Behavioral Health in DHCS' CalAIM Initiative

Summary of Proposals for CBHDA Members

Version 1 – November 13, 2019

I. CalAIM Purpose and Goals

On October 28, 2019, the California Department of Health Care Services (DHCS) released a proposal to improve and standardize California's Medi-Cal program, including the behavioral health delivery systems administered by fifty-eight California counties. The proposal outlines a multi-year, multi-part initiative called California Advancing and Innovating Medi-Cal, or CalAIM.[1] With CalAIM, DHCS seeks to improve health outcomes through delivery system and payment reforms that also create cost savings in Medi-Cal. These reforms are further intended to build on progress made under previously established Medi-Cal pilot programs, including the Drug Medi-Cal Organized Delivery System and Whole Person Care.

DHCS launched CalAIM to address the upcoming expiration of two federal Medicaid waivers that govern key elements of the state's Medi-Cal programs pursuant to Sections 1115 and 1915(b) of the federal Social Security Act.[2] In 2020, DHCS will negotiate with the United States Centers for Medicare and Medicaid Services (CMS) to update and renew these important waiver authorities. Key components of the CalAIM proposals must be approved by CMS and enacted through new waivers for California to move forward with implementation.

CalAIM incorporates strategies designed to improve the health of several distinct target populations, including high utilizers of Medi-Cal services, vulnerable children, people experiencing homelessness or at risk of experiencing homelessness, justice-involved individuals, the aging population, and Californians with behavioral health conditions. The state notes that CalAIM will also advance "Health for All" by introducing new population health strategies and improving outcomes for all Medi-Cal enrollees. Per DHCS, CalAIM has three primary goals:[3]

a. Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
b. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
c. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

DHCS emphasizes that the October 28th CalAIM concept paper represents an initial series of proposals that will be refined and amended through an extensive stakeholder process the Department will undertake in late 2019 and early 2020. In addition, the timeline and scope of the proposed initiatives will be contingent upon decisions made by the legislature and Governor's administration during the 2020 California legislative session and budget process.

II. CalAIM Behavioral Health Proposals

California counties are responsible for operating managed care plans that administer specialty mental health (SMH) and substance use disorder (SUD) benefits, which have been "carved out" from the broader package of Medi-Cal benefits overseen by Medi-Cal Managed Care Plans (MCPs).[4] California's 1115 and 1915(b) Medicaid waivers contain critical fiscal and programmatic requirements for county behavioral health services. The 1915(b) waiver authorizes specialty mental

health managed care as currently delivered by county mental health plans (MHPs). The 1115 waiver authorizes the Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration program, through which 30 counties covering 93 percent of the state's Medi-Cal population have opted to provide managed care for beneficiaries with SUDs.[5]

Consequently, behavioral health is a major focus of DHCS' CalAIM initiative. Several proposals within the CalAIM concept paper address the behavioral health delivery system exclusively. Others impact behavioral health in combination with other Medi-Cal programs. DHCS views the following behavioral health proposals as essential for meeting CalAIM goals of "moving Medi-Cal to a consistent and seamless system" and improving quality and health outcomes.

- **Behavioral Health Payment Reform.** Adopting new reimbursement mechanisms for Medi-Cal specialty mental health and substance use disorder services is a foundational CalAIM strategy. These changes would make behavioral health reimbursement more similar to payments for other Medi-Cal services and facilitate other proposed reforms.

  Currently, counties provide the non-federal share of Medi-Cal expenditures on behalf of the state using certified public expenditures (CPEs).[6] The rates at which the state and counties may claim federal dollars for those services are strictly limited to the cost of providing each service, with payments to counties subject to cost-based auditing and reconciliation at the end of each fiscal year. Consequently, counties are limited in their ability to offer value-based payments to subcontracted, community-based providers.

  DHCS proposes to replace the current system of CPEs and cost-based reimbursement with a new protocol that would allow counties to supply the non-federal share of Medi-Cal payments using intergovernmental transfers, or IGTs. IGTs would require a prospective transfer of local funds to the state, which would claim the federal share and transmit the entire payment for the Medi-Cal service back to the county. Under the IGT system, the state would set new, fee-for-service reimbursement rates for groups of counties, and counties would no longer be required to reconcile to cost. Prior to implementing IGTs counties must adopt new coding for behavioral health claims, known as Health Care Common Procedure Coding System (HCPCS) Level 1, or Common Procedural Technology (CPT) codes. These transitions would be phased in over the course of the anticipated five-year waiver period, with exact timelines still to be determined. DHCS has indicated an interest in migrating counties to HCPCS Level 1 coding as early as 2021.

  DHCS is not proposing to reimburse counties for behavioral health services via capitation or another alternative payment methodology at this time. However, part of the rationale for eliminating cost-based reimbursement is to create opportunities for counties to reinvest in their behavioral health delivery systems and develop value-based payment strategies for subcontracted providers. The IGT payment approach is also intended to simplify contracting arrangements should counties wish to contract with Medi-Cal Managed Care Plans to provide services for which the MCPs are the payer, such as services for beneficiaries with mild-to-moderate mental health conditions. In many respects, the elimination of the complexity of the CPE cost-based reimbursement opens county behavioral health up to integration on multiple fronts, and potentially sets the stage for future conversations with the state regarding the elimination of the carve-out.

- **Revisions to Medical Necessity Criteria.** DHCS proposes several conceptual changes to existing medical necessity criteria for specialty mental health and substance use disorder services. Many of the changes are intended to clarify whether a beneficiary should receive services for a "mild-to-moderate" mental health condition through a Medi-Cal Managed Care Plan, or services for serious mental illness through a county mental health plan. The CalAIM concept paper does not yet include specific regulatory language to enact these changes.
  - **Impairment over diagnosis:** DHCS seeks to reduce the current emphasis on included mental health diagnoses and focus on assessing functional impairment in determining eligibility for specialty mental health services.

- **Services prior to diagnosis:** Because it can take time to thoroughly assess and diagnose behavioral health conditions, clients should be able to access some specialty mental health and substance use disorder services prior to diagnosis, and counties should be permitted to receive reimbursement for these services.
- **Eligibility criteria vs. service criteria:** DHCS would like to more clearly distinguish between the concepts of client eligibility for specialty behavioral health services, and medical necessity for a specific type of service or intervention.
  - Related changes to SMH medical necessity criteria might include revisions to clarify that SMH services can be provided to eligible beneficiaries as long as they are medically necessary and provided in accordance with California's Medicaid state plan, and revisions to align with federal requirements that allow a physician's certification to document the need for acute inpatient psychiatric services.
- **Universal assessment for MH:** DHCS hopes to identify a single, universal assessment for mental health conditions that could be used by both county mental health plans and Medi-Cal managed care plans.
- **"No wrong door" policy for EPSDT:** Both Medi-Cal Managed Care Plans and county MHPs would be expected to offer mental health assessments for all children under 21 (the population covered under the federal Medicaid mandate for Early and Periodic Screening, Diagnostic, and Treatment services, or EPSDT). Both plans could receive reimbursement for assessment and some services rendered, even if the child is ultimately referred to the other delivery system for ongoing care. This contrasts with the current entitlement under which MCPs are responsible for screening, but no other behavioral health services, and may be a result of DHCS reports that MCPs have been billing Medi-Cal for actual services rendered to children under EPSDT.

- **Substance Use Disorder Managed Care (DMC-ODS) Renewal.** DHCS proposes to renew the DMC-ODS demonstration with some clarifying changes to current program requirements, including technical revisions to the definitions of residential treatment and recovery services. DHCS would also clarify the coverage of medications for addiction treatment (MAT) under the DMC-ODS and would require all DMC-ODS providers to either offer or make referrals for MAT. The physician consultation benefit would become optional, rather than required. DHCS would add contingency management as an evidence-based-practice for DMC-ODS providers and would remove a redundant provider appeal process from the special terms and conditions (STCs). DHCS is also considering policies to increase access to SUD care for American Indians and Alaska Natives, and will seek allowances for the reimbursement of specific cultural practices. The state wants to encourage the use of case management and other services for justice-involved beneficiaries enrolled in SUD managed care, and to allow billing for assessment and some services prior to diagnosis.

  DHCS anticipates that CMS will require California to significantly adjust its approach to covering residential SUD treatment. The current 1115 waiver enables California to receive federal dollars for SUD services delivered in residential treatment facilities of more than sixteen beds. This is an exception to a federal Medicaid rule that generally prohibits federal payments for services delivered in these larger facilities, which are known as "Institutions for Mental Disease" or IMDs.[7] Other states that have obtained federal approval for a waiver of the IMD rule for SUD treatment have been expected to demonstrate an average residential length-of-stay of no more than 30 days. California currently authorizes two residential treatment episodes of up to 90 days each within a twelve-month period. DHCS hopes to remove the current two-episode limit but expects CMS to also reduce the number of service days within a year that are eligible for federal financial participation (FFP).

  Many components of the DMC-ODS that are currently enacted through an 1115 demonstration waiver will be transferred into the 1915(b) managed care waiver in 2020. However, substance use disorder managed care will remain an option rather than a requirement for California counties. Counties will have a new opportunity to opt in to offering DMC-ODS managed care services.

- **Administrative Integration of MH and SUD Services.** At present, the bifurcated plan structure and disparate program requirements for Drug Medi-Cal and Specialty Mental Health benefits create significant administrative duplication for counties and discourage efforts to offer integrated care for clients with co-occurring disorders. Under this CalAIM proposal, counties would administer mental health and SUD benefits through a single, managed behavioral health plan by 2026. The state would hold a single contract for mental health and SUD services in each county. This proposal would facilitate integration in DMC-ODS counties and in counties that continue to operate DMC programs under the terms of the Medi-Cal state plan.

  In addition to integrating health plan and DHCS oversight functions, the state will also consider numerous policy and procedural changes for the Specialty Mental Health and Drug Medi-Cal programs that would promote clinical, service-level integration. The Department proposes to create a multi-year work plan to revise and align plan and program requirements in the following areas:
    - **Clinical integration:** Beneficiary access lines, intake/screenings, assessment, treatment planning and documentation, beneficiary informing.
    - **Integration of plan functions:** State/county contracts, data sharing and privacy issues, electronic health record re-design, cultural competence plans and activities.
    - **Integration of compliance requirements:** Quality improvement and performance measures, EQRO reviews, DHCS compliance reviews, network adequacy certification, provider licensing and certification.

- **Regional Contracting for Behavioral Health.** DHCS is interested in supporting and encouraging counties to act jointly to operate multi-county managed care plans for behavioral health. Acting jointly could help some counties increase administrative efficiency and mitigate resource limitations. Such models are permissible under state law and the terms of the DMC-ODS waiver. Current examples include the Sutter-Yuba and Placer-Sierra mental health plans, as well as the group of eight counties that intend to launch a regional DMC-ODS program administered by Partnership Health Plan. Counties could also choose to operate their fee-for-service (state plan) DMC programs cooperatively using a joint powers authority (JPA) or common administrative services organization (ASO). Entering into such arrangements will remain optional for counties.

- **SMI/SED Demonstration (Mental Health IMD Waiver).** DHCS intends to consult behavioral health stakeholders to determine whether the state should apply for a new waiver demonstration opportunity known as the "Serious Mental Illness/Serious Emotional Disturbance" (SMI/SED) Demonstration. [8] With CMS approval, participating states can begin to receive federal Medicaid dollars for mental health services delivered in residential treatment facilities with more than sixteen beds. As noted above, these facilities are known as "Institutions for Mental Disease" or IMDs, and federal Medicaid rules typically prohibit states from drawing down FFP for services delivered in programs of this size. An important component of the state's current DMC-ODS demonstration is the exception to this rule that enables FFP for residential SUD treatment regardless of facility size, and states may now apply for a similar demonstration for mental health.

  At present, California's MHPs are required to offer adult residential treatment for mental health conditions but must cover the total cost of services delivered in larger facilities using local funds. The opportunity to receive FFP for these services could bring in federal dollars to offset these costs, thereby supporting reinvestment in other parts of the state's mental health continuum of care and helping to ensure residential care is accessible for those who need it. CMS has established a high bar for participation in this program. States must demonstrate that they can provide a robust continuum of community-based, non-residential mental health services as alternatives to residential treatment in IMD facilities. As with the waivers for residential SUD treatment, participants will be expected to maintain an average length of stay of no more than 30 days in qualifying residential treatment facilities. The waiver application would also require California to undertake an extensive assessment of current mental health services and providers, develop implementation, fiscal, and evaluation plans, maintain current levels of state and local spending on mental health services, and achieve specific outcomes.

If California were to move forward with this opportunity, it would not be implemented statewide. DHCS would work with counties to identify participating regions or to permit well-prepared counties to opt in. Participating counties would likely be expected to undertake significant efforts to improve their existing delivery systems and build additional capacity for community-based services.

III. CalAIM Managed Care and Multi-System Proposals

In addition to the behavioral health proposals above, CalAIM includes numerous initiatives that target Medi-Cal Managed Care plans and/or multiple delivery systems. Some proposals impact other county-administered functions like Medi-Cal eligibility and enrollment. Many of these proposals are intended to standardize and improve Medi-Cal benefits and policies as a means of improving client experience and health outcomes. The concept paper also calls for a new focus on data-driven population health management strategies for Medi-Cal beneficiaries, and as emphasized by DHCS, seeks to expand "whole person care approaches" to address social determinants of health. Managed care and multi-system CalAIM proposals include:

- **Full Integration Plans.** DHCS hopes to test the effectiveness of administering Medi-Cal physical health, behavioral health, and oral health services under a single managed care entity/payer. The goals of administrative integration would be to simplify system navigation for beneficiaries, and to improve care coordination as a means of improving health outcomes for individuals with complex needs, including people with serious mental illness who suffer from higher mortality rates than the general population.

  This would be an optional pilot program for plans and counties interested in pursuing administrative integration. DHCS acknowledges that strategies for the financing and administration of integrated managed care plans will be complex given California law and the current structure of Medi-Cal's delivery systems. Rather than putting forward specific proposals for the structure or operations of such plans, the CalAIM concept paper outlines numerous fiscal and policy questions that must be addressed. DHCS proposes a timeline for a planning and RFP process, and suggests full integration plans could "go-live" in 2024.

- **Managed Care Population Health Management and Quality.** Medi-Cal Managed Care Plans, or MCPs (not including behavioral health or dental plans), will be required to develop and implement population health management programs. MCPs will be expected to assess beneficiary risk and design targeted interventions and care coordination strategies to improve health outcomes, address social determinants, and reduce health disparities. Each plan must submit its written population health management plan annually to DHCS for approval. Enhanced Care Management and In Lieu of Services, discussed below, should be used by the plans as components of comprehensive population health management.

  MCPs will also be required to obtain accreditation from the National Committee for Quality Assurance (NCQA) by 2025, and to require the same of any delegated entities who administer benefits on behalf of the plan.

- **Enhanced Care Management, In Lieu of Services, and Incentives.** To sustain strategies tested in programs like California's current Whole Person Care Pilots, the Health Homes program,[9] and the Coordinated Care Initiative,[10] DHCS proposes to restructure some services and activities that had been made available through these programs so they can be covered by Medi-Cal's managed care plans. These include services like housing navigation and supports, sobering centers, and intensive care coordination. Managed care plans would be able to offer these services via:

  - **Enhanced care management (ECM):** ECM would be implemented statewide as a new Medi-Cal benefit for specified target populations, including individuals with serious mental illness use or substance use plus other risk factors. These individuals would be eligible for care management services that would be

different from other case management benefits offered through Medi-Cal Managed Care Plans or county behavioral health plans. ECM is intended to be face-to-face, high-touch care coordination through which a single, dedicated care manager provides long-term, cross-system coordination to address all health and social needs for clients that must access services from multiple delivery systems. While the state has explicitly called out clients of county behavioral health as a target population, it is not clear how the state intends to avoid duplication with other county behavioral health case management efforts.

- **In Lieu of Services (ILOS):** ILOS are flexible, wrap-around services that would be offered as alternatives to services covered under the Medi-Cal state plan. Federal Medicaid rules permit managed care plans to offer these services when they are medically appropriate and cost-effective for beneficiaries with specified risk criteria. DHCS has proposed thirteen service types or bundles that managed care plans could choose to offer. The proposed ILOS bundles include many services that have been provided through Whole Person Care Pilots in California, including housing navigation and supports, medical respite, home and environmental modifications, and sobering centers.[11]

Both ECM and ILOS would be administered by Medi-Cal Managed Care Plans and not by county behavioral health plans. However, at the discretion of the MCP, county behavioral health and other county health agencies would be eligible to contract with MCPs as direct providers of these services. Many ECM and ILOS services will be targeted to the high-risk populations that receive behavioral health or other services currently offered by counties. As contracted providers, counties could also benefit from a managed care incentive program that DHCS proposes to accompany ECM and ILOS. If this program is funded by the state legislature, MCPs would have opportunities to participate in shared savings and risk models and could also access incentive payments to develop the infrastructure needed to effectively provide ECM and ILOS. MCPs could, in turn, share incentive payments with service providers that partner with plans to carry out capacity-building and quality improvement activities. It is unclear if the state will attempt to encourage counties (i.e. public hospitals, public health departments and county behavioral health) to use IGTs to fund the non-federal share for ECM and ILOS.

- **Managed Care Benefits and Enrollment Standardization.** These proposals are meant to standardize benefits and enrollment for Medi-Cal managed care beneficiaries. DHCS proposes carving in two categories of benefits that are currently only covered by some MCPs: organ transplants and institutional long-term care services. Pharmacy services, optical lenses, and the Multi-Purposes Senior Services programs will be carved out for all plans. Furth, the state proposes to carve out specialty mental health for Kaiser beneficiaries in Sacramento and Solano counties. DHCS will also standardize the populations that are automatically enrolled in managed care versus Medi-Cal fee-for-service so that the same populations are enrolled in managed care statewide. Finally, the state proposes to establish an annual open enrollment period, giving beneficiaries the opportunity to change their managed care plans once per year rather than monthly. This proposal includes several beneficiary-friendly exceptions to allow plan changes at other times under specified circumstances. These changes would help facilitate another reform: regional capitation rates that would be used by multiple plans within a geographic area and replace individual rates for each plan.

- **Dental Initiatives.** These proposals would build on the Dental Transformation Initiative included in the current 1115 waiver by adding benefits and expanding pay for performance. New dental benefits would include a Caries Risk Assessment bundle for young children and Silver Diamine Fluoride for specified populations. Pay for performance initiatives would incentivize use of preventive services and improved continuity of care through "dental home" models.

- **Other County Initiatives.** CalAIM also includes proposals related to Medi-Cal eligibility and enrollment functions administered by social services agencies in each county, and an initiative to enhance oversight and monitoring of key children's programs to improve performance and the quality of services. DHCS would develop a new strategic compliance program for California Children's Services and the Child Health and Disability Prevention

programs in all counties. County Medi-Cal eligibility and enrollment programs would also be subject to new oversight procedures. DHCS also seeks to improve the accuracy of beneficiary contact and demographic information and will convene a workgroup to develop recommendations on this issue.

Additional proposals that will impact county behavioral health and social services programs include:

- **Jail Pre-Release Application Mandate:** DHCS intends to impose a new mandate for pre-release Medi-Cal applications for individuals exiting county jails. The Department will also require warm hand-offs to county behavioral health for people who re-enter the community after receiving behavioral health services in jail.
- **Long-Term Plan for Foster Care:** The Department will convene a workgroup to develop recommendations for new care models to improve care for foster youth.

IV. CBHDA Perspective

CalAIM's emphasis on population health management and addressing social determinants of health through whole-person care approaches represents an important evolution within Medi-Cal. Medi-Cal, like many other health care delivery systems in the United States, has historically been shaped by policy decisions that prioritized fiscal and administrative considerations over beneficiary needs and evidence-informed medicine. CBHDA is eager to partner with DHCS and other Medi-Cal stakeholders to eliminate program requirements that create undue administrative burden impose unnecessary fiscal and audit risks, and compromise client-centered care. Counties are ready to help design a Medi-Cal delivery system that better supports the health and well-being of the people it serves, particularly those with behavioral health conditions. If thoughtfully implemented, many CalAIM proposals promise to address current challenges and move Medi-Cal in the right direction.

It is also worth noting that many of the proposals put forward by the state under CalAIM are reforms that have been specifically requested by county behavioral health systems. While past administrations focused many of their public waiver proposals on the physical health care delivery system, CalAIM includes a unique emphasis and attention on behavioral health reform. This presents a huge opportunity for long-overdue and needed system transformations.

- **CBHDA members are ready to lead behavioral health system transformation and partner on multi-system initiatives.** County behavioral health plans strongly support several CalAIM initiatives that address strategic priorities previously identified by CBHDA members. These include the proposals for reforming behavioral health payment, revising medical necessity, advancing the administrative integration of specialty mental health and substance use disorder services in Medi-Cal, and exploring options for regional or joint administration of behavioral health plan functions. CBHDA also appreciates DHCS' commitment to renewing the state's pioneering model for substance use managed care through the Drug Medi-Cal Organized Delivery System. These initiatives, particularly payment reform and the modernization of medical necessity, are essential if California hopes to strengthen its safety net behavioral health delivery systems and ensure that Medi-Cal beneficiaries can access timely, high-quality care for mental health and substance use conditions.

  CBHDA members are also eager to collaborate with DHCS and other stakeholders to develop a Long-Term Plan for Foster Youth and to improve access to care for the justice-involved population by supporting pre-release Medi-Cal applications and working with county jails to ensure continuity of care for individuals re-entering the community.

  Due to the nature and complexity of the proposed reforms, many of these changes will need to be further developed and implemented over the course of the next five-year waiver. Counties will need to advocate for adequate time, training, and additional resources, as needed, to ensure these significant structural transitions are successful.

- **CalAIM strategies should capitalize on county strengths and align delivery system goals and incentives.** CalAIM contemplates the Medi-Cal delivery system as a whole. In this broader context, it is critical to acknowledge that county behavioral health programs are the primary providers of health and related services for some of the most vulnerable Californians with serious mental illness and substance use disorders, particularly in regions of the state underserved by contracted providers. Many of CalAIM's population health management initiatives would target these same individuals through interventions that would be managed by Medi-Cal Managed Care Plans and may or may not include county behavioral health. It is imperative that the state implement population health management strategies in a coordinated fashion across Medi-Cal delivery systems. Counties are prepared to partner with Managed Care Plans to effectively provide whole person care through Enhanced Care Management and In Lieu Of Services, and CBHDA will urge DHCS and state policymakers to consider options for incentivizing or requiring this cross-system collaboration. Further, as Managed Care Plans seek to strengthen their capacity for disease prevention and risk management for all enrollees, counties also hope to explore strategies for more meaningful performance and outcomes measurement for behavioral health plans.

In the coming years, CBHDA will encourage the state to take additional steps to develop population health strategies that build on the expertise and infrastructure available in counties, and to align incentives across Medi-Cal's delivery systems to support common goals. In the immediate future, counties look forward to partnering with the state to refine and implement CalAIM's system transformation initiatives and to continue to improve the health and well-being of Californians with behavioral health conditions.

V. Appendix: Summary Tables - CalAIM Behavioral Health and Multi-System Proposals

CalAIM Behavioral Health Proposals	
Behavioral Health Payment Reform	• Replace certified public expenditures (CPEs) for the non-federal share of Medi-Cal payments with intergovernmental transfers (IGTs). • Behavioral health services would continue to be reimbursed on a fee-for-service basis but payments to behavioral health plans would be determined via a new rate-setting process and would no longer be reconciled to cost.
Revisions to Medical Necessity Criteria	• Clarify and revise medical necessity criteria for behavioral health services to focus on impairment rather than diagnosis, and to clearly distinguish between eligibility for specialty behavioral health services and criteria for specific interventions. • Adopt a universal mental health assessment for Medi-Cal clients and a "no wrong door" approach for children under 21 who seek MH services from either counties or MCPs.
Substance Use Disorder Managed Care (DMC-ODS) Renewal	• Renew the Drug Medi-Cal Organized Delivery System (DMC-ODS) program for SUD managed care, with some clarifications and changes to existing program requirements. • Participation would remain optional and new counties could choose to opt in.
Administrative Integration of MH and SUD Services	• By 2026, each county would operate a single managed care plan for mental health and substance use disorder benefits. • Changes to align program requirements would help facilitate clinical integration for BH clients as well as administrative integration at the health plan level.
Behavioral Health Regional Contracting	• Encourage and support counties that wish to pursue joint administration of behavioral health services and operate as multi-county managed care plans.
SMI/SED Demonstration Waiver	• With CMS approval, California could receive federal funding for mental health services delivered in residential treatment facilities of more than 16 beds, known as "Institutions for Mental Disease" or IMDs. • Counties or regions would likely opt into this pilot program. California must meet outcome targets to demonstrate that it can provide a robust continuum of community-based services as alternatives to IMD services.

CalAIM Managed Care & Multi-System Proposals	
Full Integration Plans	• Test the effectiveness of administering Medi-Cal physical health, behavioral health, and oral health services under a single health plan/entity/payer. • Optional pilot program. DHCS hopes to see plans "go-live" in 2024, with key fiscal and administrative elements to be determined.
Managed Care Population Health Mgmt. & Quality	• Require all managed care plans (not including BH plans) to develop and implement annual population health management plans. • Require managed care plans to obtain NCQA accreditation (does not include BH plans).
Enhanced Care Management, In Lieu of Services, and Incentives	• Build on Whole Person Care pilots included in current 1115 waiver by structuring non-Medicaid reimbursable activities currently available through pilots as Medi-Cal managed care "in lieu of" services (ILOS) and enhanced care management (ECM) benefits. Services to be administered only by Medi-Cal managed plans. • ECM: Statewide benefit that would cover intensive, cross-system care coordination of health and social services for high-risk target populations. • ILOS: Optional alternatives to covered state plan benefits that would enable managed care plans to pay for services like housing supports if medically necessary and cost-effective. • Establish incentive program that managed care plans could use to support the development of infrastructure for ECM and ILOS, and to promote quality improvement among plans and contracted providers.
Managed Care Benefits and Enrollment Standardization	• Standardize Medi-Cal managed care benefits by carving in organ transplants and institutional long-term care for all plans. Pharmacy benefits, the Multipurpose Senior Services Program, and specialty mental health services for Kaiser members in Solano and Sacramento counties will be carved out. • Standardize managed care enrollment so that the same populations are enrolled in managed care or fee-for-service statewide. • Create a mandatory open enrollment period for Medi-Cal managed care, with some beneficiary-friendly exceptions to allow plan changes outside of open enrollment. • Adopt regional rates for managed care plan services (distinct from BH payment rates).
Dental Initiatives	• Add new benefits and establish pay for performance initiatives to incentivize preventive services and continuity of care.
Other County Initiatives	• Enhance oversight and monitoring to improve performance of Medi-Cal eligibility and enrollment functions. • Develop recommendations to improve beneficiary contact and demographic information. • Develop new quality and compliance programs for California Children's Services and Child Health and Disability Prevention programs. • Implement statewide pre-release Medi-Cal application process for county jails and mandate warm hand-offs from jails to county behavioral health for individuals that received behavioral health treatment while incarcerated. • Convene workgroup to develop recommendations for different care models for foster youth ("Long-Term Plan for Foster Care").

Endnotes

[1] California Department of Health Care Services, "California Advancing and Innovating Medi-Cal Proposal", October 28, 2019, available at: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

[2] Additional information on California's current Medicaid waivers, including the Section 1115 and 1915(b) Medicaid waivers referenced here, is available online via the Department of Health Care Services' website at https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx

[3] California Department of Health Care Services, "California Advancing and Innovating Medi-Cal Proposal", October 28, 2019, p. 8.

[4] Administrative and fiscal responsibilities for public mental health and substance use disorder services in California were "realigned" from the state to counties through the 1991 and 2011 state budget processes. For an overview of the financing of county behavioral health systems, see Peter Harbage and Sarah Arnquist, "A Complex Case: Public Mental Health Delivery and Financing in California", July 2013: https://www.chcf.org/wp-content/uploads/2017/12/PDF-ComplexCaseMentalHealth.pdf

[5] California Department of Health Care Services, "California Advancing and Innovating Medi-Cal Proposal", October 28, 2019, p. 80.

[6] Certified public expenditure protocols for Specialty Mental Health and Drug Medi-Cal Organized Delivery System services are included in the special terms and conditions for the state's current Section 1115 and 1915(b) waivers. See https://www.dhcs.ca.gov/services/MH/Documents/CMSLetter_10.5.2016_CPETechCorrection.pdf and https://www.dhcs.ca.gov/provgovpart/Documents/DMCAttachmentAA.pdf. Non-federal share for state plan Drug Medi-Services is also paid with certified public expenditures; see California Department of Alcohol and Drug Programs, ADP Bulletin 11-17, "Certified Public Expenditure Requirements for Federal Financial Participation for Drug Medi-Cal Under the State-County Contracts", December 2, 2011: https://www.dhcs.ca.gov/services/MH/MHSUD/Documents/ADP_Bulletins/ADP_11-17.pdf

[7] United States Code: Social Security Act, 42 USC Section 1905(a)(29)(b).

[8] United States Centers for Medicare and Medicaid Services, State Medicaid Director Letter 18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance", November 13, 2018.

[9] The Health Homes program was authorized under the federal Patient Protection and Affordable Care Act and is designed to provide enhanced care management and coordination services for eligible Medi-Cal beneficiaries with complex care needs and chronic conditions. For more information visit California Department of Health Care Services, "Health Homes Program", accessed November 9: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

[10] The Coordinated Care Initiative, also known as Cal MediConnect, was a demonstration program implemented in eight counties to provide more integrated behavioral, medical, and long-term care services for Medi-Cal beneficiaries that are also eligible for Medicare ("dual eligibles"). For more information visit California Department of Health Care Services, "Coordinated Care Initiative", accessed November 9: https://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx

[11] For full descriptions of proposed ILOS bundles see California Department of Health Care Services, "California Advancing and Innovating Medi-Cal Proposal", October 28, 2019, p. 120, Appendix D.