December 9, 2019
Mental Health America of California's Analysis
CalAIM and Behavioral Health
Strategic Considerations for Change

I. Introduction and CalAIM Process

The Administration's recently proposed California Advancing and Innovating Medi-Cal (CalAIM) offers a strategic framework to standardize and progress key delivery systems within the Medi-Cal Program, including health, specialty mental health, and substance use disorder services.[1] This paper offers a summary of key content and strategic considerations for its continued development.

The CalAIM framework will be driven using the dual levers of the federal Waiver process (both an 1115 Waiver and 1915(b) Waiver) and California's annual budget process to shape its legal, fiscal and policy imprint.

California's existing 1115 Medi-Cal 2020 Waiver and 1915(b) Specialty Mental Health Waiver expire as of December 30, 2020. The federal Waiver process requires States to provide draft Waivers to the federal CMS six months prior to the end of an existing Waiver. Therefore, California will need to submit draft Waivers by June/July 2020. Administrative discussions between the DHCS and federal CMS proceed in earnest during this period until final agreement is achieved culminating with federally specified Special Terms and Conditions for each Waiver. Federally approved Waivers will need to be effective by January 1, 2021.

California's annual budget process is the other key lever which will lay the foundation for the Waivers. The budget for 2020-21 will affect which reforms proceed as well as the timeline and scope of such reforms. The Governor's January budget release will begin the conversation with additional adjustments occuring through the May Revision. The Legislature, using their Budget Subcommittee processes as well as the Joint Budget Conference Committee, will deliberate from March through May. Final negotiations with the Governor will occur in late May/early June. The Legislature must provide the Governor with a Budget Bill by no later than June 15, 2020.

In addition to funding, the budget will shape the underlying State statutory framework for CalAIM through "trailer bill legislation". At a minimum, State statutory changes are necessary to recraft certain financing mechanisms, such as how Intergovernmental Transfers (IGTs) may be accessed, proposed mandatory enrollment in managed care for specified eligibles, and how medical necessity for eligibility in County Behavioral Health is defined, as well as other State authorities and direction.

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[1] See DHCS website to review the CalAIM proposal as released on October 28, 2019. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

The timeline for trailer bill legislation closely tracks the annual budget process. The first release of trailer bill occurs in mid-February with additional changes proposed at May Revision, along with modifications by the Legislature throughout the budget process. Additional adjustments to trailer bill may occur in August or early September as additional information is acquired, such as feedback from the federal CMS or the need to make technical corrections to earlier adopted language.

Discussions have already commenced through an established series of DHCS convened workgroup sessions on CalAIM designated topics.[2] Workgroups will continue through February 2020. DHCS will also convene four Behavior Health Stakeholder Advisory Committee meetings and four Health Stakeholder Advisory Committee meetings in 2020 (February, May, July and October, and on the same days) to discuss CalAIM-related issues.

The bottom line is that change will be occuring at full-throttle and active, timely engagement is critical on all fronts in working with the Administration, Legislature, and our various health and behavioral health care colleagues.

DHCS is soliciting comments by December 16, 2019, but will continue to accept comments through February 29, 2020. Comments received after the December date may not be included in the CalAIM Workgroup discussions. DHCS has an email address to which comments may be submitted: CalAIM@dhcs.ca.gov

II. Overarching Goals of CalAIM and General Structure

The ultimate stated goal of CalAIM is to "…improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life." To achieve this endeavor, the Administration proposes key changes over the course of the two Waivers (seeking five year period commencing January 1, 2021 through December 30, 2026) that align with the following policy premises:

- Identify and comprehensively manage Medi-Cal managed care enrollees' needs through approaches piloted under Whole Person Care, coupled with addressing health needs associated with social determinants of health;
- Progress Medi-Cal to be more consistent and seamless across systems and regions by reducing complexity and increasing flexibility; and

[2] DHCS convened workgroup sessions are open to the public though only DHCS designated participants can fully participate throughout each session. Public comment only occurs at the end of each session. The five CalAIM workgroups include: (1) Population Health Management and Annual Health Plan Open Enrollment; (2) Enhanced Care Management and In-Lieu of Services; (3) Behavioral Health; (4) Full Integration Plans; and (5) National Committee for Quality Assurance (NCQA) Accreditation. To access the CalAIM schedule, see https://www.dhcs.ca.gov/calaim In addition to these five workgroups, there is a Behavioral Health Payment Reform Sub-Workgroup. Further, DHCS will also be forming a workgroup on a Long-Term Plan for Foster Care in January, 2020, and a workgroup on County Inmate Pre-Release Application for Medi-Cal in March, 2020.

- Improve quality outcomes and utilize value-based initiatives to propel payment reform and the modernization of delivery systems.

The underlying premise of CalAIM is to strengthen the role and responsibilities of both the Medi-Cal Managed Care Plans as well as that of County Behavioral Health (meaning County Specialty Mental Health Plans and DMC-ODS) in the delivery and coordination of Medi-Cal services for Medi-Cal enrollees.

CalAIM encompasses a suite of proposals which would be phased-in over the five-year period of the two Waivers. These are highlighted in the table below.

Summary Table of Key Elements within CalAIM

A. Modernizations Focused on Medi-Cal Managed Care Plan Delivery System

- *Mandatory Enrollment in Medi-Cal Managed Care*[3]. By January 2021, DHCS proposes to require all "non-dual" eligible Medi-Cal individuals to be enrolled in a Medi-Cal Managed Care Plan, with the exception of individuals receiving limited-scope Medi-Cal benefits or limited-time enrollment. Certain specified exemptions may still be applied but will be limited. Further, by January 2023, all "dual" eligibles (Medi-Cal and Medicare) will be required to be enrolled.
- *Annual Medi-Cal Managed Care Enrollment*. DHCS proposes to establish an annual enrollment process for all Medi-Cal enrollees in counties where two or more Medi-Cal Managed Care Plans operate. Certain specified exceptions would apply for good cause. In effect, this would mean that an enrollee can only change health plans once a year, and not more frequently as presently allowed. The timeline proposed by DHCS is to implement the first annual open enrollment period from November 1, 2021 to December 31, 2021 for enrollment effective as of January 1, 2022. Each year thereafter, the open enrollment period would be from November 1st through December 15th.
- *Population Health Management-- Plan and Operation*. Develop and maintain comprehensive action plan for person-centered health for all enrollees, including:
  - Offering comprehensive preventive and wellness services;
  - Identifying and assessing enrollee risks and needs on ongoing basis;
  - Managing enrollee outcomes during transitions and across delivery systems (including County Behavioral Health), and
  - Identifying and mitigating health disparities.

  Among other things, this plan would describe operational components of care coordination and referrals regarding health care, social services, behavioral health services, home and community-based services and oral health care. The Managed Care Plan is expected to coordinate with external entities to provide all necessary services and resources for the Medi-Cal enrollee. This includes transferring from one setting or level of care to another, including discharge planning.
- *Enhanced Care Management.* New Medi-Cal benefit focused on providing intensive and comprehensive care management services to high utilizers of care, including people who are homeless

[3] See Appendix G-- Managed Care Enrollment Proposed Aid Code Group Coverage-- in the CalAIM proposal as released on October 28, 2019. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

and at risk for institutionalization including serious mental illness. The intent is to have Managed Care Plans contract with public and private providers to deliver services that are person-centered, are high-touch, meet clinical and non-clinical needs of enrollee, and extend beyond standard case management or disease management activities. New incentive payments would be linked to delivery system transformation based on quality and performance improvements, including for providers.

- *In-Lieu of Services.* New distinct services, offered as an alternative (in-lieu) to other Medi-Cal services at the option of the Managed Care Plan and choice of the Medi-Cal enrollee, will be available. In-Lieu of services are to be specified in the Managed Care contract, and are only applicable if the service is medically appropriate and is a cost-effective substitute. All in-lieu services are optional for Medi-Cal enrollees—it is their choice to select the in-lieu of service or the standard Medi-Cal service. New incentive payments would be linked to delivery system transformation based on quality and performance improvements, including for providers.
- *Move Institutional Long-Term Care Services and Supports to Managed Care.* By January 1, 2021, DHCS proposes for all institutional long-term care services (i.e., nursing home facilities, specialized rehabilitation in skilled nursing or intermediate care facilities, pediatric and adult subacute care, intermediate care facilities for individuals with intellectual or developmental disabilities), and all major organ transplants to be included in Managed Care Plans (carved-in).
- *Require Dual Eligible Special Needs Plans.* By January 1, 2023, DHCS would require all Managed Care Plans to operate Dual Eligible Special Needs Plans (DSNPs) in order to serve dual eligibles.
- *Regional Managed Care Rates*. DHCS will be proceeding with a regional rate-setting methodology for Managed Care Plans through a phase-in process with completion statewide no sooner than 2023. DHCS notes they will consider health care market dynamics, including health care cost across counties when determining regional rate boundaries.
- *Expanding Use of Incentive Payments*. DHCS proposes to create a suite of incentive payments tied to Managed Care Plan delivery system reforms achieved through Enhanced Care Management and the delivery of In-Lieu of Services. These payments would be based on quality and performance improvements and specified system metrics. DHCS would be looking for the Plans to partner and share said incentive payments with providers, such as behavioral health organizations and providers, clinics, hospitals and others.
- *Require National Committee for Quality Assurance (NCQA).* DHCS is to require all Managed Care Plans to be NCQA accredited by 2025. Currently 14 of the 24 full-scope plans have this accreditation.

B. Modernizations Focused on Behavioral Health—Specialty Mental Health & DMC-ODS

- *Behavioral Health Payment Reform—Shift to Intergovernmental Transfers (IGTs).* In-lieu of the existing Certified Public Expenditure method (cost-based) to obtain federal Medicaid financial participation, California would shift to using an IGT process using a phased-in approach beginning in 2021. This change would improve financial efficiency and facilitate the use of value-based payments and incentives. DHCS would begin an IGT-based Medi-Cal reimbursement at the start of a State-county fiscal year to ease the transition. This transition would occur after adoption of the HCPCS Level I coding system.
- *Behavioral Health Payment Reform—Change Coding System.* DHCS proposes to shift from the existing Healthcare Common Procedure Coding System (HCPCS) Level II to the HCPCS Level I (CPT). The earliest this shift would occur is January 1, 2021.

- *Behavioral Health Payment Reform—Redesign Rates and Methodology for Updating.* DHCS proposes to establish new reimbursement rates for all services with the concept focused on new peer-groupings of counties. The peer-groupings would be configured around counties with similar costs of doing business. A methodology for updating rates on at least an annual basis is also proposed.
- *Medical Necessity Changes.* CalAIM proposes to shift the medical necessity focus from "diagnosis" to level of functional impairment rather than having diagnoses determine eligibility for Specialty Mental Health Services or DMC-ODS services. This would enable services to be provided and reimbursed prior to determining a Medi-Cal enrollee's diagnosis.
- *Drug Medi-Cal Organized Delivery System Renewal.* The DMC-ODS Pilot must be renewed within the CalAIM Waiver process in order to operate and receive federal funding. Under CalAIM certain modifications are proposed along with a change in its name to SUD Managed Care.
- *Regional Contracting Amongst Counties.* CalAIM proposes to work with counties, particularly small and rural, to develop regional contracting partnerships within Specialty Mental Health, and within DMC-ODS. No other aspects are proposed here, nor is a timeline provided. Since existing State law provides for two or more counties acting jointly to deliver or subcontract with each other, no special authorities are needed.
- *County or Regional Integration by 2026.* CalAIM proposes that by 2026, each county or regional area will operate a single, integrated Behavioral Health Managed Care Plan with full integration of Specialty Mental Health and SUD services.
- *Opportunity for Waiver of IMD Exclusion for Mental Health.* DHCS will be using the CalAIM workgroup process to discern if it is feasible for California to submit a proposal on this topic (i.e., possibly a Waiver amendment at a later date). The federal CMS has advanced an 1115 Waiver opportunity to States to provide federal financial participation for acute inpatient psychiatric care (short-term). This endeavor will require considerable thought and discourse prior to any submittal.

C. DHCS Directed Changes to County Systems

- *County Medi-Cal Eligibility Processing, Beneficiary Contact and Demographic Information.* A series of performance improvements, monitoring and reporting requirements are to be implemented to increase program integrity with respect to Medi-Cal eligibility and enrollment. In addition, a workgroup will be convened to develop recommendations on ways in which Medi-Cal contact and demographic information can be updated by other entities.
- *Medi-Cal Coordination with County Jails*. By January 1, 2022, DHCS will mandate counties to implement a county-inmate pre-release Medi-Cal application process, including for juvenile facilities. The intent is to eliminate potential gaps in treatment services by facilitating timely access to Medi-Cal services upon release from incarceration.
- *Mandate Warm-Handoff from Jails*. By January 1, 2022, DHCS will require all counties to effectuate warm-handoff procedures for Medi-Cal enrollees released from county jail or juvenile facilities to County Behavioral Health for people to continue behavioral health care treatment needs.
- *Comprehensive Plan for Foster Care.* DHCS will convene a broad-based workgroup to develop recommendations for comprehensive changes to how health, Specialty Mental Health, substance use disorder services, social services and other aspects may be improved and adopted comprehensively across the Foster Care system. This workgroup will commence sometime in 2020 (no date specified).

D. Full Integration Plans for Comprehensive Services

- By July 2022, DHCS is seeking to award a contract(s) for a Full Integration Plan(s) that would encompass Medi-Cal Managed Care Plan services, Specialty Mental Health services, DMC-ODS services, and oral health within one plan in a region. Readiness activities and implementation planning would occur through 2022 and 2023, with a "go-live" date of January 2024.

E. Oral Health—Dental

- *Additional Benefits.* Two new dental benefits are proposed, including a Carries Risk Assessment bundle and coverage of Silver Diamine Fluoride. These new benefits will be provided to children (0 to 6 years), and Silver Diamine Fluoride will also be offered to residents of skilled nursing homes, intermediate care facilities, and certain individuals utilizing the Regional Center system.
- *Pay for Performance.* DHCS is proposing to provide a flat-rate performance payment to a service office location for each paid claim for certain preventive treatments. Payments would be based on increased utilization for both children and adults.

The CalAIM structure shifts most Medi-Cal Program operations to the 1915(b) Waiver construct, leaving the DMC-ODS operating within the 1115 Waiver along with the Global Payment Program and certain Medi-Cal eligibility and population authorities.[4] Due to recent federal budget neutrality changes[5] the existing Whole Person Care Pilots and Home Health demonstration will not continue operation beyond 2020. However, certain elements of CalAIM such as the Enhanced Care Management and In-Lieu of Services proposals are intended to continue certain features of these demonstrations.

[4] See pages 104 through 106 of the CalAIM proposal as released on October 28, 2019. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

[5] See federal CMS Letter to State Medicaid Directors (#18-009), Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, August 22, 2018.

III. Fundamental Changes Proposed for Behavioral Health System.

Three fundamental changes are proposed for County Behavioral Health that are integral for all other components to proceed effectively. These are the (1) behavioral health payment reform; (2) medical necessity changes; and (3) DMC-ODS Program renewal. Each is discussed in detail below.

Behavioral Health Payment Reform: Shift to Intergovernmental Transfers and New Rate Structure. Behavioral health payment reform encompasses two fundamental changes. First, the Administration seeks federal CMS approval to use an Intergovernmental Transfer (IGT) approach, in lieu of the existing Certified Public Expenditure (CPE) method, to obtain federal Medicaid financial participation.[6] This shift to IGTs would be applicable for all facets of the Behavioral Health program, including Specialty Mental Health services and all Drug Medi-Cal and DMC-ODS services. The Department of Health Care Services (DHCS) proposes a phased-in approach for this shift to occur with implementation beginning in 2021 and likely corresponding with the start of a State-county fiscal year to ease the transition.

By using an IGT process it is the Administration's intent to draw increased federal financial participation through expanded financial efficiency, as well as comprehensively using the Upper Payment Limit where applicable.[7] As such, higher rates could be paid using supplemental payment or other value-based payment approaches instead of using the more cumbersome and limited cost-based approach as done presently under the CPE process.

Functionally, counties would voluntarily transfer county funds to the DHCS in order to receive the federal match for Medicaid services. DHCS would process this IGT, claim the federal match, and transmit the entire amount back to the county. Based on preliminary information, when operational DHCS intends to have full Medi-Cal claim reconciliation within 21 days to one month.

Counties would be receiving a substantially expedited receipt of federal matching funds since the existing CPE process can take up to 36 months due to the need for cost-based reconciliation prior to the receipt of federal funds. As such much less administrative overhead would be required, and counties would have timely knowledge as to actual expenditures for Medi-Cal members. Access to timely data—both for services and expenditures—can greatly facilitate development of comprehensive performance metrics, better inform on the delivery of services, and improve county fiscal accountability.

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[6] Federal Medicaid law requires States to provide a "nonfederal share" to receive federal financial participation. California's nonfederal share comes from a variety of sources including IGTs. An IGT is a transfer of funds from another governmental entity, such as a county, public hospitals (county, university and District), or other State agency, to the State before the federal Medicaid payment is made (i.e., "federal match"). California has extensively used IGTs within Medi-Cal on the health care-side of the program.

[7] Under IGTs States can claim a federal match for up to the Upper Payment Limit (UPL) for certain types of institutions and providers. Generally States use this mechanism to provide supplemental payments to certain providers to help offset uncompensated care costs. The UPL is a federal limit. It is the maximum reimbursement a State Medicaid program may pay a type of provider in the aggregate, statewide in Medicaid Fee-For-Service. The basis for this maximum reimbursement is what the federal Medicare Program would have paid for the same services.

An additional benefit of an IGT is that the health care side of Medi-Cal uses them extensively for hospital financing, and providing enhanced payments to certain provider types. As such, State and local governmental entities are familiar with their operation, as are Medi-Cal Managed Care Plans.

There are two primary concerns with the shift to IGTs. The first is federal approval which would occur through the 1915(b) Waiver process. The federal CMS has strict cost claiming protocols for which States must conform to receive federal funding. These protocols are usually contained within "Special Terms and Conditions" that become a part of any federal Waiver approval process. On November 18th, CMS published a proposed regulation—the Medicaid Fiscal Accountability Regulation (MFAR)—which proposes sweeping fiscal changes to the Medicaid Program overall. These pending changes are very likely to affect the development of CalAIM and its funding structure. These regulations are likely to become final sometime in 2020. (The federal CMS 60-day comment period on these regulations is open until January 18, 2020.)

The second primary concern is ensuring there are sufficient IGTs available to fully support the county behavioral health system, including further growth. How the State defines the IGT payment(s) to be transferred from the counties to the State will be critically important. For example, the IGT could possibly include various local funding sources such as the Behavioral Health Subaccount, Mental Health Services Act Funds, county general fund, and various other tax-based revenue sources. Further, by federal definition an IGT must be voluntary on the part of the local governmental entity.

A full discourse of IGT fund sources and its structure needs to occur through the CalAIM process and in State budget deliberations. Consistency across counties and transparency at both the county and State levels is imperative.

Using the IGT method of drawing federal funds allows for more flexibility in how Medi-Cal reimbursement rates are developed. This then opens the door for changing how California designs its rate methodology for behavioral health services.

The second fundamental change within the CalAIM behavioral health payment reform is a shift in procedure coding coupled with a redesign of the reimbursement rate system. County Behavioral Health presently uses the Healthcare Common Procedure Coding System (HCPCS) Level II, established in the 1980s, and relies on a Medi-Cal rate structure whose reimbursement to providers varies considerably across counties.

Under CalAIM, the HCPCS Level II coding would be shifted to HCPCS Level I (CPT) beginning in 2021. HCPCS Level I provides more granular data and is used by Managed Care Plans and other forms of health care insurance. DHCS will require all providers and all counties to use Level I coding. They contend this shift will provide for more accurate reimbursement to providers and more accurate data to inform policy decisions.

This shift will likely be difficult and must be done in full communication with the behavioral health provider community as well as the counties. First, certain types of services cannot easily be crosswalked to Level I coding, such as social rehabilitation services, and services that are provided by non-licensed professionals. Second, information system changes and billing system changes will be necessary at all levels, including with providers, counties, and the State. At this time it is unclear what this may entail, including an estimate of cost for the change and any needed training. Operational changes such as these need to be implemented cohesively for success to occur.

A redesign of reimbursement rates and methodology for updating rates is also contained in CalAIM. This change corresponds with shifting from CPE (cost based) to the use of IGTs. The transition from cost-based reimbursement to an established rate schedule would follow after adoption of the HCPCS Level I coding.

DHCS proposes to establish rates based on new peer-groupings. The peer-groupings would be configured around counties with similar costs of doing business. Any new rate has to be "actuarially" based and meet federal Medicaid requirements as well as obtain federal CMS approval. As such it is likely that cost data will be used to determine peer-groupings along with other potential factors such geographic cost-of-living, medical CPI and related market factors. Further, an ongoing methodology for updating rates on at least an annual basis is also proposed.

Behavioral health organizations and providers need to ensure these discussions include their participation and feedback. Participation in the Behavioral Health Payment Reform Sub-Workgroup meetings (three presently scheduled) would be useful.[8]

The table below provides a summary of the potential benefits and concerns with shifting to the IGT method.

Potential Benefits and Concerns of Behavioral Health Payment Reform

Benefits	Concerns
Ability to obtain increased federal funding and fully leverage IGT sources of funding.	Ensuring there are sufficient IGTs available to provide full funding, and future growth, for behavioral health services.
Ability to modernize and increase reimbursement rates to promote supplemental payments and value-based strategies	Changing coding systems and ensuring the fidelity of these changes.
Reduces county and State administrative requirements	Need to ensure reimbursement rates and updating methodology are actuarially based, reflective of costs, and offer value-based payment to drive system quality and performance outcomes

[8] See https://www.dhcs.ca.gov/calaim for the scheduling of the Behavioral Health Payment Reform Sub-Workgroup

Makes linkages with Medi-Cal Managed Care Plans for provision of mild to moderate services (or future services) easier since IGT process eliminates complexity of CPE and cost-based rates established by counties.	Getting new system in-place at all levels-provider, county and State, including information technology changes, billing procedures, and sufficient training across the system including with providers.
Offers increased accountabilities for it provides increased access to timely data and expenditures.	Establishing clear accountabilities across governmental entities, along with corresponding transparency to provide clarity and enable validation
Substantially more timely reimbursement for Counties to receive federal funding as compared to cost-based process.	Ability to implement system changes in a timely and coordinated approach.

Medical Necessity Changes. A long standing area of inequity has been the inability to deliver mental health or SUD services to an individual *prior* to a diagnosis determination (for eligibility designation) and receive Medi-Cal reimbursement for the services rendered. Currently there are medical necessity criteria that Medi-Cal eligibles must meet in order to be eligible for Specialty Mental Health or SUD services.

CalAIM proposes to shift the medical necessity focus from "diagnosis" to level of functional impairment rather than having diagnoses determine eligibility and drive the delivery of services and funding decisions. The goal is to (1) improve Medi-Cal enrollee experience; (2) improve treatment planning; (3) more clearly delineate and standardize benefits statewide; and (4) provide appropriate reimbursement.

Specifically, CalAIM proposes the following key revisions regarding medical necessity:

- ***Level of Care Assessment Tool.*** Implement a statewide assessment tool—either existing or design a new one—to use across the Medi-Cal systems (all entities). Both a children/adolescent assessment (21 years and under), and an adult assessment would be used to discern referral to a service delivery appropriate for the individual's identified needs. DHCS recognizes that many counties use a variety of assessment tools, such as the Level of Care Utilization System. Their interest is to have consistency across the State and within all Medi-Cal program services delivery.

- ***Modify Medical Necessity for Outpatient Services.*** Changes would be made to enable a Medi-Cal beneficiary to receive an assessment and medically necessary services based on level of functional impairment prior to a defined diagnosis, and the provider would be reimbursed for the services. This means County Behavioral Health would receive Medi-Cal reimbursement for an initial phase of treatment services even if the individual is transitioned to the Managed Care Plan suite of mild to moderate behavioral health services. The medical needs of the individual would be the focal point which should serve to expand access to care.

  Once a diagnosis and level of functional impairment is medically determined, the Medi-Cal beneficiary would be referred to the appropriate delivery system (i.e., Medi-Cal Managed

Care or Specialty Mental Health) for continued treatment services. An individualized person-centered treatment plan would still be completed. DHCS also proposes a similar change for the delivery of SUD services. A key aspect of the proposed changes is to clarify medical necessity to better align County Behavioral Health service delivery in accordance with criteria for services as provided under California's Medicaid State Plan.

CalAIM does not offer specific detail as to how these changes would be constructed but notes discussions will occur in CalAIM meetings. At a minimum, State regulations as contained in Title 9, Division 1, Chapter 11 for Medi-Cal Specialty Mental Health Services would need to be amended. (See for example, CA Code of Regulations, Title 9, Division 1, Chapter 11, sections 1820.205, 1830.205 and 1830.210.)

- ***Modify Medical Necessity Criteria for Inpatient Services.*** CalAIM seeks to establish a consistent approach across California for the authorization and reauthorization of Medi-Cal inpatient psychiatric hospital services. A key aspect would be for the State to require a physician's certification to document need for acute psychiatic services. The purpose here is to better align with federal requirements and potentially streamline procedures.

- ***Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (under 21 years).*** CalAIM proposes to also clarity the "no wrong door" requirement for both Managed Care Plans, as well as County Behavioral Health services (Specialty Mental Health and SUD services).[9] Both would be reimbursed for all medically appropriate services provided to a child/adolescent, even if the child/adolescent ultimately moves to the other delivery system. This may also be seen in the recent DHCS All Plan Letter, dated November 12, 2019, entitled *Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21*, and the All Plan Letter, dated August 14, 2019, entitled *Requirements for Coverage of EPSDT*.[10] DHCS appears to be striving to make EPSDT a truly mandated benefit.

- ***Other Technical Corrections.*** CalAIM also proposes additional technical changes such as updating to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), and updating to reflect federal requirements in the use of ICD code sets.

DHCS proposes to work through CalAIM stakeholder groups and counties to make the above outlined medical necessity changes effective as of January 1, 2021, the anticipated approval date for the CalAIM-developed 1115 and 1915(b) Waivers.

[9] See CalAIM page 78, paragraphs two and three at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

[10] See DHCS All Plan Letters at https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Changing medical necessity criteria is a positive step forward to modernizing California's program. Specific criteria will need to be completed in tandem with behavioral health care advocates, behavioral health providers and organizations, and with the counties. A few thoughts and considerations are as follows:

- Medical necessity criteria needs to clear and reflect best practices for case management and treatment services.
- Expanded service delivery access for individuals served by Medi-Cal should be the key goal.
- Documentation simplification and administrative streamlining should be advanced as part of this dialog.
- Facilitation across County Behavioral Health and Medi-Cal Managed Care Plans to ensure person-centered care is critical.
- Learning collaboratives and other forms of field-based training are necessary to establish mutual understandings and application of any new revisions prior to implementation. Unintended consequences and Medi-Cal audit exceptions are likely without upfront agreement to provide technical assistance.

Engagement in this CalAIM decision is imperative for it forms a key foundation in moving forward.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal[11]. The DMC-ODS operates under the existing 1115 Waiver which was amended as of August 2015 to accommodate this first-in-the-nation organized delivery system for SUD services, including residential treatment services (IMD-exclusion). This demonstration pilot must be renewed within the CalAIM Waiver process in order to operate and receive federal funding.

As of August 2019, 30 counties had implemented the DMC-ODS and eight other counties are working with Partnership Health Plan to design a regional model. Twenty counties continue to operate under the more limited design of the Drug Medi-Cal Program.

CalAIM proposes to renew the DMC-ODS—changing its name to *SUD Managed Care*—and to expand certain components. Most of the existing DMC-ODS will migrate from the 1115 Waiver to the 1915(b) Waiver with the notable exception of residential treatment related to the IMD exclusion (to remain in the 1115 Waiver). Counties presently not participating will have another chance to "opt-in" under the new SUD Managed Care Waiver.

DHCS recognizes that DMC-ODS is still relatively new to counties and providers. They are seeking feedback on several CalAIM proposals as outlined below.

- ***Billing for Services Prior to Diagnosis.*** As noted under medical necessity above, DHCS intends to clarify within the Waiver that Medi-Cal services and reimbursement for

[11] Discussion begins on page 87 of CalAIM at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

SUD services are to be allowed before a diagnosis is medically determined (even if multiple visits are necessary).

- ***Residential Treatment Definition.*** Currently the DMC-ODS does not clearly define the amount, duration, and scope of these services, and there are different limitations. CalAIM proposes to remove the adolescent length-of-stay limitations and to add mandatory provisions for referral to medication assisted treatment (MAT). In addition, distinctions between adults and adolescents for these services would be removed (offering the same scope of benefit), with the exception of EPSDT services (no limits).
- ***Residential Treatment Length-of-Stay Requirements.*** Presently there are limits on the length-of-stay for both adults and adolescents. CalAIM proposes to eliminate these limits and instead, base Residential Treatment on medical necessity and reimbursing services up to the maximum number of authorized days, as negotiated with the federal CMS, within a 365-day period. DHCS acknowledges that CMS is interested in only providing up to 30-days; however, DHCS contends that outcome measures and benefit-cost information could serve to highlight the need for change.
- ***Additional Medication Assisted Treatment (MAT).*** DHCS intends to broaden the access to this optional benefit provided under DMC-ODS by requiring that the county either directly offer this optional benefit or have a referral process for an individual to receive it. Counties are encouraged to have a multi-delivery system of coverage for MAT.
- ***Evidence-Based Practice Requirements.*** DHCS proposes to retain the five existing evidence-based practices within DMC-ODS, and to *at least* add Contingency Management to the SUD Managed Care Waiver. DHCS is open to potentially adding additional ones.
- ***Recovery Services.*** Medi-Cal enrollees can access recovery services after completing treatment as a preventive measure to avoid relapse, if they are triggered, or have relapsed. CalAIM proposes to significantly clarity several policies for this benefit including the following items:
    - Services to be included (e.g., assessment, group, and education sessions)
    - Establish when and how Medi-Cal enrollees may access services
- ***Physician Consultation Services.*** DHCS intends to make this benefit *optional* for counties, and to clarity the terms of the consultation, particularly with who can claim for this service. CalAIM notes that the existing Medi-Cal telehealth policy[12] will serve as a guide on how changes may be made.
- ***Treatment after Incarceration.*** DHCS is interested in exploring greater access and service options for Medi-Cal individuals leaving incarceration who have a known SUD disorder. It is noted that more individuals likely need assistance based on high risk of relapse and overdose upon return to the community.

[12] To review DHCS telehealth policies, see https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx

- ***Expansion for Tribal Services.*** CalAIM proposes to include cultural practices for Tribal 638 and urban clinics, and inclusion of traditional healers and natural helpers. Expanded access to services is emphasized as well as the need for DHCS to negotiate fuller inclusion.
- ***Eliminates DHCS Involvement in Provider Appeals for Contracting.*** DHCS proposes to eliminate their role in reviewing provider's appeals when a provider's contract is denied by a county. They contend it is rarely used and believe network adequacy requirements address any potential concerns moving forward.

Clearly DHCS seeks to improve access, and service delivery under the newly proposed SUD Managed Care program. A few thoughts and considerations are as follows[13]:

- Engagement in defining medical necessity and the "no wrong door" concept is foundational for additional aspects, such as case management and treatment facilitation across levels-of-care, to work as a system. Changes regarding same-day billing for select services needs to occur for this concept to operate as intended—i.e., person-centered outcomes.
- Thought needs to be given by providers and behavioral health organizations as to what additional evidence-based practices should be considered for inclusion. DHCS is clearly open for exploration here.
- In addition to broadening MAT access as proposed, DHCS should directly address collaboration opportunities with Emergency Departments and primary care settings. Technical assistance and engagement by the DHCS can facilitate relationships at the local level.
- Consideration for service expansion should also address recovery services for adolescents. Though the existing Waiver references this need[14], capacity building is still of considerable concern.
- Learning collaboratives and other methods of provider training should be addressed as a resource need. Training could include components of person-centered care, case management, and individual and facility therapies as part of care.
- Workforce issues, from recruitment, training and retention, abound within the SUD service delivery system. CalAIM could offer options to assist with this core issue either independently, or through linkages with the Office of Statewide Health Planning and Development (OSHPD) workforce initiatives.
- Assistance with technology infrastructure continues to be an issue among contract providers and counties. Concerns continue with the lack of interfaces across multiple

[13] Also see the most recent external quality review report: Behavioral Health Concepts, as prepared for the DHCS, Drug Medi-Cal Organized Delivery System External Quality Review Report dated October 20, 2019. https://caleqro.com/dmc-eqro#1dmc-county_annual_dmc_reports/FY2018-19reports/FY2018-19reports_annual

[14] See page 122, item 158 of Waiver Special Terms and Conditions (updated as of June 7, 2018). https://www.dhcs.ca.gov/progovpart/Pages/medi-cal-2020-waiver.aspx

data collection systems which limits data collection and analysis of quality metrics. CalAIM could offer steps forward in addressing this area of need.

IV. Regional Contracting and Integration of County Behavioral Health

CalAIM contains two proposals focused on developing regional Behavioral Health delivery systems, including facilitation of regional contracting across counties for Specialty Mental Health and SUD services (as separate programs), and administrative integration of the two programs comprehensively as one State administered contract within a county or across a region.

State law provides for two or more counties acting jointly to deliver or subcontract for Specialty Mental Health services, as well as SUD services. CalAIM proposes for the DHCS to work with counties, particularly small and rural, to identify and develop regional contracting partnership opportunities.[15] DHCS notes there are numerous benefits for counties to regionally contract with each, particularly for administrative efficiencies. No other aspects are proposed here, nor is a timeline provided. The intent is to encourage a renewed dialog with counties.

The second component is to proceed with administrative integration of Specialty Mental Health and SUD services into one Behavioral Health managed care program. The intent is for Medi-Cal enrollees to receive a full continuum of coordinated care, and for counties to more effectively utilize administrative resources. DHCS notes that county SUD programs that continue to operate as Fee-For-Service, would be able to integrate with their county Specialty Mental Health program in a similar, yet modified, manner. Integration of programs would occur across both clinical and non-clinical responsibilities.

CalAIM proposes that by 2026, each county or regional area will operate a single, integrated Behavioral Health Managed Care Plan. DHCS recognizes this goal will require substantial planning and thought to construct and implement, and a phased-in approach would be utilized. It should be noted that a system integration framework will take time to develop and that amendments to Waivers can be submitted over time.

This endeavor offers many options for collaboration and integration, including joint administration with counties, partnerships with Managed Care Plans, development of new Joint Powers Authorities, partnerships through the California Mental Health Services Authority, use of Administrative Service Organizations and similar constructs.

Much more needs to be contemplated for best approaches to emerge. A key consideration should be how to facilitate Medi-Cal enrollee treatment and recovery services with administrative simplification and efficiency, including across county-lines.

[15] See page 86 of CalAIM proposal.
https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

V. Opportunity for Waiver of IMD Exclusion for Mental Health

CalAIM makes reference to the recent federal opportunity for States to seek a Waiver of the Institutions for Mental Disease (IMD) exclusion[16] as contained in the federal CMS letter to State Medicaid Directors, dated November 13, 2018.[17] The purpose of this demonstration is to examine if increased access to acute inpatient psychiatric care (short-term—likely 30 days) reduces reliance on emergency rooms and improves linkages to outpatient community-based treatment.

Specifically, DHCS will be using the CalAIM stakeholder process to discern whether there is interest, as well as readiness, within the Medi-Cal system to pursue this specific demonstration. (This demonstration could be added at a later date as an amendment to the CalAIM 1115 Waiver.) These discussions will primarily occur within the CalAIM Behavioral Health Workgroup.[18]

Generally, under this demonstration opportunity States can seek federal CMS approval to receive federal financial participation for services furnished to Medicaid individuals during short-term stays (likely 30-day average) for acute care in psychiatric hospitals or residential treatment settings that quality as IMDs. Presently IMD services (as defined) provided to Medicaid individuals aged 21 through 65 years are not eligible for federal Medicaid reimbursement (i.e., they are excluded). County Specialty Mental Health programs incur 100 percent of the cost of this treatment service currently and typically utilize County Realignment Funds for this purpose.

For California to submit a demonstration, considerable work will need to occur. The primary elements of a demonstration submittal would include the following key aspects:

- Detailed assessment of current availability of mental health services within the State;
- Completion of CMS implementation plan template that describes how the State will increase access to community-based mental health services over the course of the demonstration, including additional measures as needed to identify gaps in the availability of mental health services;
- Commitment to ongoing maintenance of effort on funding outpatient community-based mental health services at both the State and local levels (counties would choose to opt-in);
- Commitment to improving care coordination and transitions to community-based care;

[16] 42 U.S.C. §1396d(i) defines an IMD as any "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." The federal payment exclusion applies to all Medicaid individuals aged 21 through 65 years who are receiving services in an IMD setting.

[17] See federal CMS letter to State Medicaid Directors #18-011, dated November 13, 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

[18] See workgroup materials at https://www.dhcs.ca.gov/provgovpart/pages/bhworkgroup.aspx

- Resolve to ensure quality of care in psychiatric hospitals and residential settings, including required audits; and
- Data collection and design of monitoring reports.

DHCS also notes a key threshold question regarding financial interpretation for this demonstration.[19] Specifically, California would need to obtain assurance from the federal CMS that costs not otherwise matchable under this demonstration (such as costs for psychiatric inpatient days above the defined short-stay) would be considered a pass-through of State and federal funds. This is presently provided for under the existing DMC-ODS program. This is necessary for 1115 Waivers must meet specified federal budget neutrality requirements. If these are not met, the federal CMS would end the demonstration.

A number of questions abound regarding how California could benefit from this Waiver comprehensively, including meeting the considerable federal requirements for network assessment, and ongoing fiscal maintenance of effort, as well as expanded system capacity aspects regarding levels of care availability. Continued conversations through CalAIM can hopefully identify applicable next steps. To-date, only Vermont and Washington D.C. have received federal Waiver approval.

VI. Intersections across Systems

CalAIM contains several changes to the Medi-Cal Managed Care Program delivery system that intersect with County Behavioral Health. It is imperative for these elements of CalAIM to both complement and work across systems without adding complexity or confusion. These new proposals need to add value that can be measured and translated into strengthening overall system integrity and meaningful partnership.

Enhanced Care Management[20]. The Enhanced Care Management proposal would target highest risk level Managed Care enrollees[21] who need long-term, across-system care coordination of *all* health and behavioral health needs, including clinical and non-clinical aspects. The role of Enhanced Care Management is to provide face-to-fact visits coordinating all primary, acute, behavioral, developmental, oral and long-term services and supports for the Medi-Cal enrollee. This new benefit is intended to replace aspects of the Whole Person Care and Health Home pilots as well as certain Targeted Case Management programs.

CalAIM directs that Managed Care Plans will determine the design and intensity of the Enhanced Care Management program, including the criteria for selecting Medi-Cal enrollees and contracting with public and private providers to deliver such services, based upon

[19] See page 51 of CalAIM proposal dated October 28, 2019.
[20] See pages 37 to 43 of CalAIM proposal dated October 28, 2019.
[21] Highest risk level Managed Care enrollees may include: (1) high utilizers of acute hospital care and emergency room services; (2) individuals at risk for institutionalization with serious mental illness, children with serious emotional disturbance, and individuals with co-occuring disorders; (3) nursing facility residents who want to transition to the community; (4) individuals at risk for institutionalization for long-term care; (5) youth with complex needs; (6) individuals experiencing homelessness; and (7) individuals transitioning from incarceration, including juvenile detention.

parameters established by the DHCS. An "Enhanced Care Management Model of Care" is to be submitted to the DHCS by January 1, 2021 that would articulate a Managed Care Plan's approach to meet this CalAIM directive. By January 1, 2023, it is expected that an addendum to this model of care would be done to incorporate individuals transitioning from incarceration (reentry individuals).

Though the Enhanced Care Management benefit is to be distinct from Specialty Mental Health case management and DMC-ODS case management, it is unclear at this time how these services may intertwine in actual practice and not present a potentially disjointed connection for the Medi-Cal enrollee whom everyone is trying to serve.

Behavioral health organizations and providers offer evidence-based case management for many of the individuals described in CalAIM using intensive, field-based approaches.[22] Managed Care Plans may choose to contract with some of these organizations and providers due to this expertise. So a blending of experience and best practices can be developed under the Enhanced Care Management construct, but a much more definitive framework of collaborative programming and contracting is necessary to ensure clarity, baseline consistency statewide, and that no unintended consequences occur.

More in-depth analysis and feedback are necessary for this proposal to have added value to the system as a whole. For example:

- What approaches to Enhanced Care Management are to be used?
- How may the Enhanced Care Management benefit direct services within the Specialty Mental Health system (referral for services or for actual services)?
- How is information exchanged across systems for Enhanced Care Management purposes?
- How is risk determined across systems consistently?

Continued discussions will occur through the CalAIM workgroups.

In Lieu of Services[23]. CalAIM proposes 13 distinct services that a Managed Care Plan may offer as an alternative (in-lieu) to a State Medicaid Plan benefit. This includes services provided in a different setting or by a different type of provider than otherwise contained within a service offered under the State Medicaid Plan. In-Lieu of Services must be offered in conformity to federal regulation[24] which includes the following key elements:

- Cannot be mandated by the State (i.e., otherwise would not be an alternative);
- Must be specified in the Managed Care Plan contract and authorized by the State;

[22] For examples, see the federal Substance Abuse and Mental Health Services Administration, Evidence-Based Practices Center at https://www.samhsa.gov/ebp-resource-center

[23] See pages 45 to 48, as well as Appendix D, of CalAIM proposal dated October 28, 2019.

[24] See 42 Code of Federal Regulation Part 438, Subpart A, Section 438.3.

- May only be offered to a Medi-Cal enrollee if medically appropriate and is a cost-effective substitute to the State Medicaid Plan benefit; and
- Offered as an option to the Medi-Cal enrollee (i.e., it is their choice to select the alternative or to utilize the standard State Medicaid Plan benefit).

Appendix D of CalAIM provides a definition of each proposed In-Lieu of Service, including a description, targeted population, restrictions and limitations, and the existing State Plan services that the In-Lieu of Service is focused on avoiding. The In-Lieu of Services include the following:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post Hospitalization Housing
- Recuperative Care (Medical respite)
- Respite
- Day Habilitation Programs
- Nursing Facility transitions or diversion to assisted living facilities, such as to Residential Care Facilities for Elderly and Adult, and Adult Residential Facilities
- Nursing Facility Transition to a Home
- Personal Care (beyond In Home Services and Supports) and Homemaker Services
- Environmental Accessibility Adaptations (Home modifications)
- Meals/Medically Tailored Meals
- Sobering Centers

The In-Lieu of Services present a significant step forward for offering Medi-Cal enrollees expanded options for addressing medically appropriate services in alternative settings or with applicable providers. Consistency in approach across the Managed Care Plans, coupled with clear accountabilities is critical for the use of In-Lieu services for people with mental health or co-occuring medical needs. As such, the terms of the In-Lieu of Services need to more comprehensively defined. The State needs to provide clear application of how decisions to offer In-Lieu of Services will be made in the field and abide by close monitoring of their application.

Several States, including New York, offer In-Lieu of Services as a component of their Medicaid Programs. These services are closely monitored by New York and the state has authority to cease any In-Lieu of Service by providing a 30-day notice to the Managed Care Plan in order to provide one of several patient protection features. Among other things, New York requires their Managed Care Plans to submit detailed applications for use of In-Lieu of Services which includes the following:

- Targeted population;
- Service goals and objectives
- Expected outcomes
- Cost-benefit analysis calculations

- Proposed procedure codes;
- Staffing qualifications; and
- Service monitoring activities.

Consideration of other In-Lieu of Services should also be included. For example, inclusion of Recuperative Care (psychiatric respite) could be added. Under this service, people with mental health care needs who are brought into acute care (emergency room or psychiatric emergency services) can be cleared and transferred to this service. This is a service that is known, effective, and can be replicated in other areas of the State. Inclusion of Peer-oriented services as a wrap-around service should also be considered such as in the Sobering Centers for example.

VII. Closing Thoughts

CalAIM offers a strategic framework to reconfigure Medi-Cal funding streams, pursue new innovations in service delivery, further goals to achieve quality improvement, and to effectuate care coordination across Managed Care Plan services and County Behavioral Health services. *Change needs to occur without loss of integrity to the Specialty Mental Health and SUD treatment and recovery systems.* Short-term start-up and long-term sustainability both need to be recognized.

Technical and administrative support is needed throughout the County Behavioral Health system, including for diverse provider organizations, prior to the commencement of any system transformation phases. There are multiple approaches in which this should occur, including through educational forums and learning collaboratives, and with financial incentives for overhauling coding systems, expanding data collection, and facilitating electronic health record interoperability.

Historically the Behavioral Health system has not benefited from the receipt of federal grants, State funding, or foundation support in many areas of resource needs, including workforce development, continuum of care service capacity building, and related aspects of change that are interwoven into the CalAIM framework. A commitment of new funding for sustainability and implementation of the CalAIM components is vital for the vision of CalAIM to be fully implemented.

Transparency in funding, particularly with shifting to an IGT framework, needs to be assured. Protections regarding sources of the IGTs and how they are to be expended within the County Behavioral Health services authority is important. Broad county or State authority can have the unintended consequences of shifting funds to other systems or services. Legislative protections need to be framed in statute.

Active engagement by all stakeholders within the behavioral health community is imperative throughout the entire CalAIM workgroup process, through the annual State Budget process, as well as directly with the DHCS and other Administration representatives. Keep abreast of the CalAIM workgroup discussions on the DHCS website, provide written comment as noted within

the DHCS timeframes, and be prepared for the upcoming Governor's January Budget release and the Legislature's budget deliberations. Advocacy and constructive discourse is imperative for shaping CalAIM and the direction of our Medi-Cal Program comprehensively over the next five-years.