2021 CBHDA Strategic Plan
California Advancing and Innovating Medi-Cal (CalAIM)

CBHDA History

CalAIM and Medi-Cal Waiver Renewals. DHCS released its formal CalAIM proposal on October 29, 2019. CalAIM is a multi-year initiative to improve population health outcomes in Medi-Cal through significant delivery system, program, and payment reforms. Major components of CalAIM must be approved by the federal Centers for Medicare and Medicaid Services (CMS) as part of California's renewal of the Section 1115 and 1915(b) Medicaid waivers. The current 1115 waiver includes core programs like Medi-Cal managed care, as well as demonstration programs like the Drug Medi-Cal Organized Delivery System and Whole Person Care Pilots. In California, the 1915(b) waiver is the key governing authority for county Specialty Mental Health Plans.

CalAIM Timelines. The COVID-19 pandemic delayed enactment and implementation timelines for all CalAIM proposals. DHCS has now proposed brief extensions of the existing 1115 and 1915(b) waivers. If approved by CMS, both waivers will be extended through December of 2021 with only minor amendments to existing terms and conditions. During 2021, DHCS will work with CMS to negotiate the more substantive proposals included in CalAIM, with a goal of enacting new waivers on January 1, 2022. Some proposals will be implemented immediately, with others taking effect on slightly extended timelines (e.g., BH payment reform would be implemented July 1, 2022, to coincide with the fiscal year).

CalAIM Proposals. CalAIM includes several proposals specific to Medi-Cal behavioral health, as well as proposals that cut across Medi-Cal delivery systems. The behavioral health proposals include key changes that CBHDA had consistently advocated for prior to the release of DHCS' proposals, such as BH payment reform and improved integration of Medi-Cal mental health and substance use disorder services. The multi-system proposals include new managed care benefit structures and requirements that are intended to build on existing pilot programs like Whole Person Care. These proposals would also further DHCS' vision for administrative simplification within Medi-Cal by increasing the responsibility of Medi-Cal Managed Care Plans (MCPs) to manage population health, address disparities and social determinants of health, and coordinate care across health and social services programs. Key CalAIM proposals include:

Behavioral Health	Multi-System Proposals
• Medical necessity changes • Payment reform • DMC-ODS renewal • Integration of MH & SUD services • SMI/SED IMD waiver • BH regional contracting	• Full integration pilots • Foster youth model of care • MCP Population Health Management • Enhanced Care Management (ECM) • In-lieu-of-services (ILOS) • Benefits & enrollment standardization • Dental initiatives • Other county initiatives, e.g., pre-release Medi-Cal application process in county jails

CBHDA Advocacy to Date. In late 2019 and early 2020, CBHDA engaged with DHCS to help shape CalAIM proposals through targeted stakeholder engagement. CBHDA staff and BH Directors representing large, medium, and small counties also participated in DHCS' formal CalAIM stakeholder workgroups. The Association provided specific policy and implementation recommendations during these discussions and via formal comment letters. DHCS now plans to meet with CBHDA members again between late October and December 2020 to re-visit certain proposals, particularly changes to medical necessity, documentation reform, and the adoption of universal screening and transfer of care tools. These meetings will include targeted engagement with CBHDA members as well as a larger forum with MCP representatives.

For additional information on CalAIM and CBHDA advocacy to date, please see:

- DHCS CalAIM home page
- DHCS CalAIM BH Workgroup
- CBHDA CalAIM resources for members *(*includes public comment letters)*

Current Political Landscape

Opportunities and Challenges. CalAIM presents critical **opportunities** for CBHDA to ensure that BH proposals like payment reform and medical necessity changes are designed and implemented in a way that strengthens the ability of counties to provide high-quality care for Californians with BH conditions.

- **Health equity, justice, and healing:**
  - MCP **population health management plans** should prioritize the identification and reduction of health disparities, and the development of new programs and strategies to better serve individuals with disabilities, serious mental illness, substance use disorder needs, communities of color, individuals with diverse sexual orientation and gender identities, and other underserved ethnic, cultural, or linguistic groups.
  - Changes to **medical necessity and documentation standards** must eliminate administrative requirements that disproportionately deter some populations from attaining care. Lower-barrier engagement in BH services, and new, client-centered approaches to clinical documentation, can be tools to address health disparities within our county-based delivery systems.
- **Financial stability and continuum of care:**
  - The **SMI/SED waiver** opportunity could help the state draw down new federal dollars, relieve pressure on county realignment funds, and make new, targeted investments in community-based placements and supportive services for individuals with SMI.
  - **BH payment reform** should be an incremental step toward new, value-based payment models that reward performance, maximize FFP, and support stability in the event of emergencies like the COVID-19 pandemic. Between payment reform and MH/SUD integration, we also hope to see increased parity in reimbursement for MH and SUD services.

In the short term, **key challenges** associated with CalAIM include the "heavy lift" needed for counties to successfully implement proposals like payment reform and medical necessity/documentation changes. CBHDA must work to obtain **implementation funding** for counties and partner with DHCS to devise timelines, policy guidance, and technical assistance opportunities that support successful implementation.

CalAIM also raises a fundamental, **long-term challenge:** Many CalAIM proposals are meant to further goals of administrative simplification, via delegation of responsibility for Medi-Cal quality and outcomes to MCPs. The proposal for "**full integration pilots**" is the state's attempt to make incremental progress toward eliminating the carve out of specialty mental health and SUD services by encouraging counties or regions to pilot a carve-in of behavioral health and utilize a single plan/entity to administer all Medi-Cal benefits. DHCS has also discussed **enrolling all child welfare-involved youth in a single managed care plan** with comprehensive physical, behavioral health, and dental coverage. This desire for administrative simplification and a single point of accountability within Medi-Cal may not always support improved outcomes for county behavioral health clients. Over the long term, CBHDA is concerned that the state's drive toward carving in behavioral health benefits could lead to policy changes that actually reduce investment in specialty behavioral health and produce poor

outcomes for clients by relying on a medical model approach that fails to appreciate the differential needs of long-term recovery grounded in a client and community-based biopsychosocial and multi-payer model of care.

Strategic Relationships and Targets. To date, CBHDA has engaged very productively with DHCS to help shape CalAIM proposals. Other strategic partners include:

- CWDA – joint proposal for foster youth
- CSAC and other county affiliates, e.g. CHEAC, CAPH - cross-cutting proposals
- Health plans and their Associations, i.e., LHPC & CAHP – MCP proposals and screening/transition of care tools
- Advocates like National Health Law Program, Children NOW
- Consumers and consumer associations, e.g., NAMI
- Providers and provider associations, e.g. CBHA, CAFCS, CAADPE, including hospitals (CHA)

Key Questions

1-2 year questions. CBHDA will need to provide additional input on various CalAIM policy and implementation issues. Key questions may include:

- *How would the overarching policy drive toward outcomes measurement fold into specific CalAIM proposals, such as the Joint Foster Care Proposal, or Medi-Cal specialty behavioral health as a whole?*
- *How can counties partner with MCPs to develop population health management plans and strategies that improve outcomes individuals with behavioral health conditions?*
- *Should county behavioral health plans promote development of their own, unique population health management planning and strategies, given the importance of population health management in creating a more equitable delivery system?*
- *What strategies can improve coordination between MCPs and counties? Are there different approaches for child-welfare involved youth? All children/youth? Adults? Other populations?*
- *How can we achieve meaningful data-sharing between MCPs, counties, hospitals and other key Medi-Cal partners to support care coordination and population health management strategies?*
- *What role should counties play in delivering ECM and ILOS?*
- *How can we ensure adequate rates and mitigate new risk under BH payment reform?*

3-10 year questions. The current waivers, which may remain in effect from 2022-2026, will also serve as stepping stones toward more significant structural changes in the future. CBHDA must begin to answer long-term, existential questions such as:

- *What role should counties play in administering public BH services?*
- *How should Medi-Cal managed care be organized, in order to attain the best outcomes for individuals with behavioral health conditions?*
- *How can we ensure that our BH mandates are appropriately financed and funded?*

Existing Workload

CBHDA will continue to participate in stakeholder engagement opportunities throughout the waiver negotiation period. We assume this will include significant, ongoing implementation work with DHCS during 2021 and 2022. For example, CBHDA has already committed to partnering with DHCS and CalMHSA to develop new documentation standards and universal screening and transition of care tools.

2021-22 Policy Proposals for Consideration

- **Identify county BH vision for the administrative structure of public BH within Medi-Cal.** CBHDA will analyze options for the structure and financing of BH benefits and begin to develop recommendations for state policymakers.
- **Advocate for CalAIM implementation funding.** Secure dedicated resources for counties to successfully implement CalAIM initiatives. Activities to be funded would include I.T. system upgrades and staff training needed for payment reform and medical necessity and documentation changes.
- **Medical necessity & documentation reform:** Secure changes to medical necessity to maximize Medi-Cal FFP and support FURS implementation and the adoption of the CBHDA/CWDA Foster Care Proposal. Implement new documentation standards for SMH and DMC/DMC-ODS that maximize FFP, reduce disallowances, and center client needs, including health equity and culturally responsive care.
- **Payment reform:** Develop adequate rates and successfully implement BH payment reforms that pave the way for future adoption of a more flexible, resilient, value-based payment methodology.
- **MH/SUD Integration:** Begin to implement administrative reforms and identify additional changes to service definitions and program requirements that align the SMH and DMC programs and promote integrated care for clients with co-occurring conditions.
- **DMC-ODS renewal:** Update DMC-ODS STCs to reflect lessons learned in initial waiver and improve client access and quality. Enable new counties to participate in the program.
- **IMD waiver:** Advance an IMD waiver proposal to secure FFP for MH services delivered in IMDs in participating counties or regions.
- **ECM & ILOS:** Secure right of first refusal for counties to contract with MCPs as ECM providers. Ensure that eligibility criteria and service definitions for ILOS enable use of these services by county BH clients.
- **Population Health Management:** Require MCPs to collaborate with counties, utilize behavioral health data, and identify at least one population health goal focused on behavioral health.
- **Foster youth:** Spearhead, with CWDA, and secure the adoption of the Joint CBHDA/CWDA Foster Care Proposal.
- **Peers:** Secure the waiver for implementing Peer Support Services as a Medi-Cal county option.