



**California
Children's
Trust**

Medi-Cal Managed Care: A Primer to Inform Youth Mental Health

Introduction/Overview

California's Medicaid program, known as Medi-Cal, is the largest Medicaid program in the U.S. The program covers one-third of all Californians (12.8 million individuals), including 5.2 million children.¹ Medi-Cal provides both physical health and behavioral health services to eligible beneficiaries. The program pays for more than 50 percent of all births and covers more than 40 percent of all children in the state. In addition, one in 10 children in California living at or below the poverty level has a serious emotional disturbance (SED).²

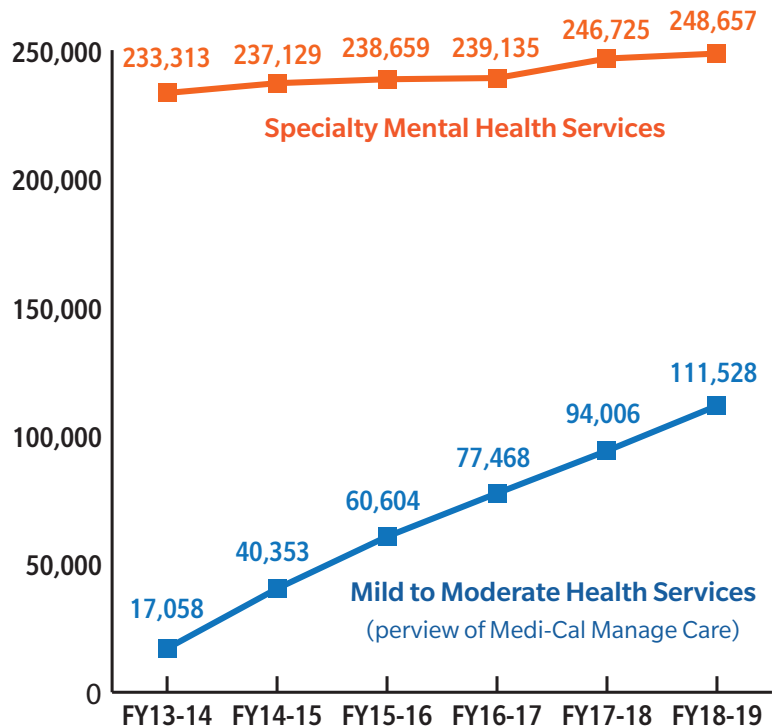
Medi-Cal has grown significantly in recent years, largely due to the Affordable Care Act's (ACA) coverage expansion which was implemented in 2014 and allowed low-income adults, who were previously not eligible, to qualify for the program. Under the ACA, the state expanded the Medi-Cal benefit package to include mild-to-moderate behavioral health services. In 2016, California also expanded Medi-Cal eligibility to include all low-income children, regardless of immigration status. Prior to the ACA changes, the state consolidated the Healthy Families program into Medi-Cal in 2013, adding approximately 750,000 children to the Medi-Cal program.³

Within Medi-Cal for all age groups, the majority of beneficiaries (roughly 80 percent) are enrolled in a managed care plan:⁴ 89 percent of children in Medi-Cal are in a managed care plan.⁵ Even as Medi-Cal has expanded to cover more children, the program has struggled to provide children's preventive care. A recent study found that the quality of care for California children has declined or remained unchanged for preventive care and primary care access between 2009-2018.⁶ As shown in Figure 1, the mental health

utilization rate for children enrolled in a Medi-Cal health plan is low but has been growing steadily in recent years. As a result, it is critical for children's mental health advocates to understand Medi-Cal managed care and the role of the health plans in providing mental health services to California's children.

This issue brief provides an overview of California's Medi-Cal managed care program, the children's managed care mental health benefit, and the issues and challenges with the current structure.

Figure 1. Year-Over-Year Growth in Medi-Cal Beneficiaries Accessing Mental Health Services



Source: Data provided to CCT by DHCS

California's Medi-Cal Managed Care Program

California has a long history with managed care for the Medicaid population and was the first state to implement a managed care program beginning in the 1970s.⁷ In the early 1990s, moving slowly at first, the state began to shift a significant portion of the Medi-Cal population out of the fee-for-service (FFS) delivery system into managed care—initially in response to pressure to control costs and improve access to services. Initially, managed care was available to Medi-Cal beneficiaries residing in certain counties and, depending on the county, to specific Medi-Cal subpopulations (e.g., children and families enrolled in CalWORKs). Over time, the state has expanded managed care to include all 58 counties and most Medi-Cal beneficiaries. Today, the majority of Medi-Cal beneficiaries receive their care through one of six Medi-Cal managed care models: Two-Plan Model, County Organized Health System (COHS) Model, Geographic Managed Care (GMC) Model, Regional Model, Imperial Model, or San Benito Model. Essentially, these models differ in terms of the number of health plans the beneficiary can choose from and whether a public health plan is available.

California's Medi-Cal managed care program is unusual among the states in its reliance on public health plans: 15 local, county-based health plans serve the program as well as nine commercial health plans. The local health plans include six County Organized Health Systems (COHS) and nine Local Initiatives (LI) that offer coverage in 36 counties and enroll the majority of the Medi-Cal managed care population across the state. In September 2020, 68 percent of Medi-Cal managed care enrollment was held by the local health plans.⁸ Table 1 below presents the key characteristics of the Medi-Cal managed care models.

Medi-Cal Managed Care Models

Source: California Department of Health Care Services

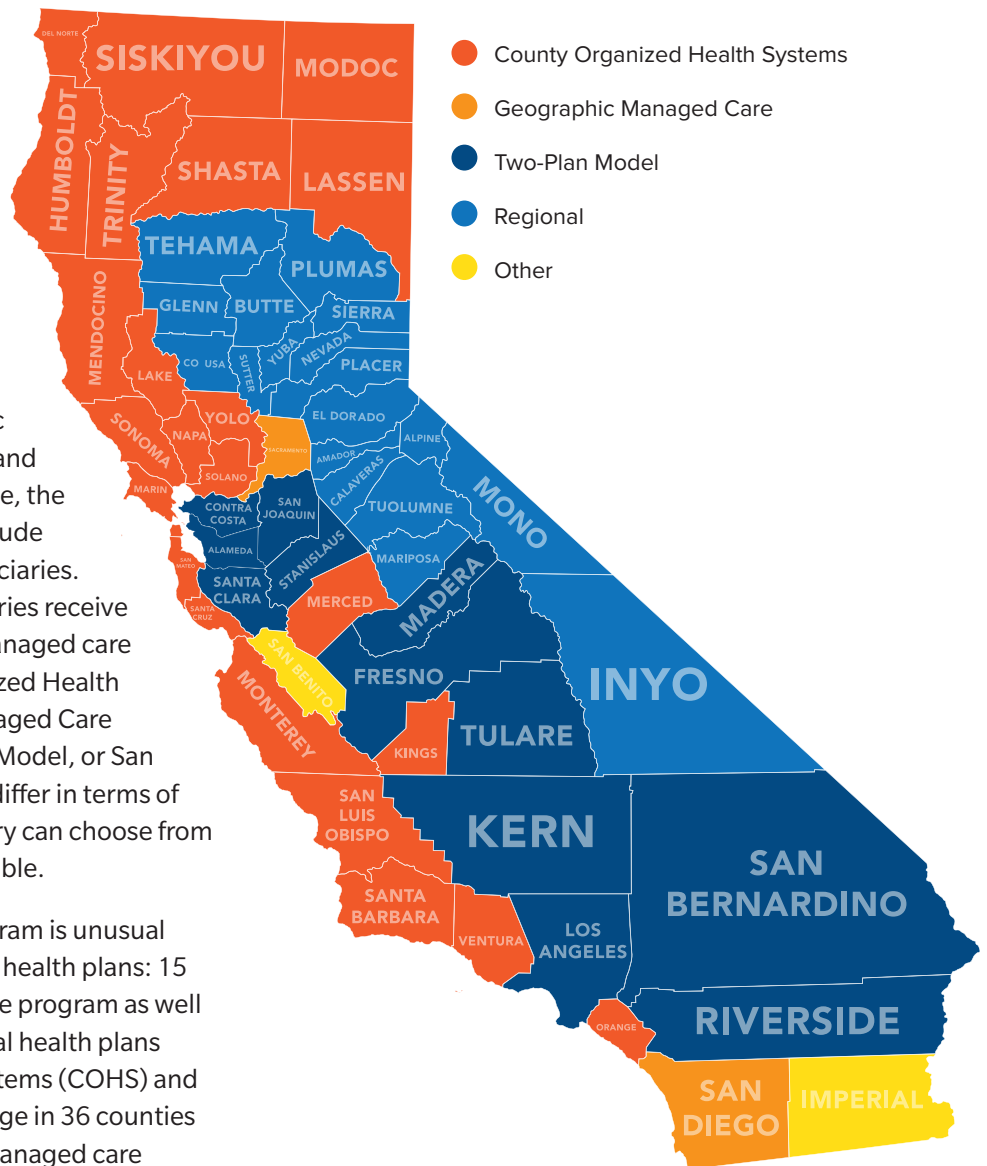


Table 1. Medi-Cal Managed Care Models—Key Characteristics

COHS	<p>Operates in 22 counties</p> <p>Single public health plan enrolls all Medi-Cal beneficiaries in the county</p> <p>Six COHS operate across the state</p> <p>Three COHS operate in more than one county</p>
GMC	<p>Operates in two counties</p> <p>Multiple private, commercial health plans offer coverage to beneficiaries in the county</p> <p>Eight commercial plans participate in the GMC model</p> <p>Four commercial plans operate in both GMC counties</p>
Two-Plan	<p>Operates in 14 counties</p> <p>Two health plans—one LI and one commercial plan—offer coverage to beneficiaries in the county; the lone exception is Tulare County where two commercial plans offer coverage</p> <p>Nine LIs and three commercial plans operate across the state</p> <p>Three LIs operate in more than one county; the commercial health plans all operate in multiple counties</p>
Regional	<p>Operates in 18 largely rural counties</p> <p>Two commercial health plans offer coverage to beneficiaries in the county</p>
Imperial	<p>Operates in Imperial County</p> <p>Two commercial health plans offer coverage to beneficiaries in the county</p>
San Benito	<p>Operates in San Benito County</p> <p>Beneficiaries can choose to remain in FFS or enroll with the single commercial plan offering coverage in the county</p>

Information about which health plans provide coverage in each county can be found on the DHCS website which includes a [directory](#) of the Medi-Cal health plans.

Managed Care Enrollees

Enrollment in a health plan is mandatory for most Medi-Cal beneficiaries. In the non-COHS counties, key Medi-Cal subpopulations not required to enroll in a health plan include foster children and youth, adults without satisfactory immigration status, beneficiaries with approved medical exemptions, and Medi-Cal beneficiaries dually-eligible for Medicare.⁹ In addition, Medi-Cal beneficiaries residing in San Benito County can choose to remain in fee-for-service Medi-Cal or enroll with the single commercial health plan operating in the county.

In the non-COHS counties, new Medi-Cal enrollees can choose their health plan. If an enrollee does not choose a health plan, DHCS assigns the enrollee to a health plan using an algorithm that gives preference to the health plan with the highest quality scores on a subset of the Medi-Cal quality metrics tracked by DHCS annually.

Covered Benefits

Under federal law, states are required to offer a defined set of Medicaid benefits (known as “mandatory benefits”) and can choose to offer additional benefits (known as “optional benefits”). Under the Affordable Care Act (ACA), Medi-Cal is required to cover all 10 of the essential health benefits.¹⁰ In addition, Medi-Cal covers a number of optional services, including specialty mental health, substance use disorder (SUD) treatment services, dental services for adults, and long-term care services and supports.

In general, the Medi-Cal health plans offer most of the mandatory benefits. Services that are “carved out” of the list of benefits provided by the health plans include specialty mental health and SUD services; however, the health plans are responsible for providing mental health services for lower-acuity conditions (known as “mild-to-moderate” services). This benefit was added in 2014 to align the Medi-Cal benefit package with the ACA’s 10 essential health benefits.

Focus on Local Health Plans

The local health plans—the six County Organized Health Systems (COHS) and nine Local Initiatives (LI) serving the Medi-Cal program—pride themselves on their strong ties to their communities. They work closely with local stakeholders—providers, community-based organizations, and members—to develop programs and initiatives tailored toward the unique circumstances of their communities. In addition, the local health plans’ governing boards include local stakeholders (e.g., local providers, the county health director, community-based organizations, health plan members) with the composition of the board typically defined in county ordinance. With roughly 70 percent of managed care enrollment, these health plans are the backbone of the Medi-Cal managed care program and could be good partners for community-based organizations interested in expanding mental health access and utilization.

Managed Care Contracting

The California Department of Health Care Services (DHCS) is the state’s Medicaid agency, responsible for the day-to-day operation of the Medi-Cal program. To administer the Medi-Cal managed care program, DHCS contracts with health plans. The contract specifies the health plans’ responsibilities and the requirements they must comply with, and DHCS monitors health plan compliance with the contract standards.

Managed Care Capitation Rates

The state sets the Medi-Cal managed care capitation rates in accordance with federal and state statutory and regulatory requirements. Federal regulations require states pay managed care rates that are (1) developed in accordance with generally accepted accounting principles, (2) appropriate for the population served and benefits offered, and (3) certified by an actuary. To be approved by CMS, the rates must be “actuarially sound.”¹¹ DHCS and its actuaries, Mercer, work with the Medi-Cal health plans to develop the rates. The annual rate development process takes one year to complete, and the rates must ultimately be approved by the federal government.

The health plan rates are based on plan-specific encounter data as well as supplemental data submitted by the plans on costs and utilization. Mercer adjusts the base data to account for projected changes in health care costs and anticipated programmatic changes. The actuaries then apply “efficiency adjustments” (e.g., for potentially avoidable pharmacy costs, potentially preventable hospital admissions) to the capitation rates as well as adjusting the rates to reflect the relative health of the health plans’ members. Finally, Mercer adjusts the rates for administrative costs and underwriting gain for profit/risk. The Medi-Cal rates must be set to achieve an overall medical-loss ratio (MLR) of 85%.¹² The complexity of the rate-setting process results in health plan rates that are based on data that is almost two-and-a-half years old.¹³

Medi-Cal Managed Care and Behavioral Health

Medi-Cal covers both mental health and SUD services for adults and children who meet medical necessity criteria. In addition, states are required to provide mental health services to children under age 21 in accordance with the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Within the Medi-Cal program, the delivery of behavioral health care (to both children and adults) is fragmented, with counties responsible for specialty mental health and SUD services and the Medi-Cal health plans responsible for lower acuity, “mild-to-moderate” mental health services. The bifurcated structure of the behavioral health benefit is challenging for beneficiaries, health plans, and providers to navigate and results in a fragmented delivery system that can lead to gaps in care.

Under managed care, the Medi-Cal health plans are required to provide the same mental health services as provided under the fee-for-service program. These include the following mental health services:

- » Individual and group mental health evaluation and treatment (psychotherapy);
- » Psychological testing (when clinically indicated and medically necessary to evaluate a mental health condition);
- » Outpatient services to monitor drug therapy;
- » Outpatient lab, drugs, supplies and supplements; and
- » Psychiatric consultation.

In addition, under the EPSDT benefit, health plans are required to provide access to services that are medically necessary “to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.”¹⁴ EPSDT-covered services include anything that could be covered by Medicaid, regardless of whether the service is in California’s Medicaid State Plan approved by the federal government.¹⁵

Medi-Cal health plans contract with providers to deliver services to their enrollees and must meet network adequacy standards defined by DHCS. For mental health care, some Medi-Cal health plans manage the mental health benefit directly, while other health plans contract with a managed behavioral health organization to administer the benefit.

In recognition of the bifurcated mental health delivery system, the Medi-Cal health plans are required to enter into a memorandum of understanding (MOU) with the county specialty mental health plan (MHP) in each county in which the health plan operates. The MOUs delineate the responsibilities of the health plan and the county MHP, including referral processes and the dispute resolution process.¹⁶ The Medi-Cal managed care contract also requires the health plans to develop and maintain an internal policy and procedure for the referral of members needing specialty mental health to an appropriate Medi-Cal fee-for-service provider or the county MHP.¹⁷

In addition, the Medi-Cal health plans are required to provide comprehensive medical case management services for their members, including services provided by out-of-network providers. The health plans also must coordinate carved-out services (including specialty mental health care) and referrals to community-based resources and organizations regardless of whether the health plan is required to pay for the service.¹⁸ Under EPSDT, health plans are also responsible for care coordination and case management.¹⁹

Issues, Challenges and Recommendations with Children’s Mental Health and Managed Care

Key aspects of the Medi-Cal managed care structure limit access and utilization for children who need mental health care.

Medi-Cal’s mild-to-moderate benefit is limited in scope.

DHCS could take several steps that would expand the mild-to-moderate benefit and access to services. This includes removing diagnosis as a prerequisite for care, which would allow providers to treat children pre-emptively and address issues before they become serious. DHCS could also clarify for the health plans that clinical trainees under supervision can be credentialed just as they are for specialty mental health care. In addition, the allowable provider types for these services could be expanded to include diverse community health outreach workers, including promotoras to best serve the Latinx community, health advocates, peer counselors, and peer support specialists.

Bifurcated structure is challenging to navigate, provides wrong incentives.

Under the current structure, health plans accrue mental health savings when a child moves to the county MHP; likewise, the county accrues savings when a child moves from the MHP to the health plan for their mental health care. This can lead to a child getting “lost” between the two systems and causes delays in accessing needed care. Furthermore, it is challenging for children and their parents/caregivers to navigate between the two systems as a child’s condition may change over time, requiring switching between the health plan and the county delivery system. If a single entity were responsible for the provision of mental health services, a child could access the full continuum of mental health care without needing to transition from one system of care to another. In addition, the misalignment of financial incentives between the health plans and the county MHPs would no longer be a concern.

Medi-Cal managed care rate-setting process disincentivizes health plans from covering different/additional mental health services.

Under the current managed care rate-setting methodology, health plan payment rates are developed based on prior utilization of services specified in the health plan contracts. If a health plan offers different services or services that lead to lower utilization of more expensive services (e.g., hospital inpatient services, emergency department use, etc.), DHCS

may not recognize the costs for rate-setting purposes or reduce health plan rates to reflect the lower costs associated with the alternative services. The two-year lag in the data used for rate-setting also impacts health plan willingness to offer new or different services. As a result, the health plans may be wary of providing mental health care to members that deviate from the benefits included in their contracts. Working within the parameters established in federal law, the state could reform the managed care rate methodology to recognize the costs of providing non-traditional Medi-Cal mental health services to children.²⁰

DHCS lacks the needed resources to monitor health plan compliance with mental health contract requirements.

DHCS is responsible for oversight and monitoring of health plan performance to ensure contract requirements are met; this includes the mental health services children are entitled to under EPSDT. DHCS should strengthen administrative oversight and enforcement to focus on children’s mental health care. This will require additional state-level resources and staff with expertise in this area.

Medi-Cal Procurement Offers Opportunity to Influence Children’s Mental Health Coverage

DHCS has announced plans to re-procure the health plans serving the Medi-Cal program in 2021 with the release of a Request for Proposal (RFP) for the commercial plans serving the Two-Plan, GMC, Regional, Imperial, and San Benito models. This is the first Medi-Cal managed care procurement in more than 15 years. DHCS anticipates implementation of the new contracts will occur in January 2024.²¹

DHCS issued a Request for Information (RFI) in September 2020 to solicit input from stakeholders on the content of the RFP and new contract.²² In addition, the state will issue a draft RFP and draft contract template for public feedback in early 2021. Both the RFI and the forthcoming RFP provide the opportunity to influence the DHCS procurement and shape the content of the health plan contracts. While the procurement does not impact the LIs or COHS, DHCS is expected to revise the LI and COHS contracts to align with the new commercial contract template. The last major revision to the Medi-Cal contracts occurred in the early 2000s, making this procurement a rare opportunity to update and revise the contract language.

When the draft RFP is released for public comment in 2021, stakeholders should review the draft for the following areas to understand how health plans will be expected to support children with behavioral health needs:

- » What are the behavioral health benefits included in the contract that focus on early interventions and treatment for children and youth?
- » What are the requirements for health plans related to EPSDT and ensuring health plans provide services appropriate to support children and youths' social and emotional development and address adverse childhood events?
- » What are the care coordination and integration requirements for health plans related to specialty mental health and other carved-out services? How are health plans required to work with their county partners to coordinate delivery of specialty mental health to their mutual Medi-Cal enrollees?
- » How are health plans required to address the related areas of social determinants of health (SDOH), health disparities, and inequities?
- » How will health plans be required to partner with schools and other child-serving systems to improve access to care and address increases in mental health utilization and acuity?

When the final RFP and contract template are released later in 2021, stakeholders should review and understand any changes from the draft RFP as these will be the requirements that the commercial health plans, as well as the LIs and COHS, will have to adhere to once the procurement is completed and the new contracts are awarded.

Looking Ahead

The upcoming Medi-Cal health plan procurement process offers a rare opportunity to influence the content of the contract between DHCS and the Medi-Cal health plans. Using the overview of the Medi-Cal managed care program and the health plans provided in this issue brief, stakeholders concerned about children's mental health can advocate for changes to Medi-Cal to improve access to needed services and support the overall health and well-being of California's children.

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Endnotes

- 1 California Department of Health Care Services, "[Medi-Cal Monthly Eligible Fast Facts](#)," September 2020 (data from June 2020). Accessed October 13, 2020.
- 2 California Health Care Foundation, "[Mental Health in California: For Too Many, Care Not There](#)," March 2018.
- 3 California Department of Health Care Services, "[Healthy Families Program Transition to Medi-Cal: Final Comprehensive Report](#)," February 4, 2014, and California Department of Health Care Services, "[Medi-Cal's Historic Period of Growth: A 24-Month Examination of How the Program has Changed since December 2012](#)," August 2015.
- 4 California Health Care Foundation, "[Medi-Cal Facts & Figures, 2019](#)," February 2019.
- 5 Children Now, "[Children's Medi-Cal Managed Care in California Counties: A Landscape](#)," July 2020.
- 6 Andrew B. Bindman, Denis Hulett, Isabel Ostrer, and Taewoon Kang, "[A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade](#)," California Health Care Foundation, September 25, 2019.
- 7 Margaret Tater, Julia Paradise, and Rachel Garfield, "[Medi-Cal Managed Care: An Overview and Key Issues](#)," The Kaiser Commission on Medicaid and the Uninsured, March 2, 2016.
- 8 California Health & Human Services Agency Open Data Portal, "[Medi-Cal Managed Care Enrollment Report](#)." Accessed October 18, 2020. Total local health plan enrollment includes nine LIs and six COHS.
- 9 In the COHS counties, beneficiaries are not able to request a medical exemption. In addition, dual eligibles and foster children/youth are enrolled in the health plan. Seven counties also participate in Cal MediConnect (CMC), California's dual-eligible pilot which integrates Medicare and Medi-Cal benefits under a single health plan. In these counties, dual-eligible Medi-Cal beneficiaries can choose to enroll in a health plan.
- 10 The ACA defines the following 10 essential health benefits (EHBs): ambulatory services; emergency services; prescription drugs; rehabilitative and habilitative services and devices; hospitalization; preventive and wellness services, and chronic disease management; mental health and SUD services, including behavioral health treatment; maternity and newborn care; pediatric services, including oral and vision care; and laboratory services.
- 11 Federal Medicaid regulations provide the following definition of actuarial soundness: "Actuarially-sound capitation rates are projected to provide for all reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the managed care organization (MCO) ... for the time period and the population covered under the terms of the contract." (42 CFR 438.4(a))
- 12 The medical-loss ratio measures the percent of the health plans' payments that are spent on clinical services and quality improvement. An MLR of 85% means the health plan must spend 85% of payments on medical care. State law requires DHCS to recoup funds from Medi-Cal health plans that do not meet the 85% MLR requirement.
- 13 Manatt Health & Optumas Healthcare, "[Intended Consequences: Modernizing Medi-Cal Rate-Setting to Improve Health and Manage Costs](#)," California Health Care Foundation, March 2018.
- 14 California Department of Health Care Services, "[All-Plan Letter #19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21](#)," August 14, 2019.
- 15 Medicaid and CHIP Payment and Access Commission, "[EPSDT in Medicaid](#)." Accessed October 21, 2020.
- 16 California Department of Health Care Services, "[Medi-Cal Managed Care Two-Plan Non-CCI Boilerplate Final Rule Amendment Contract](#)." Accessed October 18, 2020.
- 17 Ibid.
- 18 California Department of Health Care Services, "[All-Plan Letter #17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services](#)," October 27, 2017.
- 19 California Department of Health Care Services, "All-Plan Letter #19-010."
- 20 For a discussion of possible revisions to the Medi-Cal managed care rate methodology to incentivize health plans to invest in new service delivery models, see: Manatt Health & Optumas Healthcare, "[Intended Consequences: Modernizing Medi-Cal Rate-Setting to Improve Health and Manage Costs](#)," California Health Care Foundation, March 2018.
- 21 California Department of Health Care Services, "[Medi-Cal Managed Care Request for Proposal \(RFP\) Schedule by Model Type \(Updated 2/27/20\)](#)." Accessed October 19, 2020.
- 22 The California Children's Trust submitted comments to DHCS on the RFI. For more information, please see the [CCT letter](#).