characteristics. The case studies described the state's Medicaid BH system, including its financing and the nature of the carve-out prior to the carve-in, distinctive characteristics of the carve-in design, and implementation issues identified by our informants. We compared the design and implementation issues across states to identify common themes. In the next section, we explain each of the major themes and illustrate them with quotations from the interviews. Similarly, we abstracted major themes related to potential impacts of a carve-in in California through team discussions from the interviews with policy experts and California officials.

There is little evidence about the impact among Medicaid enrollees of carving in BH services.

Findings

Effects of the Carve-In Model as Gleaned from the Research Literature

There is little evidence in the research literature regarding the impact among Medicaid enrollees of carving in BH services on key outcomes of interest and its generalizability to California is uncertain (see the section titled "What Is Known About the Carve-In Model from the Available Evidence?"). Our literature review identified only three single-state studies that have examined impacts of the carve-in model using a quasi-experimental design—that is, one in which outcomes were compared between a group of enrollees that were in a carve-in arrangement and a control group of enrollees. The carve-in states are Illinois (Xiang et al., 2019), New York (Frimpong et al., 2021), and Oregon (Charlesworth et al., 2021).

Although all three studies focused on adult Medicaid enrollees with BH conditions, the studies varied in the severity of those conditions and the states' policy context prior to and following the MMC carve-in. Moreover, only the Illinois and New York studies examined the outcomes of the transition to a MMC BH carve-in, with the Oregon study examining a health plan carve-out in the context of a system carved in at the payer level.

The New York study (Frimpong et al., 2021) examined the impact of SNPs embedded in compre-

hensive MCOs on enrollees with SMI/SUD, rather than the overall impact of the state's transition from fee-for-service to a MMC BH carve-in arrangement. The control group in this study was a population of SNP-eligible enrollees whose BH benefit was carved in to comprehensive MCOs, that is, were enrolled in standard MMC carve-in plans, or remained under a FFS arrangement. While the authors report outcomes separately for New York City and the rest of the state, we highlight outcomes in our summary of findings if at least one of the two regions had a statistically significant result.

The Oregon study (Charlesworth et al., 2021) examined the impact of a health plan carve-out in the setting of a system carved in at the payer level that featured MCOs with accountable care organization characteristics called *coordinated care organizations* (CCOs). Prior to the carve-in, implemented in 2012, BH services had been managed by a county-based BH system. However, the study authors conducted a cross-sectional analysis during the post-carve-in stage between a CCO that remained carved-in and another that reproduced a carve-out through a subcontract for BH services to the county BH authority.

The Illinois study (Xiang et al., 2019) examined six Chicago suburban counties that transitioned from a FFS system for all covered Medicaid services to a carved-in MMC system; the control group in this study was a carve-in-eligible FFS population residing in the city of Chicago. The study findings vary depending on the period when they were assessed:

- the initial period following the implementation of the carve-in ("initial")
- two subsequent periods following the implementation of two policies
  - first the Save Medicaid Access and Resources Together (SMART) Act, which reduced reimbursement rates and services for the Medicaid program, primarily affecting outcomes for FFS enrollees
  - later, a slight reduction of the capitated payment rates to the carve-in plan, which only affected carve-in outcomes for enrollees (both periods are combined in our summary and referred to as "subsequent")
- the entire study period ("overall").

Given the potential influence of these other policies on the study outcomes, we decided a priori to only highlight in our summary of findings the outcomes that consistently had statistically significant effects in the same direction for the "initial" period and at least one of the "subsequent" periods. In this case, cost outcomes is the only outcome category that fit this criterion. However, we provide a more complete set of results in the table, which include outcomes that were inconsistent across the observation periods.

The outcomes in these studies were primarily BH and PH care utilization, although they produced some evidence on costs and equity. Table 3 lists the results of the three studies by outcome category. Relative to their respective control groups, the BH carve-ins were associated with higher likelihood of BH outpatient care utilization among SNP enrollees in New York and also in Oregon, but, in the case of Oregon, only among enrollees with mild-to-moderate mental illnesses. The Oregon carve-in provided greater access to primary care physicians (PCPs), psychologists, and social workers, but less access to psychiatrists and specialists. In both states, the carve-ins were associated with higher likelihood of PH outpatient utilization. Specifically, the Oregon carve-in was associated with higher rates of primary care visits, while the New York carve-in SNP program was associated with higher rates across all non-BH services.

The studies were less consistent with regard to other measured outcomes. In terms of acute care, the Oregon carve-in was associated with less PH ED utilization relative to the carve-out, while the New York carve-in SNP carve-in program was associated with decreases in BH and PH inpatient utilization but increases in any BH and PH ED utilization relative to the study's mixed (MMC carve-in and FFS for BH) control group. Illinois was the only state to measure costs; although the carve-in was found to be associated with reductions in initial and subsequent period expenditures per patient from the payer's perspective relative to the FFS control group, there were no overall cost effects. The Oregon study, which was the only one that examined equity, found that, relative to the carve-out, the carve-in was associated with a higher

TABLE 3

Outcomes of Behavioral Health Carve-Ins

	Oregon Study (Charlesworth et al., 2021)	New York Study (Frimpong et al., 2021)	Illinois Study (Xiang et al., 2019)
Type of carve-in	All BH into CCOs	All BH for SMI into SNPs	All BH into MCOs
Control condition	Carve-out created through subdelegation	SNP-eligible individuals in standard MMC carve-in or FFS for BH	A carve-in-eligible FFS population
Outcome Category			
BH outpatient care access	Carve-in associated with greater probability of any utilization (by enrollees with mild-to-moderate mental illness) and greater number of visits Carve-in more likely to access care provided by PCPs, psychologists, and social workers, but less likely to access care provided by psychiatrists and specialists	Carve-in (SNP) associated with increases in probability of any utilization and greater number of visits	Carve-in associated with initial decrease in utilization, but no overall change[a]
PH outpatient care access	Carve-in associated with greater probability of any utilization but no difference in number of visits	Carve-in (SNP) associated with increases in probability of any utilization and greater number of visits	Carve-in associated with initial decrease but subsequent and overall increase in utilization
Acute care utilization	Carve-in associated with lower probability of PH emergency department utilization and lower number of visits Carve-in not associated with differential BH emergency department utilization Carve-in not associated with differential PH and BH inpatient visits	Carve-in (SNP) associated with decrease in probability of any PH and BH inpatient utilization and number of PH and BH inpatient utilization visits Carve-in (SNP) associated with increase in probability of any PH and BH emergency department utilization and decrease in number of BH emergency department utilization visits	Carve-in associated with initial decrease in PH inpatient utilization, but no subsequent nor overall changes Carve-in associated with overall increase in PH and BH emergency department utilization
Costs	N/A	N/A	Carve-in associated with initial and subsequent reductions in total costs per individual from the payer perspective, but no overall changes
Equity	Carve-in associated with higher likelihood of outpatient BH visits among black enrollees compared with white enrollees Carve-in did not have differential effects for Latinx enrollees compared with white enrollees	N/A	N/A

SOURCES: Charlesworth et al., 2021; Frimpong et al., 2021; Xiang et al., 2019.

NOTES: N/A = not applicable. Terms used to denote differences between study findings may differ as a result of differences in study designs—*cross-sectional* in the Oregon study, and *longitudinal* in the New York and Illinois studies. Thus, *greater utilization* is appropriate for the Oregon study, and *increase in utilization* is appropriate for the New York and Illinois studies.

[a] Initial changes refer to the period after carve-in implementation but before the SMART Act implementation. Subsequent changes refers to the periods after SMART ACT implementation (and later on, reductions in capitation payment rates). Overall changes refer to the cumulative effect of the carve-in.

likelihood of BH outpatient visits for black enrollees but not for Latinx enrollees.

Informant Perspectives on Carve-In Design, Implementation, and Impact

Policy experts, state informants with experience designing and implementing carve-ins, and California officials highlighted several policy-relevant issues to consider. Through interviews with state officials and stakeholders from Arizona, New York, Oregon, Texas, and Washington, we identified the policy context and goals of carve-ins, their implementation, and lessons learned. Many of the issues raised in the interviews are also reflected in the peer-reviewed and gray literatures. We identified five articles that examined these topics using qualitative methods (Bachrach, Anthony, and Detty, 2014; Bachrach, Boozang, and Davis, 2017; Palmer and Markus, 2020; Smith, Edwards, and Frederick, 2020; Soper, 2016). All these articles consisted of interviews with officials in states that transitioned to BH carve-ins during the 2010s. The carve-in states' experiences described in these articles included some of the states on which we obtained primary information through interviews and additional states, including Florida, Kansas, Louisiana, New Mexico, Ohio, and Tennessee.

Table 4 summarizes the major themes that emerged from our interviews with policy experts, California officials, and state informants, as well as from our review of qualitative studies also reflecting state informants' perspectives. We use the term *interviewee* to refer to individuals with whom we conducted key informant interviews, and we use the term *informant* to refer both to them and to individuals who performed as informants for the qualitative literature.

TABLE 4

Issues in the Design and Implementation of Behavioral Health Carve-Ins Raised by Informants

Major Themes	Specific Concerns
I. Carve-in does not necessarily result in financial, organizational, or clinical integration or other expected outcomes.	1. Where allowed, payers tend to subdelegate BH financing and/or maintain separate administrative structures for BH and PH services. 2. The lack of appropriate payment to plans and providers can impede integration and other expected outcomes. 3. Underdeveloped health information technology infrastructure limits integration. 4. Payers lack expertise in specialty BH services and clinical needs of enrollees with SMI/SUD. 5. The carve-in model is not necessarily associated with greater capacity for implementing value-based payment.
II. States have taken additional regulatory actions to promote organizational and clinical integration and other outcomes.	1. States have invested in health information technology. 2. States have strengthened their case management systems.
III. States have used other approaches to mitigate potential risks of the carve-in model.	1. States have employed contracts and data analytics to improve quality and accountability. 2. States have created mechanisms to reduce the risk that MCOs will not appropriately finance care for enrollees with BH needs. 3. States have enacted regulations to reduce MCO abusive practices. 4. States may provide the MMC system with tools to better address enrollees' social needs.
IV. Carve-in implementation requires an incremental, stakeholder-engaged process.	1. Pilot the carve-in roll-out in a county or region prior to scale up. 2. Engage key stakeholders through learning collaboratives, readiness activities and cross-training.

I. Carve-in does not necessarily result in financial, organizational, or clinical integration or other expected outcomes.

1. Where allowed, payers tend to subdelegate BH financing and/or maintain separate administrative structures for BH and PH services.

State informants described ways in which MCOs created separation within their organizations between the newly carved-in BH services and their prior PH services. Subdelegation is the clearest example, and it was raised as an issue by interviewees in every state we spoke with. States used slightly different strategies, but, in general, this approach creates a new carve-out at the level of the health plan, thus creating a barrier to financial integration.

For example, in Oregon, most CCOs created health plan carve-outs by subcontracting with specialty BH payers, which could transfer the financial risk from the carve-in CCO to the specialty BH payer. In order to mitigate this issue, Texas imposed a set of contractual requirements for parent MCOs, requiring them to be at risk financially for their specialty BH payers and to submit financial reporting on their arrangements with these payers. As one interviewee from Texas explained:

> We also put in additional language in the managed care contracts at the time to say that integration doesn't happen because you carve-in services. Because if the health plan carves out BH with some other company and they never talk to those people, that's not integration . . . if [the MMC plan is] still using a subsidiary, then they have a lot of integration at least on paper in the contract, around medical review, looking at things more holistically. They are required to have an integrative model.

Subdelegation could be used by MCOs to afford them more time to scale up their management of BH services and develop the systems needed to achieve financial integration without disrupting existing services. For instance, our New York interviewees described that they had expected a smoother transition and better outcomes for plans that used subdelegation to finance BH services immediately after the carve-in. However, their expectations were not always met, and MCOs brought the financing for BH "in-house" several years later.

Even when MMC plans do not formally subdelegate BH services to an external organization, they may maintain separate management and operations internally that can act as a barrier to financial and organizational integration. As one of our expert interviewees stated:

> Most financial carve-ins don't result in any meaningful change at the level of integrated care that the provider sees and is expected to execute, or that the patient experiences. They just move the level of carve-out one tier from the state level to the MCO level because most MCOs do not truly integrate their budgets. They have separate IT systems, case management staff, prior authorizations, and budgets for different populations. They are all held to those budgets, and they are not managed interactively. There's no substantive sea change.

Carve-in models where the state simply combines budgets for PH and BH care and distributes these funds to MCOs without additional provisions might not yield the anticipated benefits.

A related issue, which has been highlighted in the literature on carve-ins, concerns the fact that under carve-out arrangements, the management of the BH pharmacy benefit (i.e., psychotropic drugs) is typically kept under the comprehensive MCO or carved-out as a FFS benefit, as is currently the case in California for drugs used to treat SMI/SUD. This design feature may create incentives for the carve-out to over-rely on psychotropic drugs and underuse psychosocial services (Busch, Frank, and Lehman, 2004). The carve-in model may be regarded as a means to integrate these BH services and thus improve quality of BH care for enrollees with SMI/SUD, but this might not be the case if pharmacy benefits are carved out through FFS (McConnell et al., 2021), as planned by California if the transition to the Medi-Cal Rx program is implemented (DHCS, 2021c).

2. The lack of appropriate payment to plans and providers can impede integration and other expected outcomes.

Informants highlighted the critical role of appropriate payment to health plans and providers to ensure that the needs of enrollees with SMI/SUD are adequately met. This issue was well summarized by two California interviewees:

> BH needs to catch up to rest of the medical field in that you should be paid more to take care of the hardest person to care for. This is the case because some important [BH] services aren't reimbursable, but this wouldn't be the case for specialty heart surgery. . . . We've left the public mental health system with very high-cost people. If we ever had carve-in, we would need to address these other costs.

> My rates are systemically lower than they should be. Rates haven't gone up for contract providers in years. Money from realignment does not grow based on demand. We don't want rates based on current rates but what the actual market says it costs to do things. We lose licensed clinicians to other settings, such as Kaiser and schools, because we don't pay them enough. This is especially a problem now with COVID because the workforce is attracted by telehealth. We need to pay more to get people who will do community services. . . . Yes [it would be possible for the county to pay contract providers more], but we would need to get more local match. We don't have the money.

Our interviewees emphasized the need for adequate risk-adjustment methods to reduce the risk of adverse selection and ensure that health plans are able to serve a socially disadvantaged population with complex and costly health care needs:

> An advantage of carve-outs is essentially you're removing "bad risk" from the competition. That's a helpful thing. So what you need to do if you're going to bring them in you have to ensure that there isn't bad behavior and adverse selection being one of them. You fix that through accountability, through performance measurement and through risk adjustment.

> We created our own custom risk adjustment model. It incorporates variables on SMI [serious mental illnesses], SUD [substance use disorders], and SDOH [Social Determinants of Health] based on zip code and income level to improve accuracy of the model. . . .

Ensuring that providers, especially small BH providers, are paid fairly and in a timely manner when they enter into contracts with health plans is of crucial importance as states transition to MMC carve-in systems. An interviewee from a state that transitioned its disabled population from a FFS arrangement to a MMC BH carve-in noted the key role of the state setting provider rates:

> You need to standardize billing and claiming across the state—you can't have counties or plans set their own rules. The providers cross boundaries so you can't have each plan setting it. Can't have plans or counties doing things different. Set rates for services under state law.

3. Underdeveloped health information technology infrastructure limits integration.

Informants highlighted the lack of health information technology (HIT) infrastructure among specialty BH providers and the challenges this presented to integrating these providers into MCO-administered networks. HIT, including electronic health records (EHRs) and health information exchange (HIE), enables organizational integration and facilitates communication between providers; improved communication between BH and PH providers can in turn facilitate clinical integration (Cipriano et al., 2013; Hsiao et al., 2015). As one interviewee said:

> The great advantage of the carve in is you have the physical health folks near your mental health folks. Make requirements that they should have shared access to the databases, whether it's county or a payer. The care manager doing utilization review for physical health can see the behavioral health and vice versa. . . . If you're going to do it, the infrastructure needs to support the utilization review people seeing all sides—physical health and behavioral health and all interventions, resources, services.

States addressed these challenges by investing in their HIT systems during their carve-in transition. Arizona, for example, used a $300 million investment from CMS to expand its statewide HIE, which significantly increased the number of behavioral health providers using its platform (Bachrach, Boozang, and Davis, 2017). Similarly, New York invested in HIT expansions that were targeted toward BH providers (Smith, Edwards, and Frederick, 2020). Despite investments in information technology, state interviewees reported ongoing challenges. A New York official noted that years after interoperative EHR systems were promised, information sharing between providers, plans, and the state remained impractical:

> The EHR system is terrible. We're trying to get a new and better one, but the EHR provider is having trouble interfacing with the state to get the product to speak to the state side.

In states that have transitioned to carve-ins, some providers had neither the capacity nor experience with managed care billing, which can involve increased administrative activities, such as negotiations on payment rates, service authorization, and quality reporting, all of which can lead to increased labor and infrastructure costs. Moreover, providers often had to transition from billing a single payer under the carve-out to billing multiple payers under the carve-in. State interviewees in New York, Washington, and Texas confirmed this finding—they underscored in interviews how they spent considerable resources to train providers for managed care billing. State interviewees also highlighted similar problems for the MCOs, as some of them lacked knowledge and experience on how to process billing for BH services. In New York, problems on both sides resulted in high rates of claims denials, particularly early in the carve-in process, despite extensive planning prior to implementation. The financial burden of claim denials and delays in payment can be a prohibitive burden for smaller BH provider organizations.

Given the importance afforded by our interviewees to the existence of a robust HIT infrastructure for a successful carve-in transition, it is concerning that California county interviewees reported variability in BH providers' use of EHR and a lack of a single interconnected platform:

> The way we implemented the EHR was we said that we'll buy yours if you use our system for those providers. We knew we couldn't wait for them to get the revenue to invest in EHR. It would take a decade. For the ones that already had an EHR, which is a minority of our larger and medium sized agencies, we said you can keep yours if you want and we just work with our technical folks to link them. That's the process we have now. Sixty percent of the network is using our EHR, 40 percent is using something else.

4. Payers lack expertise in specialty BH service system and clinical needs of enrollees with SMI/SUD.

Informants expressed concerns that MCOs and Medicaid officials lack expertise in the complex health and social needs of enrollees with SMI. Informants indicated the need for specialized knowledge at both the state and MCO levels on the design and management of financing systems, integration of BH and PH care, network adequacy, performance measurement, and other aspects of the BH system. The concerns raised about MCOs' lack of specialized BH expertise echoed longstanding concerns among advocates for specialty MH care that as reviewed in the introduction, was an important motivation for the implementation of carve-out models. One of the major challenges that informants reported related to MCOs' capacity to administer efficient billing systems for BH services. One interviewee highlighted the challenges of this mismatch between MCO expectations and the realities of provider billing capacity:

> We spent so much time trying to get providers paid . . . they don't have resources, staff, training, IT systems. And then the [managed care] plans . . . did not understand behavioral health billing.

Some states included requirements in their contracts with carved-in MCOs to ensure inclusion of BH expertise within the MCO's policy and administrative teams overseeing decisions affecting access to critical services for enrollees with SMI/SUD. In New York, for instance, MCOs were required to include

BH professionals when designing policies and regulations, such as utilization review. One interviewee described these requirements as critical to ensuring adequate recognition of the needs of the SMI population:

> We put requirements [that] each of the carve-ins need[ed] a behavioral health clinical director. . . . Insisting on competence and breadth of behavioral health leadership, which the payers won't do unless you make them.

Because of MCOs' lack of expertise and experience with BH services, there has been concern among states implementing carve-ins that MCOs will not support networks of community-based BH providers, thus potentially harming not just clinical integration but also access, equity, quality, and outcomes of BH care. Many BH providers are small nonprofit organizations that operate on small margins. Despite their small size, these organizations are thought to be critical to meeting the BH needs of Medicaid enrollees, particularly in areas poorly served by large health systems. In California, these providers will be critical to the success of the IMD exclusion waiver, given the expectation of greater access to community-based BH services (see "CalAIM as a Means to Address the Challenges" in the Introduction). There is a risk that MCOs, which lack detailed knowledge of local provider networks or interest in supporting small-scale provider organizations, might undermine those networks. To mitigate these potential consequences of carving in BH care, states used contract stipulations to force plans to contract with the existing provider network. For instance, in New York, plans were required to offer a Medicaid contract to any BH provider that had seen five or more Medicaid patients in the past year.

5. The carve-in model is not necessarily associated with greater capacity for implementing value-based payment.

Because MCOs are generally equipped with sophisticated data collection and analysis systems to monitor service utilization and quality of care, it is thought that MMC carve-in might enable payment reform aimed at tying payment to quality measurement, i.e., value-based payment (VBP). However, this is not necessarily the case. In New York, the VBP Roadmap approved by CMS in 2015 established targets for the proportion of VBP contracts between MCOs and providers as well as a "menu" of types of VBP contracts. The main types were Total Care for General Population (TCGP), Integrated Primary Care that provided primary care-based episodic care arrangements, and Total Care for Special Needs Subpopulation Arrangements, including members of special needs plans (SNPs) for enrollees with SMI/SUD. The state had hoped—but did not mandate through prescriptive contracting language—that MCOs with such SNPs would implement SNP contracts and use distinct quality measures specified by the state for enrollees with SMI/SUD. The goal was to focus the value-enhancing enterprise on adults with SMI/SUD, a population with a large unmet need for health care. However, essentially all MCOs opted for TCGP arrangements instead. As one interviewee explained,

> MCOs said, "How can we take highest cost people into a risk arrangement? We need to spread out the risk." We had thought, "Oh, you can really focus by putting all people with SMI into the same kind of contract." But plans said this didn't make sense. How do you do an alternative payment model for high-cost, high-need people? Where is the opportunity to save?

Conversely, maintaining a carve-out does not preclude states from transitioning to VBP models. For example, Pennsylvania, a carve-out state, has been quite successful at implementing health care delivery and payment reform. As of 2021, for example, the state's MMC carve-outs must pay 20 percent of medical expenses through VBP arrangements (Pennsylvania Department of Human Services, 2021).

II. States that have transitioned to carve-ins have taken additional regulatory actions to promote organizational and clinical integration and other outcomes.

1. States have invested in health information technology.

As mentioned above ("Underdeveloped health information technology infrastructure limits integration"), several carve-in states have invested in their HIT systems to enhance organizational integration.

2. States have strengthened their case management systems.

Case management programs have been associated with reductions in avoidable hospitalizations and ED visits (Afifi et al., 2007; Rossiter et al., 2000). Unfortunately, MCO uptake of case management strategies is suboptimal, especially for BH services (Stewart et al., 2017). Informants pointed to the importance of case management services not just as a means to bridge the BH/PH divide but also to connect enrollees to needed services and prevent poor outcomes. As stated by one interviewee:

> Carve them [people with SMI] in and do the intensive care management that's consistent with health care reform and the person-centered reform that's in the Affordable Care Act and other initiatives. Incentivize identifying a patient with high needs, predictive modeling, surveillance of populations, identifying high complex needs patients. Incentivize getting people into enhanced care management, Health Homes, and intensive care management services sooner, and control costs that way, before they relapse and end up homeless or in jail.

Informants also reported on carve-in states' efforts to strengthen case management programs—one interviewee reported on their state's requirement that MCOs use a single case management system permitting access to data on all the care received by high-need enrollees.

III. Carve-in states have used other approaches to mitigate potential risks of the carve-in model.

1. States have employed contracts and data analytics to improve quality and accountability.

Several interviewees stressed the critical role of well-written contracts as a tool for the state to achieve its overall goal of ensuring adequate access to high-value care for enrollees with SMI/SUD:

> We don't have concerns [about MMC contractors offering SNPs for people with SMI as an add-on line of business]. . . . We're known for being detailed and thoughtful in contracts for having different product lines. . . . We have clear expectations for products.

States should be deliberate in their selection of quality measures to be included in contracts.

Contracts can be used to promote improved performance on specific quality domains including clinical integration, and enable accountability by specifying who is responsible for which service:

> If I were the state, saying to the health plans, I'm going to put together really good performance measurements, I'm going to make sure we risk adjust really well, I'm going to make sure that in my contract I'm really going to ding you if you depart from the good performance measurement outcomes, and I'm going to let you run the system the way you think you should run it because you're closer to the ground than I am.

States—and also health plans in their contracts with providers—should be deliberate in their selection of quality measures to be included in contracts. An interviewee with expertise in BH care quality measurement suggested that payers should first focus on process measures:

> Most providers don't have systematic reliable process to get a particular outcome. So, if you measure them on outcome without a process, it gets nothing. You need to teach process by having them meet process measures.

Although there are barriers to the adequate measurement of quality of BH care, valid and feasible process measures are available (Kilbourne et al., 2018; Niles and Olin, 2021). The interviewee quoted above suggested several process measures that may be used to promote clinical integration and improvements in quality of care for enrollees with SMI/SUD: follow-

Interviewees stressed the importance of developing a robust data analytics department.

up after hospital discharge; medication adherence; medication reconciliation (CMS, 2014); measures of care for chronic medical conditions that are prevalent among adults with SMI, such as metabolic screening, diabetes care, and interventions for smoking and obesity; and measures capturing delivery of EBPs. The Kansas Medicaid program established several process measures, including utilization of preventive/primary care services, with the express goal of reducing premature mortality rates among enrollees with SMI; this measure has been found to improve among individuals with SMI who have received integrated BH and PH care (Druss et al., 2001; Wells et al., 2018).

Contracts can also be used to promote appropriate access to the full range of BH clinicians routinely involved in care for people with SMI/SUD by requiring MCOs to meet specific standards regarding the adequacy of their provider networks. In this regard, an interviewee referred to the use of the contract as a tool that may be used by the state to regulate the relationships between MMC plans and BH providers:

> In [state] there was a trick where [MCOs based in a specific city of the state] were contracting with partial hospitalization programs in [other cities of the state], which meant that no one was going to use it because it's a half hour to an hour drive and no one wanted to drive out there. So what you could do is say that I insist that you contract with the following providers for BH. . . . That's another way you can do it—regulate who the MCO contracts with. You could put that in a contract.

As mentioned above ("Payers lack expertise in specialty BH service system and clinical needs of enrollees with SMI/SUD"), state informants reported using the contracting process to ensure that BH expertise informs MCO decisions affecting access to critical SMI/SUD services.

Relatedly, interviewees stressed the importance of developing a robust data analytics department within the state, with unfettered access to health plan data; this resource is essential to the task of monitoring performance, conducting oversight, and ensuring accountability:

> Other ways to make sure plans do not skimp on care include contract infrastructure. Health plans are not great at providing lots of data, so we built robust reporting mechanisms. Plans tell us how many members have been assigned and assessed and have had their PCP sign off on their care plan. We can look at claims data pre and post enrollment and care patterns changing. This requires good contract and analytics infrastructure and dedicated people to do it.

> We underutilize the power of data. MCOs don't use their data nearly as effectively as they could. Part of it is they are afraid to make data public. Data is most powerful when you show it to everybody. Then people fall in line without having to tell them anything.

2. States have created mechanisms to reduce the risk that MCOs will not appropriately finance care for enrollees with BH needs.

Concern over the risk that funds for enrollees with SMI/SUD might be used for other priorities instead of addressing these enrollees' significant BH and PH needs drove New York and Arizona to enroll their SMI/SUD populations in SNPs, as standalone plans (Arizona) or specialty MCO products (New York) (Soper, 2016). Through SNPs, states can ensure dedicated budgets, targeted oversight, and focused expertise to address the health care needs, including that of integrated care, of the SMI/SUD population; among other advantages, SNPs permit the implementation of higher medical loss ratios and risk-mitigation strategies such as higher premiums. As one interviewee said,

> Carve-in is the way to go with a person-centered approach. The risk there is that the dollars are so small they'll get lost. That's

> why in NY they needed a "special needs plan" where you identify the high-need population, SMI, etc., and you ensure that there are guard rails around those dollars, so they get spent on behavioral health and not get diverted to other services.

New York also instituted behavioral expenditure targets for comprehensive MCOs as a means to ensure that plans would not divert BH funds to other areas of health care. As an interviewee explained,

> Financial, with [medical loss ratio] requirements that "x" dollars allocated get spent on BH and [plans] get penalized if they don't. Dollars do not get to be diverted to cover other costs or profits.

3. States have enacted regulations to reduce MCO abusive practices.

A potential risk of MMC carve-in is for MCOs to employ aggressive practices to curb access to care and thus contain costs. For example, a New York interviewee described how the state has increased the monitoring of denials of payment, which can have catastrophic consequences for the viability of small BH providers, and expanded its use of regulations to curb aggressive utilization review practices for both parity-sensitive and not-sensitive services:

> We said to plans from day 1 that we are going to monitor your claims denial rate because they're not submitted accurately. Also said we'd monitor your utilization review denial rate. . . . We also said to the plans we'd also monitor your utilization review clinical denial, medical necessity denial rates. You'll have to report to us each month what those are. . . . Our message was, we're going to monitor to make sure you're not aggressively denying. . . .

4. States may provide the MMC system with tools to better address enrollees' social needs.

A narrow focus on health care can be detrimental to achieving adequate outcomes for enrollees with SMI, particularly those with comorbid SUD, a population with significant social needs resulting from profound functional impairments (Levinson et al., 2010). In California, the current carve-out system enables counties to integrate their BH services with a variety of social services that are essential parts of the care for Medi-Cal enrollees with SMI/SUD (also see the previous section titled "County-Based Specialty Behavioral Health System"). This level of integration was well captured by a California official:

> Right now, the public health system is an "invisible hand" holding people together acting—the whole system really—with a whole person care model. Taking people to the doctor's office, securing housing, managing finances, etc. Economic conditions really negatively impact clients and their ability to continue on a recovery trajectory, and that increases a lot of staff demand.

Interviewees mentioned homelessness services, K–12 and postsecondary educational institutions, and criminal justice institutions. They noted that many of these programs have been developed through local connections between counties, BH providers, and partner institutions and are funded through braided mechanisms that include Medi-Cal funds, other county BH funding, and non-BH funding. As mentioned previously ("CalAIM as a Means to Address the Challenges"), California is about to launch two new MMC benefits providing plans with tools to address social determinants of health. These benefits might mitigate the loss of integration of BH and social services in a future MMC carve-in, but California county officials whom we interviewed expressed significant concern about the implications of a carve-in on this important interface. They discussed MCOs' relative inexperience engaging with community stakeholders and social service providers, and their limited capacity to adequately meet enrollees' social needs even when incentivized:

> I'm concerned with managed care plans' understanding of community mental health, local services in the community as opposed to the office. We [the county] have people going into peoples' homes and homeless camps. This isn't where managed care's expertise is.

There is very limited quasi-experimental evidence on the impacts of the carve-in model to help inform the benefits and trade-offs associated with carve-in transitions.

IV. Carve-in implementation requires an incremental, stakeholder-engaged process.

1. Pilot the carve-in roll-out in a county or region prior to scale up.

Carve-in implementation can be facilitated by having a pilot roll-out prior to expanding to the entire state, such as in New York and Arizona. Arizona started the transition to carve-in in Maricopa County in April 2014, followed by the rest of the state in October 2015. This staggered approach allowed the state to identify desired features of carve-ins and problem solve on a smaller scale, to which they could apply these lessons when extending carve-in statewide (Soper, 2016).

2. Engage key stakeholders through learning collaboratives, readiness activities and cross-training.

Additionally, carve-in states engaged key stakeholders through learning collaboratives, readiness activities, and cross-training. Arizona, Texas, and Washington held trainings for the BH providers participating in the MMC carve-in. These trainings covered a wide range of topics, such as managed care billing practices, communication strategies with MCOs, and information on the technological and administrative support that providers may need to achieve clinical integration. States gave these trainings to providers both before and after carve-in implementation. One interviewee described that:

> We did a lot of learning collaboratives and readiness activities. . . . We underestimated the change management involved for providers; providers had contracted with one entity, but then needed to contract with three to five MCOs and speak contracting language, do claims processing in new way, evolve their business strategy, and implement technology for claims.

Implications for the Implementation of Carve-Ins in the California Behavioral Health System

Our work has generated valuable insights that can assist California policymakers as the state considers a potential transition to MMC carve-in for specialty BH services currently financed and managed by counties through county MHPs. In this section, we summarize what is known about the carve-in model and discuss implications for California.

What Is Known About the Carve-In Model from the Available Evidence?

Although there has been a large amount of interest by CMS and Medicaid agencies in pursuing carve-in financing for BH care, there is very limited quasi-experimental evidence on the impacts of the carve-in model to help inform the benefits and trade-offs associated with carve-in transitions. However, policy experts, state informants with experience designing and implementing carve-ins, and California officials highlighted policy-relevant issues to consider. In this section, we describe the evidence, including findings and insights, gaps, and its utility for California.

Quasi-Experimental Evidence

We found only three studies, each conducted in a single state, that have examined the outcomes of the carve-in model with rigorous designs (Frimpong et al., 2021; Xiang et al., 2019; Charlesworth et al., 2021). Although observational studies do not provide

the strength of evidence afforded by randomized designs, each of these three studies used a strong quasi-experimental design to estimate the effects of carve-ins. However, the studies generated a narrow evidence base focused on (1) access to BH and PH care for enrollees with SMI/SUD, as measured by utilization of outpatient services, (2) utilization of acute BH and PH care, and (3) costs.

Of these studies, only one (Charlesworth et al., 2021) directly compared a carve-in and a carve-out; outcomes were utilization of BH and PH outpatient and acute care among Medicaid enrollees with any severity of BH need residing in Portland Oregon. Charlesworth et al. also assessed whether carve-in effects were moderated by race/ethnicity and illness severity. Although Oregon had a county-based BH carve-out prior to a carve-in transition that took place in 2012, the Oregon study did not focus on the outcomes of that transition; rather, it examined the outcomes of two *post-transition* CCOs, one of which carved out BH care through a subcontract with the county. Due to its design, this study provides evidence on the outcomes of a carve-in system relative to a *health plan carve-out* created through subdelegation.

The second study (Frimpong et al., 2021) evaluated the impact of a transition from FFS Medicaid to a carve-in specialized in enrollees with SMI and/or SUD (i.e., a SNP); outcomes were utilization of BH and PH outpatient and acute care among Medicaid enrollees with generally high severity of BH need residing in the state of New York. The control group for this study included Medicaid enrollees who transitioned to a comprehensive Medicaid managed care carved-in plan as well as Medicaid beneficiaries whose BH care remained carved out in a FFS arrangement. Due to its design, this study provides evidence on the outcomes of a SNP carve-in relative to a standard MMC carve-in *and* a FFS carve-out arrangement.

The third study (Xiang et al., 2019) evaluated the impact of a transition from FFS Medicaid to a carve-in; outcomes were utilization of BH and PH outpatient and acute care as well as a system outcome, total costs per person, among Medicaid enrollees with disabilities with any severity of BH need residing in six Illinois counties. The control group for this study included Medicaid FFS enrollees in a nearby county. In the months following carve-in implementation, the state implemented other polices that are likely to have impacted the carve-in and FFS populations. As noted previously ("Effects of the Carve-In Model: State of the Evidence"), we have addressed the potential threat to the validity of the Illinois study findings posed by the concurrent implementation of additional Medicaid policies by focusing only on the findings that were robust to these policy changes. Due to its design, this study provides evidence on the outcomes of a standard MMC carve-in relative to Medicaid FFS.

The findings of these studies permit several preliminary conclusions:

- The carve-in models in New York, a SNP carve-in, and in Oregon were associated with higher likelihood of BH and PH outpatient utilization among adult enrollees with BH conditions. However, results from the Oregon study (Charlesworth et al., 2021), the only one that evaluated the moderating effect of illness severity, suggests that the BH effects stem from the greater utilization of BH outpatient care by those with mild-to-moderate mental illnesses. Moreover, that same study suggests that the increased utilization might not encompass greater access to psychiatrists, whose role is particularly critical to individuals with SMI, but rather PCPs and nonspecialists.
- The Oregon study suggests that carve-ins might be associated with higher BH outpatient utilization for black enrollees relative to white enrollees. However, this is a positive effect from the standpoint of equity, as black individuals experience greater difficulty accessing OP services in the BH system than their white counterparts (Cook, McGuire, and Miranda, 2007). Although the absence of information on the base rates of illness in the population suggests caution in the interpretation of this finding, this effect may reflect greater ease with accessing BH care through primary care settings for black enrollees (Frank, 2021; Charlesworth et al., 2021). The study did not

Implementing carve-ins is not sufficient to achieve financial, organizational, or clinical integration or other expected outcomes.

find a similar effect for Latinx enrollees, a sizable ethnic group in California.

- Carve-in effects on acute care utilization appear mixed, with lower inpatient utilization rates in New York's SNP carve-in for PH and BH and in Oregon for PH, lower number of ED visits in New York, but a higher probability of any ED utilization in New York's SNP carve-in.
- Carve-ins might be associated with lower total costs to Medicaid. This was a finding in the beginning and one of the subsequent periods in the Illinois study, though the overall effect was one of no association with cost changes. Moreover, this finding is consistent with the expectation that transitions from FFS to MMC, as was the case in the Illinois study, will result in at least short-term cost savings as a result of the use of managed care techniques, and thus, it may not be necessarily related to carve-in financing.

Qualitative Evidence

The source of this evidence was qualitative research, which consisted of our own interviews with policy experts and informants from California and other states, some of whom have been involved in implementing BH carve-ins, and five studies identified in the gray and peer-reviewed literature (Bachrach, Anthony, and Davis, 2014; Bachrach, Boozang, and Davis, 2017; Palmer and Markus, 2020; Smith, Edwards, and Frederick, 2020; and Soper, 2016.). Collectively, this research covered nearly all of the states that have transitioned to carve-ins over the past decade, including Arizona, Florida, Kansas, Louisiana, New Mexico, New York, Ohio, Oregon, Tennessee, Texas, and Washington. Our own sampling strategy for identifying states to interview considered the inclusion of states with features of possible relevance to California's Medicaid program, e.g., pre-carve-in arrangement featuring a county-managed BH carve-out, geographic coverage (see "Identification of States for Interviews" under "Methods").

Through this research, we uncovered evidence on clinical, organizational, and financial integration, integrity of BH budgets, and subdelegation. We describe four major themes distilled from the interviews and our review of the qualitative literature:

1. Implementing carve-ins is not sufficient to achieve financial, organizational, or clinical integration or other expected outcomes. Subdelegation, inadequate payment to payers and providers, and deficient HIT infrastructure pose particularly serious threats to achieving expected outcomes.
2. Where carve-ins have been implemented, states have taken additional regulatory actions to promote organizational and clinical integration, including investing in HIT and strengthening case management programs.
3. Carve-in states have used multiple mechanisms to mitigate potential risks of the carve-in model. Key among them are the use of contracts and data analytics to improve quality and accountability for achieving specific outcomes, the creation of mechanisms to ensure that MCOs will appropriately finance care for enrollees with BH needs, and the enactment of regulations to reduce MCO abusive practices.
4. Carve-in implementation requires an incremental, stakeholder-engaged process.

Gaps in the Evidence

Our review of the literature and environmental scan of recent Medicaid BH carve-ins failed to identify evidence on multiple outcomes of high policy significance.

At the person level, we did not identify evidence on quality of BH and PH care or patient outcomes, including behavioral and physical symptoms and overall health, social functioning, and quality of life. Moreover, we did not find evidence on carve-in outcomes among children with SED or enrollees with SUD, or whether carve-in financing has differential effects for minority groups other than black and Latinx enrollees.

At the system level, we did not identify evidence related to enrollment of beneficiaries with SMI and/or SUD, value of BH and PH care, IMD-related outcomes, provider behavior, or whether carve-in effects vary by the payment model used by the health plan. Also, we did not find evidence on cost shifts to other public payers.

Utility of the Evidence for California

We identified and generated valuable evidence, some of it suggesting some potential benefits associated with carve-ins and other, based on the experience of carve-in implementer states, highlighting important issues for California to ponder. However, not only is this evidence insufficient in its scope but its generalizability to California is uncertain because most of it pertains to policy contexts that are significantly different from that of present-day California. The state's BH carve-out, responsible for meeting the BH needs of child and adult Medi-Cal enrollees with SMI/SUD, is quite unique as it is publicly funded, with some county MHPs also directly providing care. Another important consideration in this regard is the fact that although California has had relatively high public BH spending (e.g., the state was 14th in the nation in per capita spending in fiscal year 2014), the state also has a high level of social need (e.g., the state had the highest poverty rate in the nation in 2017–2019), much of which is also addressed by counties (see the introduction section titled "Medicaid-Financed Care in California—Challenges and Opportunities").

Moreover, the finding from the Oregon study of a higher likelihood of BH outpatient care for the carve-in relative to the carve-out but only for those with mild-to-moderate mental illnesses (Charlesworth et al., 2021), highlights the potential impacts of the models' differences in incentives and BH specialization when they are implemented without additional safeguards. Since California has already carved mild-to-moderate mental illness services into the MMC system, policymakers might consider assessing the degree to which this specific carve-in has produced similar positive results as it may hold important lessons for the state.

The Expected Benefits of Carve-In Models Can Be Achieved in a Carve-Out Environment

The evidence uncovered by our work suggests that the *carve-in and carve-out models can have comparable performance if designed to both facilitate their expected benefits and minimize their potential risk*s. Whereas the carve-in model's main expected benefit is clinical integration and its main potential risk is adverse selection, the carve-out model's main expected benefit is adequate access to specialty BH care and its main potential risk is inadequate access to PH care contributing to poorer PH outcomes (see

Our review of the literature and environmental scan of recent Medicaid BH carve-ins failed to identify evidence on multiple outcomes of high policy significance.

Payment amounts should be set to ensure that health plans and providers are able to provide evidence-based and level-adequate care to enrollees with SMI/SUD.

the introduction section titled "Transitioning from a Carve-Out Model to a Carve-In Model"). This notion was well articulated by an expert informant with whom we spoke:

> I think either carving in or carving out can both work. . . . Think about it this way. You have a toolbox with ten tools in it and very often we debate them one at time, and in fact I think how successful you are about carving in and carving out depends on how you set up the full set of tools.

Key Design Features for Behavioral Health Financing Models

According to the evidence we collected, these design features—the tools referenced in the above quote—might be categorized as being related to contracts and data analytics, payment, and regulations and administrative processes. As detailed earlier, most informants spoke to the importance of these design features in the service of optimizing carve-in outcomes. *However, these design features are equally relevant to the task of optimizing carve-out outcomes, even if not all are applicable to public carve-outs such as California's.* These features are important for achieving the goals of quality and integrated care in a carve-in or carve-out setting. We elaborate on these design features below.

Contracts and Data Analytics

Contracts should contain clear expectations, including details on penalties and rewards, regarding (1) *performance on quality and other key outcomes of care*, including for services not covered by the health plan, in order to promote clinical BH-PH integration and balanced use of evidence-based psychotropic-based and psychosocial services, and (2) *relationships between health plans and providers*, including which providers to contract with.

Contracts should be written with specificity regarding who is responsible for the delivery of which Medicaid-covered service. Clear accountability permits the targeting of performance monitoring to determine whether contract expectations are met and whether penalties or rewards are warranted. In MMC carve-in environments, contracts should stipulate whether subdelegation is permitted and, if it is—given that a carve-out model will be reproduced—its design features, expectations for performance and relationships with providers, and lines of accountability should be described. Additionally, contracts could stipulate the use of higher medical loss ratios and BH expenditure targets to ensure that enrollees with SMI/SUD and high BH needs are adequately served.

Because of the importance of robust contracts with health plans, states should have specialized knowledge of key aspects of the BH system and in-house expertise in contracting. States should also have data analytics expertise to permit performance monitoring and oversight. Lack of contracts and data analytics expertise limits states' ability to ensure access to high-quality care for a stigmatized and high-need population that is at high risk for adverse selection.

Payment

Payment amounts should be set to ensure that health plans and providers are able to provide evidence-based and level-adequate care to enrollees with SMI/SUD. Given the severity of health challenges among this population, their social precariousness, and the likelihood of higher health care costs, states should employ state-of-the-art risk adjustment methods and use risk-mitigation tools, such as higher premiums, to create the right mix of incentives.

States should consider designing payment structures, such as value-based payments, to promote better overall health by incentivizing specific targets for improved health plan performance, such as greater utilization of both primary care services and EBPs of high significance to enrollees with SMI/SUD. The VBP model can be implemented in various ways, but the main arrangements involve connecting payment only to quality (e.g., pay-for-performance), implying that the target(s) of the VBP only faces upside gainsharing, or to both quality and costs, implying downside risks. Despite great policy interest in VBP, however, there is little empirical evidence on whether the model can equitably improve outcomes for people with SMI/SUD. States should consider setting provider rates to ensure that providers, especially small BH providers, are paid fairly and in a timely manner when they enter into contracts with plans; however, rate-setting can be challenging because historical expenditures may not reflect costs of high-quality care.

Regulations and Administrative Processes

States can employ regulatory and administrative tools to improve access to needed services, particularly if costly to health plans. Tools to reduce MCO abusive practices include regulation of medical necessity criteria and payer practices regarding utilization review, and increased monitoring of denials of services to patients and payments to BH providers. Additionally, states can promote organizational integration by conditioning participation in the Medicaid system on the adoption of linking structures such as HIT and case management services.

Promoting Integration in Carve-In or Carve-Out Environments

States can use additional approaches to reduce care fragmentation and improve integration regardless of the BH financing model. The Kaiser Family Foundation describes four approaches in addition to carve-in that can be used by state Medicaid programs, health plans, and providers to promote organizational integration and ultimately, clinical integration (Nardone, Snyder, and Paradise, 2014).

Screening

PCPs can use several evidence-based tools to screen patients for BH conditions such as SUD. Oregon, for example, uses percentage of members screened for SUD with the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool as a metric to reward CCOs. BH care providers can screen for PH conditions using basic tools, such as scales and blood pressure cuffs. As an example of this approach and in the context of the existing carve-out, county MHPs that participated in the California Institute of Mental Health's Small County Care Integration Quality Improvement Collaborative recorded blood pressure, weight, and body mass index at patient visits and referred patients for PH care if they identified a health concern (California Institute for Behavioral Health Solutions, 2021).

Navigators

Enrollees with SMI frequently experience challenges with accessing and negotiating PH care, which states typically address through case management services. States can employ navigators to assist in this process. Unlike case managers, the navigator workforce is composed of individuals with personal experience with BH conditions. States can fund navigator programs, as in the case of Wellness Recovery Teams piloted in one county in Pennsylvania, which included Medicaid-funded navigators. The Wellness Recovery Teams' functions included coordinating care with all agencies involved with the enrollee, reviewing and helping to reconcile medications, and teaching self-management and self-advocacy to patients. The pilot was associated with fewer ED visits and fewer BH and PH inpatient admissions (Nardone, Snyder, and Paradise, 2014).

Colocation

Colocation, meaning the provision of BH and PH care at the same site, can greatly reduce barriers to accessing services. Models of colocation that entail providing BH care at health centers have been the focus of significant policy efforts to promote BH/PH integration (Substance Abuse and Mental Health Services Administration, Center for Integrated Health Solutions, 2016). However, colocation entail-

ing "reverse integration"—that is, providing primary care in specialty BH settings—is a more appropriate model for individuals with SMI because the specialty BH sector is the health care home for most of them (Alakeson, Frank, and Katz, 2010). Medicaid's system of prospective payment to federally qualified health centers (FQHCs) facilitates colocation by allowing FQHCs to build the cost of licensed BH practitioners into their payment rates in states with colocation-friendly regulatory environments. In California, multiple counties and provider organizations have used state and federal resources to provide PH services in BH settings (California Mental Health Services Authority Integrated Behavioral Health Project and AGD Consulting, 2013).

Health Homes

The Affordable Care Act enabled incentivized states to establish Health Homes for the purpose of coordinating BH and PH services for Medicaid enrollees with chronic conditions; thus far, 22 states, including California, have adopted the model (Nardone, Snyder, and Paradise, 2014). The Health Home model includes management and coordination of services by a Health Home provider, health promotion and family support, and referral to community and social support services. States can target their Health Home models to serve specific patient populations, including people with SMI/SUD; as of April 2021, 20 of 22 states with Health Homes used at least one model focused on SMI or SUD (CMS, 2021). A variety of providers can be designated as Health Homes, and designating BH agencies as Health Homes provides a means for states to expand reverse clinical integration. California implemented a Health Homes program starting with San Francisco County in 2018; by April 2021, it had expanded the program to 12 counties with nearly 43,000 enrollees (DHCS, 2021f). Early evaluation of Health Homes in California (Pourat et al., 2020) and other states (Spillman and Allen, 2017) shows some success with meeting Health Home goals. Under CalAIM, the program will be folded under the ECM benefit to be managed by the MMC system.

Conclusions

In the context of justified alarm over the poor PH outcomes of Medicaid enrollees with SMI, partly stemming from their difficulties accessing PH care, many states and localities have adopted BH carve-ins as a strategy to promote greater clinical integration for a population whose health care home is the specialty BH sector.

However, there are important differences among existing MMC BH carve-ins in terms of the characteristics of both the system that served Medicaid enrollees with BH needs before the carve-in transition and the carve-in currently serving those enrollees—thus, the model is as varied as the many states and localities that have implemented it. The critical experience for California to draw lessons from is that of settings which, prior to the transition, used carve-outs to manage the BH care of enrollees with SMI/SUD. *Carve-out systems* have an incentive to focus on the sickest enrollees, whose needs are best met through specialty BH provider networks they can readily access as a result of their specialization in BH care; as already discussed, this may result in greater attention to the BH needs of those with SMI but also lead to inadequate access to PH care. Conversely, *carve-in systems* rely on primary care practices as the point of entry into health and BH care; while this set-up might lead to greater attention to enrollees' PH care needs and the BH care needs of enrollees with mild-to-moderate mental illnesses, but the BH needs of those with SMI may might be overlooked because of insufficient training, resource constraints, or stigma (Horvitz-Lennon, Kilbourne, and Pincus, 2006; Frank, 2021). Appropriate access to BH care for these individuals might be further affected by carve-ins' greater vulnerability to adverse selection, particularly when compared with payer carve-outs such as California's.

Despite the momentum for MMC BH carve-ins, as reviewed earlier ("What Is Known About the Carve-In Model from the Available Evidence?"), evidence regarding the impact of the model is surprisingly limited in scope, with much yet to be understood about key enrollee- and system-level outcomes; moreover, the significance of this evidence

Design considerations are more important than the decision to finance BH services as a carve-in versus carve-out.

for California is uncertain because of differences in policy contexts.

However, our qualitative work identified important issues for California to consider regarding the decision to implement a MMC BH carve-in and, if the state decides to pursue a carve-in, its design and implementation strategy. Our findings suggest that transitioning to a carve-in is not sufficient to achieve financial, organizational, or clinical integration or other expected outcomes, and that states that have made the transition have taken regulatory actions to promote integration and used multiple mechanisms to mitigate potential risks associated with the carve-in model.

Whether carve-in states' efforts to achieve the model's expected benefits and avoid the model's potential risks will be successful is not well understood. *Despite this gap in evidence, our qualitative work suggest that design considerations are more important than the decision to finance BH services as a carve-in versus carve-out, with three design features having particularly critical importance: contracts, payment, and regulations and administrative processes.* Hence, given the limited evidence of benefits and the potential for some significant risks from a carve-in transition, the decision point for California may not be whether to transition to a MMC BH carve-in. Rather, the decision may be what design features may need to be adopted or strengthened to achieve the expected benefits of both models while minimizing their risks and *preserving what works well in the current system*. In this regard, we highlight two strengths of the county-based carve-out: counties' capacity to leverage multiple funding streams to address the BH and social needs of all residents regardless of insurance status or payer, and counties' nimbleness and expertise in crossing the divide between BH care and social services. If the state were to transition to a carve-in, MMC plans would not be able to braid diverse funding streams or easily replicate the high level of integration between the BH and social services sectors, both of high significance for enrollees with SMI/SUD.

Our work points to three potentially effective strategies that California should consider given that its priority is to improve outcomes for Medi-Cal enrollees through a greater focus on quality and equity:

1. **Provide adequate and timely payment to payers and their contracted providers to enable the delivery of evidence- and need-based specialty BH care.** Because MHPs are responsible for a Medi-Cal population with a high likelihood of needing intensive and costly care, budgets should reflect this complexity—for example, through the use of risk-adjustment methods that account for *both* health and social risks, and other risk-mitigation strategies. This is particularly important for county MHPs with IMDs, because they are responsible for the entirety of those costs, a reality that might change only for some counties with IMDs and for some of the costs if the IMD exclusion waiver is approved. Additionally, the state may consider gradually moving to a VBP model that rewards good performance on specific targets of high significance for enrollees with SMI/SUD; targets may include measures of clinical integration and quality such as those recommended by our expert informant and social indicators such as rates of homelessness or criminal justice system involvement.

State expertise in BH care and a robust regulatory capacity are key to the success of the model chosen to finance BH care.

2. **Strengthen state capacity for monitoring performance and conducting oversight.** State expertise in BH care and a robust regulatory capacity are key to the success of the model chosen by the state to finance BH care, particularly if the state adopts a VBP model. Expertise in contract-writing is critical both for (1) developing a clear understanding of expectations for how the funds will be used and what goals will be achieved and (2) promoting accountability for achieving specific outcomes by specifying clear lines of responsibility, as well as penalties and rewards. Effective oversight requires that the state identify quality measures of high relevance to enrollees with SMI/SUD, a key task that can benefit from technical expertise, and have the ability to access and analyze payer data to monitor performance. Although measures capturing health and social outcomes might be preferable to process measures, it typically takes a long time and significant resources for health care systems to affect outcomes. Moreover, feasible process measures of adequate predictive validity are available (Kilbourne et al., 2018; CMS, 2020; Watkins et al., 2010). However, limitations to a state's ability to monitor quality of BH care and plan performance creates a greater need for more direct oversight methods aimed at ensuring that health plans meet their contractual obligations. The state might develop in-house or contracted expertise in claims and EHR data analysis and use of state-of-the-art risk-adjustment methods and validated benchmarks. California's plan to adopt the Health Care Payments Data Program, an All Payer Claims Database that will aggregate claims data across public and private payers (California Office of Statewide Health Planning and Development, 2021), is an important step in this direction.
3. **Promote clinical BH/PH integration through investments in linking structures that enhance organizational integration.** Investments in HIT might have particularly high returns given that small providers lacking resources for non-service-related expenditures are overrepresented in the BH provider network. Developing a well-connected informational platform across the BH and PH care systems through a single EHR and well-functioning HIE is an important first step. California should also consider strengthening case management systems and expanding reverse integration through colocated practices and the health homes program soon to be folded under the ECM benefit.

Lastly, if California decides to embark on a transition to a MMC BH carve-in, it should carefully evaluate whether it will allow the use of subdelegation. Not only does this contracting model reproduce a carve-out model but, as discussed in the introduction ("Transitioning from a Carve-Out Model to a Carve-In Model"), the resulting health plan carve-out might be more vulnerable to adverse selection, and state oversight might be less straightforward when compared with existing county-based BH carve outs (McConnell et al., 2021; Frank, 2021).

Appendix. Detailed Descriptions of Carve-In States

This appendix describes carve-in initiatives in the five states that were the focus of this study. For each state, the "Carve-In Description" section provides an overview of each initiative. The "Behavioral Health System Pre-Carve-in" section describes management of BH services before the initiative. The "Design Details" section identifies populations and services covered, allocation of financial risk, and provisions for subcontracting under the carve-in initiative.

Arizona

Carve-In Description

Arizona implemented SNPs called regional behavioral health authorities (RBHAs) that carved in BH services for Medicaid enrollees with SMI. Arizona implemented the carve-in using a phased approach: In 2014, the state implemented a carve-in for adults with SMI and comorbidities, and children with special health needs, in Maricopa, its largest county. Subsequently, the carve-in was implemented for those populations in the rest of the state. By 2019, the state had implemented the carve-in for all people with SMI except children in foster care. To promote physical and behavioral health care integration, the state also brought the Department of Health Services' Division of Behavioral Health Services into the state's Medicaid agency, the Arizona Health Care Cost Containment System, and integrated the two organizations' teams. State informants described strong contract management, extensive stakeholder engagement, and a phased approach that provided time to learn what went well and plan for the future as important components of their approach.

RBHA contracts include targets for value-based payment. In 2021, the state released a request for proposals for new RBHA contracts and other MMC contracts that will take effect in 2022. The new contracts will include financial incentives for performance on quality measures.

Behavioral Health System Pre-Carve-In

Before 2014, RBHAs managed BH services for people with SMI/SUD, and MMC plans overseen by the Arizona Health Care Cost Containment System managed PH services. As a result, people with SMI needed to navigate separate systems to obtain PH and BH services (Arizona Health Care Cost Containment System, 2021).

Design Details

RBHAs cover most people with SMI except children in foster care. They cover PH services; inpatient, specialty outpatient, and pharmacy services for MH and SUDs; and crisis services (McConnell et al., 2021). RBHAs receive full capitation payments and assume full risk. The state generally prohibits subcontracting of BH management to other entities.

New York

Carve-In Description

In 2015, New York implemented its latest carve-in transition, enabling qualified mainstream MMC plans to comprehensively manage a more generous BH benefit for Supplemental Security Income (SSI) beneficiaries who had been excluded from a previous MMC carve-in. The expanded BH benefit was made available to all adult Medicaid enrollees, except those dually enrolled in Medicare and Medicaid, through (1) MMC plans covering the expanded BH benefit and (2) SNPs called health and recovery plans (HARPs) operated by qualified MCOs that managed all health care services, as well as a new benefit—home and community-based services (HCBS)—for eligible adults with SMI/SUD. HARP enrollment began in 2015 in New York City and in 2016 in the rest of the state (New York State Office of Mental Health, 2017).

The state attempted to promote VBP in mainstream MMC plans and SNPs through the VBP Roadmap, implemented in 2015. The VBP Roadmap established VBP targets for MCOs and allowed MCOs to choose from a menu of VBP arrangements models and performance metrics focused on the general population or special-needs populations, such as HARP members (New York State Department

of Health, 2019). A state interviewee reported that MCOs tended to adopt VBP arrangements for the general population rather than special-needs populations to meet VBP targets. The interviewee described challenges with data sharing among plans and providers as barriers to VBP arrangements.

Behavioral Health System Pre-Carve-In

Before the carve-in, PH services were managed through the MMC system for nearly all Medicaid enrollees; BH services were also managed through the MMC system for non-SSI Medicaid enrollees, with SSI enrollees' BH services paid through FFS arrangements. The carve-in was part of effort by Governor Andrew Cuomo to fundamentally restructure the state's Medicaid program to improve health outcomes, control costs, and increase efficiency.

Design Details

HARP eligibility is based on age (minimum 21 years), SMI and/or SUD diagnoses, and HARP risk factor criteria largely determined by intensity of BH utilization patterns. HARP-eligible individuals are identified quarterly and are passively enrolled into HARPs. HARPs cover all PH services and a full continuum of BH services, including inpatient, ED, specialty outpatient, and pharmacy services, and, for eligible HARP members, HCBS such as employment and crisis services (McConnell et al., 2021). Through their parent MCOs, HARPs receive full capitation payments (with a higher premium relative to the non-HARP members) and assume full risk; although the state allows subdelegation, the MCO retains responsibility and the majority of HARPs manage both PH and BH services.

Oregon

Carve-In Description

In August 2012, Oregon created 15 CCOs responsible for managing BH and PH services and integrating and coordinating these services for most Medicaid members across the state. Each CCO finances the health services for Medicaid members in a specific geographic region of the state and is required to include health care providers, members of a community advisory council, and members of the community at large in its governance structure. The CCO model operates within global budgets and includes VBP, as CCOs can receive incentive payments for improvement on performance metrics (McConnell et al., 2014). The 14 incentive metrics for 2021 include four that pertain to BH (Oregon Health Authority, 2020a).

In 2019, the state executed new contracts with CCOs (Oregon Health Authority, 2018). The state's request for applications included strong language to prohibit subdelegation and promote integration of BH and PH services (Oregon Health Authority, 2020b). The new language responded to concerns about lack of improvement on BH performance measures under the 2012 waiver and findings that most CCOs had continued to carve out and pass on BH funding to counties (Kushner et al., 2017).

Behavioral Health System Pre-Carve-In

Before the Medicaid reform that led to the MMC carve-in as part of the creation of CCOs in 2012, mental health organizations (MHOs) managed services for enrollees with SMI and mild-to-moderate MH needs. MHOs were single-county governmental, multi-county governmental, not-for-profit, or for-profit entities that received capitation payments from the state and operated or contracted with community-based or private provider organizations to deliver MH services (Oregon Legislative Committee Services, 2012; Oregon Health Authority, 2012a). Fully capitated MMC plans managed PH and SUD services (Oregon Health Authority, 2012b). With the transition to CCOs in 2012, MCOs and MHOs became part of CCO governance or financing structures (Broffman et al., 2016).

Design Details

CCOs cover all adults and children, including people with SMI. CCOs cover PH services, inpatient and specialty outpatient services for MH and SUD conditions, and crisis services. The state carved out psychotropic drugs and pays for them on a FFS basis (McConnell et al., 2021). CCOs receive full capitation payments and assume full risk. Before 2020, they had

the option of subdelegating management of BH services to former MHOs (Broffman et al., 2016).

Texas

Carve-In Description

In 2014, Texas carved BH rehabilitation and case management services into its existing MMC plans. Rather than issue a request for proposals for new contractors, the state chose to expand the responsibilities of its existing MMC contractors to encompass carved-in services. The state divided carve-in implementation into two phases. In Phase 1, it focused on "revising MMC contracts, communicating with stakeholders, and developing its oversight approach" (Soper, 2016). In Phase 2, it focused on increasing integration of BH and PH services and designing integrated quality measures. The state also required MMC plans to demonstrate that they had the capacity to coordinate BH services through a readiness review (Soper, 2016).

Texas implemented an MCO Pay-for-Quality program in 2014. The program provides financial incentives and disincentives to MCOs based on their performance on a set of quality measures, including process and outcome measures. The measures focus on prevention; chronic disease management, including BH; and maternal and infant health (Texas Health and Human Services Commission, 2021).

Behavioral Health System Pre-Carve-In

Before 2013, BH rehabilitation and case management services were provided on a FFS basis by local mental health authorities (LMHAs) that make up the state's network of community mental health centers. Comprehensive MMC plans managed MH and SUD services, with the option for subdelegation. These plans worked with LMHAs to coordinate BH services, providing a foundation for coordination under the carve-in. In preparation for the carve-in, the state worked closely with trade organizations representing LMHAs to understand how carve-in would affect provider operations.

Design Details

State of Texas Access Reform (STAR), the largest MMC program, serves low-income families, children, pregnant women, and some foster care youth and manages PH, pharmacy, and BH services, including BH rehabilitation and case management services (Texas Health and Human Services Commission, 2021). Under the carve-in, MMC plans contract directly with LMHAs and other BH entities to provide services (Soper, 2016). However, crisis services are carved out and managed by LMHAs, with funding from state revenue and block grants. The state allows MMC plans to subcontract with specialized BH MCOs to manage BH services but requires that plans retain financial risk (Soper, 2016). MMC contracts include requirements for substantive integration and the state requires financial reporting on subcontracted BH arrangements.

Washington

Carve-In Description

Washington contracts with five MCOs that manage PH and most BH benefits for all adult and child Medicaid members. The state began integrating financing for MH and SUD services in 2016 by creating behavioral health organizations (BHOs) that jointly managed both types of services (Washington State Department of Social and Health Services, 2016). In the same year, two southwestern "early adopter" counties carved in the BH benefit to MMC plans. The state required all geographic regions to transition to a MMC BH carve-in by 2020 but allowed regions to choose whether they would be early, midpoint, or on-time adopters. State interviewees described challenges that these comprehensive MMC plans created for providers, including the need to learn about MMC contracting, implement processes and technology to process claims, and contract with multiple MCOs instead of one local entity. They recommended using learning collaboratives and other readiness activities for providers and transferring knowledge about local BH systems to MCOs in preparation for a carve-in. With the transition to a MMC BH carve-in, BHOs were converted to BH administrative service organizations (BHASOs) in

most regions of the state. BHASOs manage crisis-only and Substance Abuse and Mental Health Services Administration (SAMHSA) services, as well as smaller programs. The state vested these functions in BHASOs to preserve the regional crisis system. The state's contracts with MCOs require MCOs to negotiate VBP arrangements with providers in their networks. Under the contracts, MCOs can earn incentive payments based on the portion of total dollars paid to providers through VBP arrangements and the achievement of quality improvement targets for the MCO's population (Washington State Health Care Authority, 2020a). The seven measures for VBP arrangements within the 2021 contracts include four BH measures (Washington State Health Care Authority, 2020b).

Behavioral Health System Pre-Carve-In

Before 2016, MCOs managed PH and mild-to-moderate MH services. Quasi-government entities called regional support networks managed MH services for enrollees with SMI, and counties managed SUD services, with each type of organization using a mix of Medicaid and state-only dollars (Kelly, 2020).

Design Details

Comprehensive MMC plans cover all adults and children, including people with SMI. They cover PH services and inpatient, specialty outpatient, and pharmacy services for MH and SUD conditions. Crisis services are carved out and managed by BHASOs (McConnell et al., 2021). Comprehensive MMC plans receive capitation payments that cover PH and BH services. However, they have the option of subcontracting with BHOs (McConnell et al., 2021).

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Abbreviations

BH	behavioral health
BHASO	behavioral health administrative service organization
BHO	behavioral health organization
CalAIM	California Advancing and Innovating Medi-Cal
CBHDA	California Behavioral Health Directors Association
CCO	coordinated care organization
CMS	Centers for Medicare and Medicaid Services
COHS	county organized health system
CPE	certified public expenditures
DHCS	California Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
ECM	enhanced care management
ED	emergency department
EHR	electronic health record
FFP	Federal Financial Participation
FFS	fee for service
FQHC	federally qualified health center
HARP	health and recovery plan
HCBS	home and community-based services
HIE	health information exchange
HIT	health information technology
IMD	institute for mental disease
MCO	managed care organization
MH	mental health
MHO	mental health organization
MHP	mental health plan
MMC	Medicaid Managed Care
PCP	primary care physician
PH	physical health
SED	serious emotional disturbance
SMART	Save Medicaid Access and Resources Together
SMI	serious mental illness
SNP	special needs plan
SSI	Supplemental Security Income
SUD	substance use disorder
VBP	value-based payment

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About This Report

Since the beginning of the Medi-Cal program in 1966, financing for behavioral health services has been separated, or "carved out," from financing for all other types of health care. In other states that have also carved-out behavioral health services in Medicaid, there has been a recent trend toward "carve-ins," whereby financing for behavioral health care is integrated with financing for other types of care. In California, where a broad reform in Medicaid delivery and payment is about to be launched, a potential move to a behavioral health carve-in is being considered.

To inform the policy discussion in California, the County Behavioral Health Directors Association of California (CBHDA) contracted with RAND to study recent experiences with carve-ins in other states, the evidence regarding the impact that carve-ins have had, and the implications for California's unique behavioral health care system.

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