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Joint Informational Hearing

Assembly Health Committee and Budget Subcommittee No. 1

Behavioral Health Components of California Advancing and Improving Medi-Cal

Tuesday, March 9, 2021 - 1:30 p.m.
State Capitol, Assembly Chambers

BACKGROUND

Introduction

The California Advancing and Innovating Medi-Cal (CalAIM) is the Department of Health Care Services (DHCS) framework for changes to the Medi-Cal program that encompasses broad-based delivery system, program, and payment reform. DHCS indicates CalAIM advances several key priorities of the Newsom Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

First released in October 2019, CalAIM was the multi-year product of DHCS site visits, a DHCS 2018 care coordination advisory committee, and an extensive CalAIM stakeholder workgroup process (November 2019 to February 2020) consisting of over 20 in-person workgroup meetings across five separate workgroups. CalAIM had an original initial implementation date of January 1, 2021, but due to the COVID-19 Public Health Emergency's (PHE) impact in the state's budget and health care delivery system, CalAIM was put on hold for the duration of 2020, as were the five bills[1] introduced to implement the various proposals.

As part of the Governor's January 2021 budget, DHCS released an updated 230 page CalAIM proposal with modifications resulting from the workgroup process, stakeholder input, ongoing policy development, and new implementation dates. In addition, the Administration released 94 pages of CalAIM proposed TBL with over 20 policy proposals.

To implement CalAIM effective January 1, 2022, the Budget proposes $1.1 billion total funds ($531.9 million General Fund [GF]) for fiscal year (FY) 2021-22, growing to $1.5 billion total ($755.5 million GF) in FY 2022-23. This spending is for enhanced care management (ECM) and

funds in lieu of services (ILOS) provided by the Medi-Cal managed care (MCMC) plans (to be discussed in the March 16, 2021 hearing), promote necessary infrastructure to expand whole person care (WPC) approaches statewide, build upon existing dental initiatives, and promote greater consistency in the delivery systems where beneficiaries receive services. Beginning in FY 2024-25, the Administration proposes to phase out incentive funding to plans, resulting in ongoing costs of $846 million total funds ($423 million GF). DHCS also released a Budget Change Proposal as part of the Governor's Budget requesting 69 permanent positions, limited term resources equivalent to 46 positions, and expenditure authority of $23.9 million ($11 million GF and $12.8 million in federal funds) for FY 2021-22.

Due to the scope, complexity, amount of detail, and number of proposals in CalAIM, this hearing will hear a brief overview from DHCS on the CalAIM behavioral health change and then focus on the following specific behavioral health changes proposed in CalAIM:

1) Changes to Behavioral Health Medical Necessity Criteria, No Wrong Door, Standardized Screening Tool, Standardized Transition Tool, Mental Health Documentation Requirements, Documentation Standards and Concurrent Review Protocols, specialty mental health services (SMHS) Psychiatric Inpatient Medical Necessity Criteria;

2) Behavioral Health Payment Reform (shift from claiming federal financial participation (FFP) from Certified Public Expenditures [CPEs] to Intergovernmental Transfers [IGTs]);

3) MCMC Benefit Standardization (related to mental health, SMHS provided by Kaiser in Sacramento and Solano are proposed to be shifted back to the respective counties);

4) Administrative Integration of SMHS and Substance Use Disorder (SUD) Services;

5) Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal and Policy Improvements;

6) Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Demonstration Opportunity (allow counties to draw down federal Medicaid matching funds for services provided to adults in an Institution for Mental Disease [IMD] facility with over 16 beds);

7) Behavioral Health Regional Contracting (allowing counties to combine to offer DMC-ODS services); and,

8) Full Integration Plans (one health plan providing all Medi-Cal services, including SUD, SMHS, dental, and typical MCMC plan services; not proposed for implementation until 2027).

A second joint hearing (scheduled for March 16, 2021) will focus on the MCMC rates, benefits and eligibility changes. The overall CalAIM proposal raises multiple policy, financing, process and timing issues for legislative consideration, including the following overarching questions:

- Are MCMC plans able to deliver the expanded scope of the proposed benefit changes (such as an ECM and ILOS) intended to address social determinants of health (SDOH) (for March 16th hearing)?

- Is the CalAIM implementation timeframe for the proposed changes (and the ability of the various Medi-Cal delivery system to implement the proposed changes) realistic given the PHE and competing demands on those systems?

- How does the Administration propose to ensure the CalAIM behavioral health changes are evaluated to determine if goals and outcomes are being achieved?

- To what extent should policy issues be delegated to executive branch discussions for yet to be determined Terms and Conditions (T&Cs) of the waiver?

- Should, as the proposed Trailer Bill language (TBL) requires, in the event of a conflict between the state law CalAIM-related provisions, the T&C control? Should this requirement be in statute in advance of the Legislature and the public knowing and analyzing what is contained in the T&C?

- Should the TBL focus only on those provisions necessary to avoid the expiration of an existing program or service under a prior waiver (such as WPC), and allow more time to analyze those provisions that change the Medi-Cal program?

- Is the financing of CalAIM, including the additional state GF and the state assumption of county-funded benefits sustainable?

- Several of the proposed CalAIM changes are enacted by adding a new article of law instead of amending existing state law provisions by using the phrase "notwithstanding any other law." This method of drafting makes understanding the changes to existing law difficult. Should existing statutory requirements be amended, rather than notwithstood?

Background on Medi-Cal

The Medi-Cal program is projected to provide services to about 14 million individuals each month at a projected cost of $117.9 billion total funds ($22.5 billion GF) in 2020-21, increasing to 15.6 million individuals each month and a cost of $122.2 billion ($28.4 billion GF) in 2021-22. Over the last decade, Medi-Cal has significantly expanded and changed, most predominantly because of changes enacted and funding provided through the federal Patient Protection and Affordable Care Act (ACA), federal regulations, as well as state-level statutory and policy changes. In addition to the program growth, the Medi-Cal delivery models have changed as the number of beneficiaries receiving the majority of their physical health care through MCMC plans has increased from less than 50% to over 80%. SUD and mental health benefits have also been expanded through state law changes enacted as part of ACA-implementation and through federal Medicaid waivers.

Medi-Cal is a complex program, and services are delivered by multiple different governmental

administrative entities and public and private payors and providers and delivery models. Depending on a person's needs, some Medi-Cal beneficiaries may access six or more separate delivery systems (MCMC, fee-for-service [FFS], SMHS, SUD, dental, developmental services, and In Home Supportive Services) in order to receive services to address health-related needs.

CalAIM Goals and Guiding Principles

In order to address the complexity of the program and the medical needs of the population the program serves, DHCS has proposed the below as CalAIM goals and guiding principles:

CalAIM Goals

- Identify and manage member risk and need through WPC approaches and addressing SDOH;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and,
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

CalAIM Guiding Principles

- Improve the member experience;
- Deliver person-centered care that meets the behavioral, developmental, physical, long-term services and supports and oral health needs of all members;
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals;
- Build a data-driven population health management strategy to achieve full system alignment;
- Identify and mitigate SDOH and reduce disparities and inequities;
- Drive system transformation that focuses on value and outcomes;
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation;
- Support community activation and engagement;
- Improve the plan and provider experience by reducing administrative burden when possible; and,
- Reduce the per-capita cost over time through iterative system transformation.

DHCS argues the CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person

Care (WPC) Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation (to be discussed at the March 16, 2021 hearing), that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Medi-Cal Behavioral Health Delivery System

The Medi-Cal behavioral health delivery systems (BHDS) are established through two separate Medicaid waivers, which enable the state to waive federal Medicaid requirements (such as freedom of choice) to require beneficiaries to enroll in different types of managed care plans and receive non-emergency services from managed care plan providers.

California delivers Medi-Cal services (including non-SMHS mental health services for most Medi-Cal beneficiaries) through MCMC plans under a federal Section 1115 Medicaid demonstration waiver known as "Medi-Cal 2020." Section 1115 of the Social Security Act gives broad authority to the federal Secretary of the Department of Health and Human Services (DHHS) to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives" of the programs. Under Section 1115 research and demonstration authority, the Secretary may waive certain provisions of the Medicaid (statutes related to state program design. Such projects are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state. Medi-Cal 2020 expired in December 31, 2020 and the state is operating under a one-year extension.[2] Medi-Cal 2020 waiver also includes the state's DMC-ODS. The Special Terms and Conditions (STCs) of Medi-Cal contain the detailed provisions of Medi-Cal 2020 in the agreement between DHCS and the Centers for Medicare and Medicaid Services (CMS) (the CalAIM proposal uses the phrase "Terms and Conditions" to describe the CalAIM proposed waiver provisions).

SMHS are delivered through counties (county mental health plans (MHPs)) delivered under a Section 1915(b) waiver. Section 1915(b) waiver authority provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. MHPs have operated under a Section 1915(b) waiver since 1995.[3] The 1915(b) waiver was in its the ninth renewal of the SMHS waiver, effective from July 1, 2015 to June 30, 2020. DHHS granted a six month extension and a subsequent three month extension until California March 31, 2021.[4]

Because of a change in federal policy, the state is no longer able to claim federal funds under Section 1115 waivers as it has in the past. The conclusion of the 1115 waiver results in a several programs (Whole Person Care and the Dental Transformative Initiative) ending and needing to be transitioned. Because of the federal change resulting in the unavailability of previously available federal funds, the state is shifting the current MCMC plan delivery system from a Section 1115 waiver to its Section 1915(b) waiver.

The Specialty Mental Health Plan and DMC "Carve Outs"

CalAIM builds upon a BHDS that funds and delivers SMHS services and SUD (except for one

plan) outside of MCMC plans. For SUD services, Medi-Cal benefits are delivered either through county opt-in DMC-ODS (in 37 counties serving over 95% of the state's population, with the DMC-ODS SUD benefit provided in seven of the 37 counties through Partnership Health Plan instead of through the counties directly) or in State Plan counties. The FFS benefit in State Plan counties is more limited than the DMC-ODS benefit in terms of covered services, and it is not a managed care program.

Medi-Cal mental health benefits are also delivered primarily through two separate systems (county MHPs and MCMC plans), with some prescription drug coverage through the FFS system (eventually all of outpatient prescription drugs will be delivered through FFS when Medi-Cal Rx takes effect). County MHPs provide a broad range of SMHS to individuals with more severe mental illnesses, while MCMC plans provide non-SMHS (the MCMC plan benefit is often referred to as the "mild to moderate" benefit). The delivery of SMHS through MHPs and SUD services outside of MCMC plans is commonly referred to as a "carve out," as is the coverage of anti-psychotic prescription medication through FFS Medi-Cal). A "carve out" is when services covered by the Medi-Cal program are delivered outside of a MCMC plan. Services for physical and behavioral health (which includes mental health and SUDs) historically have been financed and delivered under separate systems.

MHPs are responsible for providing SMHS to Medi-Cal beneficiaries who meet SMHS medical necessity criteria. SMHS are delivered through 56 county MHPs (Placer and Sierra Counties and Yuba and Sutter Counties operate two separate dual-county combined MHPs). Medi-Cal beneficiaries that meet medical necessity criteria for SMHS are entitled to receive medically necessary SMHS from their county MHP, regardless of whether or not they are enrolled in a MCMC plan.[5] MHPs that deliver SMHS are considered a prepaid inpatient health plan (PIHP) under federal Medicaid managed care regulations. PIHPs provide services to Medi-Cal enrollees under contract with the State, and meet specified criteria but do not have a comprehensive risk contract.[6]

MCMC plans operate under a risk contract with DHCS through several different models across. MCMC plans are responsible for providing non-SMHS, and for prescription drug coverage for mental health conditions, except for approximately 40 anti-psychotic medications. These medications are contractually carved out of nearly all MCMC plan contracts and instead reimbursed through Medi-Cal FFS.[7] Twenty-five contracting MCMC plans and their subcontracting providers and plans deliver services. MCMC plans are projected to cover 84.2% or 13.1 million of Medi-Cal's 15.6 million beneficiaries (over 40% of the state's population) projected to enroll in the program each month in FY 2021-22. Medi-Cal beneficiaries who are not enrolled in MCMC plans receive non-SMHS through Medi-Cal FFS.

MCMC plans deliver their scope of mental health coverage in different ways. For example, some MCMC plans use a specialized health care service plan to administer their mental health benefit (such as Beacon), while other plans manage the benefit directly, and one plan (Health Plan of San Mateo) contracts with its county behavioral health department. The chart below shows the type of mental health benefits provided by MCMC plans and MHPs:

	MCMC Plan	MHP – Outpatient	MHP– Inpatient
SERVICES	Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications,* supplies, and supplements • Psychiatric consultation	• Mental Health Services o Assessment o Plan development o Therapy o Rehabilitation o Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential Treatment • Adult Residential Treatment • Crisis Intervention • Crisis Stabilization • Targeted Case Management • Intensive Care Coordination • Intensive Home-Based Services • Therapeutic Foster Care • Therapeutic Behavioral Services	• Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in FFS hospital

Source: DHCS All Plan Letter (APL) 17-018.

*Approximately 40 psychiatric drugs are contractually excluded from coverage from MCMC plans and reimbursed through FFS Medi-Cal. The list of carved out drugs is in APL 17-08.

1) Changes to Behavioral Health Medical Necessity Criteria, No Wrong Door, Standardized Screening Tool, Standardized Transition Tool, Mental Health Documentation Requirements, Documentation Standards and Concurrent Review Protocols, SMHS Psychiatric Inpatient Medical Necessity Criteria

Current state law, regulation, and federal law establish medical necessity requirements in Medi-Cal. Under state and federal law, the Medi-Cal necessity requirements differ for adults versus youth under age 21, as the children's standard is broader. For example, for adults, a service is "medically necessary," or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.[8] Under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program Medicaid benefit for any individual under 21 years of age, services include screening, vision, dental, hearing and other Medicaid health care, diagnostic services, treatment, and other measures "to correct or ameliorate" defects and physical and mental illnesses and conditions discovered by the screening services.[9]

In addition to the medical necessity definition, the level of impairment and intervention criteria for eligibility for Medi-Cal SMHS differ between children[10] and adults[11] under state regulation. Both children and adults have to be diagnosed with one of 19 of the following diagnoses[12] in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:

a) Pervasive Developmental Disorders, except Autistic Disorders;
b) Disruptive Behavior and Attention Deficit Disorders;
c) Feeding and Eating Disorders of Infancy and Early Childhood;
d) Elimination Disorders;
e) Other Disorders of Infancy, Childhood, or Adolescence;
f) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition;
g) Mood Disorders, except Mood Disorders due to a General Medical Condition;
h) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition;
i) Somatoform Disorders;
j) Factitious Disorders;
k) Dissociative Disorders;
l) Paraphilias;
m) Gender Identity Disorder;
n) Eating Disorders;
o) Impulse Control Disorders Not Elsewhere Classified;
p) Adjustment Disorders;
q) Personality Disorders, excluding Antisocial Personality Disorder; and,
r) Medication-Induced Movement Disorders related to other included diagnoses.

A Medi-Cal beneficiary meets SMHS medical necessity criteria when the beneficiary has a covered mental health diagnosis (one of the 19 conditions), and meets specific impairment and intervention criteria related to that diagnosis (as defined in state regulations). The "impairment" criteria component of SMHS medical necessity is also broader for children than for adults. For example, a child with a mental health diagnosis that results in "a reasonable probability a child will not progress developmentally as individually appropriate" meets the impairment criteria, whereas adults must have a higher level of impairment.[13]

For those beneficiaries that do not meet medical necessity criteria for SMHS, MCMC plans must provide mental health benefits covered in California's Medicaid State Plan.[14] Disputes between MHPs and MCMC plans about which entity is responsible for providing services to a beneficiary are handled according to a dispute resolution process described in the memorandum of understanding between the two entities.[15] Disputes that cannot be resolved between the two entities can be submitted to DHCS for resolution in accordance with plan and county information notices.[16] With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. DHCS' goal is to ensure beneficiary access to the right care in the right place at the right time. DHCS proposes to:

Medical Necessity. DHCS states it intends to update and clarify medical necessity criteria for SMHS for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met. DHCS argues the current medical necessity

criteria for SMHS are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care.

DHCS indicates the current requirement for a diagnosis (the 19 mental health conditions) can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring SUD whose diagnosis may not be immediately clear. Under the DHCS-proposed changes, beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. For example, eligibility for SMHS for adults would be based on impairment or probability of significant deterioration and either a diagnosed mental health disorder or suspected mental health disorder, instead of a diagnosis of one of the 19 mental health conditions listed in regulation and the current impairment and intervention criteria.

EPSDT and Medical Necessity. DHCS proposes to clarify EPSDT protections for beneficiaries under age 21, and create criteria for children to access SMHS based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness. Rather than have one of the 19 mental health conditions listed in regulation and the existing impairment criteria, DHCS proposes broader criteria for eligibility for SMHS. DHCS argues the EPSDT protection for beneficiaries under age 21 are inconsistently interpreted which leads to confusion and variation in practice.

Standardized Screening Tool. DHCS proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the SMHS delivery system or in the MCMC plan or FFS system. DHCS does not currently standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and MCMC plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county MHPs (for SMHS) or with MCMC plans or FFS delivery systems (for beneficiaries not meeting criteria for SMHS).

Standardized Transition Tool. DHCS proposes to develop a standardized transition tool for when a beneficiary's condition changes, and they would be better served in the other delivery system. DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices.

"No Wrong Door." DHCS proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where a beneficiary seeks care. DHCS states this policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or

psychiatrist in one delivery system while requiring medically necessary services in the other.

Mental health documentation requirements. DHCS proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

SMHS Psychiatric Inpatient Medical Necessity Criteria. DHCS proposes to update the criteria for SMHS psychiatric inpatient medical necessity currently provided for in state regulation.[17]

Documentation Standards and Concurrent Review Protocols. DHCS proposes to develop documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review to facilitate improved communication between MHPs and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders.

Proposed Timeline: DHCS recommends making changes to the SMHS and SUD medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

CalAIM Proposed TBL:

1) Requires, notwithstanding any other law, commencing no sooner than January 1, 2022, all medical necessity determinations, screenings, assessments, and documentation associated with covered benefits delivered in any Medi-Cal BHDS to be made in accordance with the CalAIM T&C and any written instructions issued by the DHCS pursuant to the TBL, including mandatory screening and transition of care tools.

2) Requires DHCS to amend, and periodically update as it deems necessary, the medical necessity definitions, criteria, mandatory screening and transition of care tools, documentation requirements and related procedures for Medi-Cal BHDS.

3) Requires, in the event of a conflict between the CalAIM T&C, or DHCS' written instructions to implement the medical necessity changes, or the medical necessity provisions in state SMHS regulation or Medi-Cal regulation, the CalAIM T&C and DHCS' written instructions to control.

Policy Questions:

1) California has existing state law and regulation on medical necessity, including changes enacted in 2018 pursuant to SB 1287 (Hernandez), Chapter 855, Statutes of 2018, and a requirement that regulations be adopted by July 1, 2022. Should the medical necessity, no wrong door, screening, assessment, and documentation changes be delegated to

forthcoming discussions between the state executive branch and the federal executive branch over the T&C of the waivers needed to implement CalAIM, instead of being proposed for change in state law?

2) Should the CalAIM T&C and DHCS' written instructions on these issues prevail over state law and regulation, as the TBL proposes, without codifying these changes in statute?

3) Should DHCS be provided authority to amend and update medical necessity definitions, criteria, mandatory screening and transition of care tools, documentation requirements and related procedures for Medi-Cal BHDS, as the TBL proposes?

4) Should the statutory authority to make the medical necessity, no wrong door, screening, assessment and documentation changes proposed in CalAIM be delayed until the T&C have been federally approved?

Witnesses:
Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Corey Hashida, Fiscal & Policy Analyst, LAO and Mark C. Newton, Deputy Legislative Analyst, LAO
Ryan Quist, Ph.D., Behavioral Health Director, Sacramento County, Secretary-Treasurer, County Behavioral Health Directors Association
Kim Lewis, Managing Attorney, National Health Law Program
Chris Stoner-Mertz, LCSW, Chief Executive Officer, California Alliance of Child and Family Services
Connie Picaso, Marriage & Family Therapist II, Santa Clara County Behavioral Health Services, Member, SEIU Local 521

2) Behavioral Health Payment Reform (shift from claiming FFP via CPEs to IGTs)

Medicaid is a state and federal partnership, and federal law establishes requirements for the source of funds used to draw down FFP. At least 40% of funds must be financed by the state and up to 60% may come from local governments. The GF is the predominant fund for financing state government programs, including Medi-Cal. The primary sources of revenue for the GF are the personal income tax, sales tax and bank and corporation taxes. Through Realignment in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the SMHS and SUD services became the responsibility of the counties. Under both the 1991 and 2011 Realignment, the state dedicates a portion of sales tax and vehicle license fee revenue to counties to pay for their residents' mental health and SUD services. This is the primary source of nonfederal funding county Medi-Cal SMHS and SUD. In 2019-20, an estimated $2.6 billion in local realignment revenues supported county mental health and SUD services (Medi-Cal and non-Medi-Cal) for county residents. In addition,

counties use Proposition 63 funds (Mental Health Services Act funds for mental health), and county GF (in some counties), to draw down federal Medicaid matching funds.

MCMC plans and county MHPs and DMC-ODS claim FFP and are reimbursed differently in Medi-Cal. Unlike the reimbursement system for MCMC plans, which is based on an up-front per member per month payment based on one of over ten categories of beneficiaries to the MCMC plan primarily using state GF and federal Medicaid matching funds, county MHPs and county DMC-ODS are reimbursed retrospectively on a FFS rate based on certifying their costs (known as CPEs). Under CPEs, state or local governmental entities certify that they have spent CPE funds on items and services that are eligible for federal matching Medicaid funds. Federal matching funds are then provided for the federal share of the CPE.

Another method of claiming FFP under federal law is to use local funds through IGT. IGTs are transfers of public funds between or within levels of government. The transfer of funds may take place from one level of government to another (e.g., county to state) or within the same level of government (e.g., from a state university hospital to the state Medicaid agency). States can use county or state funds as the match for federal funds.

Unlike IGTs, CPEs do not involve an actual transfer of funds to the Medicaid agency. Instead, the federal government recognizes the expenditure by the state or local governmental entity as eligible for federal match and provides the federal share to the Medicaid agency.

For SMHS, DHCS utilizes CPEs made by counties for the state share of funding each type of payment made to an MHP.[18] MHPs pay for the total cost of services using non-federal funding sources and then submit a claim to the state for FFP reimbursement using the CPE process. The claiming process for Medicaid FFP using CPEs is complex and involves signed certifications, interim payments, cost reports, audits, and reconciliation, and takes multiple years to be finalized. Under CPEs, DHCS issues an interim payment to the county for approved claims. The interim payment includes the federal share (FFP) and state share, if any, of the approved amount. The interim payment is limited to a county interim rate for SMHS and DMC-ODS counties, and to the Statewide Maximum Allowances (SMA) for DMC State Plan counties (the SMA is the upper limit rates, established for each type of service, for a unit of service that will be reimbursed).

All network health care providers (including the county) must prepare a cost report for SMHS, DMC, and DMC-ODS, except for Narcotic Treatment Program (NTP) providers. The cost report determines how much it cost each provider to render the services DHCS reimbursed over the course of the FY. DHCS audits each county's cost report. DHCS compares interim payments to actual costs as determined in the cost report. The audit results in adjustments and/or reclassification of costs. Adjustments and reclassifications result in either recoupments from or additional payments to the county. DHCS recoups from the county if interim payments exceed actual cost, and DHCS makes an additional payment for actual costs that exceed interim payments. Counties may appeal the result of the final audit. The appeal decision may result in another calculation of the final audit settlement. Counties

state that the final reconciliation to cost takes years, including up to six years.

DHCS is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient SMHS and SUD from CPE-based methodologies to other rate-based/value-based structures that instead utilize IGTs to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition SMHS and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and,

- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via IGTs instead of CPEs, eliminating the need for reconciliation to actual costs.

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities. To start, DHCS is proposing to process IGTs and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly IGTs and payments to reduce the administrative burden tied to processing IGTs and payments on a monthly basis. According to DHCS, the state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

Under CPE-based methodologies, DHCS argues all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The proposed shift will incentivize additional investment in the delivery systems and reduce overall burden on counties and the state as the current CPE methodology does not allow counties to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. The shift from CPE to IGT-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;

- Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value;

- Create opportunities for improved coordination of care by simplifying options for contracts and payments between MCMC plans and counties, without limiting financial benefits for the county; and,

- Reduce state and county administrative burden and allow counties to close their accounting records closer to the end of a FY by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

Proposed Timeline: DHCS indicates that, given the need to ensure county readiness for this change in approach, it is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for SMHS and SUD services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the IGT-based reimbursement at the start of a state-county FY to ease the transition.

Proposed TBL:

1) Requires DHCS, as a component of Behavioral Health Payment Reform under CalAIM, at a minimum, to design and implement an IGT-based reimbursement methodology to replace the use of CPEs for claims associated with covered SMHS and DMC services provided through Medi-Cal BHDS.

2) Requires, notwithstanding any other law, commencing no sooner than July 1, 2022, the nonfederal share of any payments associated with each Medi-Cal BHDS to consist of voluntary IGT funds provided by eligible governmental agencies or public entities associated with a respective Medi-Cal Behavioral Delivery System.

3) Requires each transferring entity, upon providing any IGT of funds, to certify that the transferred funds qualify for FFP pursuant to federal Medicaid regulation, and any other applicable federal Medicaid laws, and the CalAIM T&C, and in the form and manner specified by DHCS.

4) Requires any IGT of funds made to be considered voluntary for purposes of all state and federal laws.

5) Prohibits, notwithstanding any other law, DHCS from assessing the state 20% fee on IGTs to reimburse DHCS for administrative costs described in a specified provision of law, or any other similar fee on IGTs made under these provisions.

6) Requires DHCS to establish and implement prospective reimbursement rate methodologies utilizing past county cost experience for covered SMHS and DMC services provided by Medi-Cal BHDS. Requires such methodologies to make use of peer groups whereby counties are grouped according to past cost experience, where DHCS determines appropriate.

7) Requires DHCS to determine the frequency of payments and IGTs made pursuant under these provisions.

Policy Questions:

1) The proposed shift of the nonfederal share of payments from CPE to IGT is proposed to occur "no sooner than" July 1, 2022? Is this sufficient time for county MHPs and DMHC-ODS plans and their contracting health care providers to make this transition?

2) How will the proposed prospective reimbursement rate methodologies differ from how payments are made now?

3) What is the purpose of transitioning from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code already exists?

4) What training will be available to counties and health care providers as they transition to a new coding, reimbursement system, medical necessity requirements and other CalAIM provisions? Is there funding for training for counties and providers?

Witnesses:

Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Corey Hashida, Fiscal & Policy Analyst, LAO and Mark C. Newton, Deputy Legislative Analyst, LAO,
Ryan Quist, Ph.D., Behavioral Health Director, Sacramento County, Secretary-Treasurer, County Behavioral Health Directors Association
Le Ondra Clark Harvey, Ph.D, Chief Executive Officer, California Council of Community Behavioral Health Agencies

3) MCMC Benefit Standardization (related to mental health; requires SMHS provided by Kaiser in Sacramento and Solano counties to be shifted back to the respective counties)

As part of its CalAIM proposal, DHCS is proposing to align benefits across the different MCMC plans. This issue will be discussed more fully on March 16th hearing except for the

requirement that shifts SMHS benefits currently "carved in" (provided directly) by Kaiser in two counties back to the respective county MHPs. Specifically, DHCS is requiring, effective January 1, 2022, SMHS that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties to be provided by those respective county MHPs. Kaiser is a subcontracting plan of Partnership Health Plan in Solano under the county organized health system model of MCMC, and a direct contracting plan under the geographic managed care model in Sacramento County. This "carve in" arrangement is not required through codification in statute or regulation. In the Medi-Cal Estimate, DHCS assumes the estimated savings for managed care annually on an accrual basis is estimated to be $16.7 million total funds (TF) to remove SMHS from the capitated payments to the Solano and Sacramento Kaiser managed care plan. Beginning January 1, 2022, DHCS estimates the estimated savings for five months, on a cash basis is estimated to be $6.9 million TF for FY 2021-22. DHCS assumes that the services would shift to be paid through the county MHPs at the same level, $16.7 million TF annual costs.

Proposed CalAIM TBL:
Requires DHCS, notwithstanding any other law, to standardize those applicable covered Medi-Cal benefits provided by MCMC plans under comprehensive risk contracts with DHCS on a statewide basis and across all models of MCMC in accordance with the proposed TBL and the CalAIM T&C.

Policy Questions:
1) How many Medi-Cal beneficiaries are receiving SMHS through Kaiser in Sacramento and Solano counties?

2) Does shifting this benefit back to the counties require state GF to backfill the shift in service under the requirements of Proposition 30?

3) Does DHCS have a plan for continuity of care so that patients receiving SMHS can maintain their current patient-provider relationship with their Kaiser provider?

Witnesses:
Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Corey Hashida, Fiscal & Policy Analyst, LAO and Mark C. Newton, Deputy Legislative Analyst, LAO
Ryan Quist, Ph.D., Behavioral Health Director, Sacramento County, Secretary-Treasurer, County Behavioral Health Directors Association
Stuart Buttlaire, PhD, Regional Director of Behavioral Health and Addiction Medicine for Kaiser Permanente, Northern CA

4) DMC-ODS Renewal and System Improvements

The DMC-ODS is part of a five-year pilot program originally approved by CMS in 2015 under the Section 1115 Bridge to Reform Demonstration Waiver and continued under the current waiver and waiver extension to test a new method for the organized delivery of health

care services for Medi-Cal-eligible individuals with an SUD. One of the key goals of the DMC-ODS was to treat more people more effectively by reorganizing the delivery system for SUD treatment through Medi-Cal. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction. The benefits under the DMC-ODS, which counties administer as PIHPs under federal Medicaid regulation, include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, NTP and naltrexone), plus the following additional services: case management, multiple ASAM levels of residential SUD treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional MAT, and partial hospitalization.

As part of its CalAIM proposal, DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. The following are the DMC-ODS proposed changes, several of which were included in the 12 month extension request to CMS of Medi-Cal 2020:

Residential Treatment Length-of-Stay Requirements. Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays. DHCS argues residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.

DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements. These changes are subject to CMS approval, and DHCS indicates CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days.

Residential Treatment Definition. DHCS indicates the current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents. DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment (MAT). DHCS would also propose to remove the distinction

between adults and adolescents for these requirements, with the exception of EPSDT services.

Recovery Services. DHCS states that, as part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries are required to be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term "after completing their course of treatment," to not inadvertently prohibit beneficiaries receiving long-term MAT from having access to recovery services. If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022 through December 31, 2026.

Additional MAT. Counties are required to cover opioid treatment program services, also called NTPs. Currently counties may elect to cover additional MAT, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional MAT services as an optional benefit but clarified the coverage provisions to require that all SUD managed care providers demonstrate that they either directly offer, or have referral mechanisms to MAT, with the goal of having a county-wide multi-delivery system of coverage.

Clinician Consultation Services. Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites. DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified DMC

providers. Counties may contract with SUD clinicians not certified by DMC. DHCS indicates its telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements. Currently, providers are required to implement at least two of the following five evidence-based treatment practices based on a timeline established in the county implementation plan:

a) Motivational Interviewing;
b) Cognitive Behavioral Therapy;
c) Relapse Prevention;
d) Trauma-Informed Treatment; and,
e) Psycho Education.

The two evidence-based practices are a per-provider per-service modality. DHCS proposes to retain the five current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process. Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract. DHCS proposes removing this process, arguing it is convoluted, has rarely been used, and it is already addressed by the federal network adequacy requirements, which provide a right to appeal.

Tribal Services. DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices; and,
- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

DHCS indicates these changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based SUD treatment.

Treatment after Incarceration. DHCS indicates the current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, because the individual's substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use. Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known SUD.

Billing for Services Prior to Diagnosis. DHCS indicates that counties may not begin billing for SUD services until a beneficiary has been diagnosed. For example, counties may not bill for time spent conducting SUD assessments. Because it takes time for clinicians to evaluate a beneficiary for a SUD, and sometimes presenting symptoms are due to a combination of mental illness, SUD, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver STCs to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with the previously described requirements for assessments for SMHS.

Medical Necessity for NTP. DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5). DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a SUD.

Proposed Timeline: The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period;
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis;
- Clarify the recovery services benefit;
- Expand access to MAT; and,
- Increase access to SUD treatment for American Indians and Alaska Natives.

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Proposed TBL:

1) Requires DHCS, commencing January 1, 2022, subject to federal approval, to continue to implement the DMC-ODS program, previously authorized under the California Medi-Cal

2020 Demonstration as a component of CalAIM and in accordance with the CalAIM T&C.

2) Requires a county, or consortium of counties in a regional model, that elects to administer, or elects to continue to administer, a DMC-ODS pilot to enter into and maintain an IGT agreement with DHCS.

3) Requires DMC-ODS counties to comply with all applicable CalAIM STCs and any guidance issued by the DHCS.

4) Requires an election by a county, or consortium of counties in a regional model, to participate as a DMC-ODS pilot to be considered voluntary for purposes of all state and federal laws.

Policy Question: Unlike much of the Medi-Cal program, the DMC-ODS provisions are contained almost entirely in the STCs of the state's Medi-Cal waiver. The CalAIM changes to DMC are similarly not proposed for codification in statute. Should these changes be codified in state law or left to the T&C of the CalAIM Waiver?

Witnesses:
Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Veronica A. Kelley, DSW, LCSW, Director, San Bernardino County Department of Behavioral Health, President, County Behavioral Health Directors Association
Albert M. Senella, CEO, Tarzana Treatment Centers, California Association of Alcohol and Drug Program Executives

5) Federal Medicaid Funding Availability for Medi-Cal Beneficiaries in IMDs

In November 2018, CMS announced via a State Medicaid Director letter[19] opportunities for demonstration projects (waivers) under Section 1115 of the Social Security Act to improve care for adults with SMI and children with SED, referred to as the "SMI/SED demonstration opportunity." This SMI/SED demonstration opportunity will allow states, upon CMS approval, to receive FFP for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services.

Under existing federal law, an IMD is defined 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."[20] Services provided to beneficiaries in residential settings may be subject to the payment exclusion for IMDs,[21] which prohibits federal Medicaid payments for an individual who is a patient age 21-64 in an IMD. Under current federal Medicaid managed care

regulations, states can receive FFP for monthly capitation payments paid to Medicaid managed care plans for coverage of Medicaid beneficiaries residing in IMDs when the enrollees that are inpatients in a hospital providing psychiatric or SUD inpatient care or in a sub-acute psychiatric or SUD crisis residential setting if the stay is for no more than 15 days during the period of the monthly capitation payment and certain other conditions are met.[22] Because inpatient SMHS are the responsibility of MHPs, and MHPs are not paid under capitation, California cannot use this option under its existing payment arrangements.

Under the CMS-proposed demonstration, FFP would be available for services for beneficiaries who are short-term residents in IMDs primarily to receive mental health treatment. This option could be used by county MHPs. While residing in those facilities primarily to receive mental health treatment, CMS indicates Medicaid beneficiaries should also be screened for co-occurring SUDs as well as physical health conditions. States with approved demonstrations could also receive FFP for Medicaid coverable services provided to otherwise eligible beneficiaries to treat any co-occurring SUD and physical health conditions while those beneficiaries are residing short term in IMDs primarily to receive mental health treatment.

CMS indicates it will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government. Further, CMS will consider a state's commitment to on-going maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project in order to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. CMS also strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, particularly crisis stabilization services. The CMS guidance sets forth goals, multiple milestones for states to commit to meet, an implementation plan, and a requirement that states include in their 1115(a) demonstration reports information detailing milestones and performance measures representing the key indicators of progress toward meeting the goals of the initiative.

California's current waiver implementing DMC-ODS authorizes expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in IMD.

CalAIM Proposed TBL:

1) Authorizes DHCS, in consultation with counties and other affected stakeholders, during the CalAIM term, as a component of the Specialty Mental Health Program, to seek federal approval for a demonstration project under federal law to receive FFP for services furnished to Medi-Cal beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an IMD.

2) Permits DHCS to elect to seek approval for this demonstration project to operate on a statewide basis, or on a county-by-county basis.

3) Requires DHCS, to the extent DHCS receive the necessary federal approvals to implement the demonstration project, to implement the demonstration in accordance with the terms of that federal approval and only to the extent that FFP is available and is not otherwise jeopardized.

Policy Questions:

1) Does DHCS have authority to submit an IMD waiver under existing law, such as Welfare and Institutions Code Section 14012?

2) How will the state determine whether the mental health delivery system meets the requirements outlined in the CMS guidance?

3) Should this option be subject to an evaluation as it is proposed as a demonstration project under federal law and only for the duration of CalAIM?

Witnesses:

Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Corey Hashida, Fiscal & Policy Analyst, LAO and Mark C. Newton, Deputy Legislative Analyst, LAO
Ryan Quist, Ph.D., Behavioral Health Director, Sacramento County, Secretary-Treasurer, County Behavioral Health Directors Association
Steven Kite, Chief Operating Officer, NAMI – California
Chad Costello, Public Policy Director, California Association of Social Rehabilitation Agencies

6) Administrative Integration of Specialty Mental Health and SUD Services

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. DHCS' goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state. For counties participating in DMC-ODS, DHCS is interested in working toward integrating the two behavioral health programs/PIHP into a single behavioral health plan structure. The result would be a single PHIP structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease

their administrative burden. Additionally, DMC FFS counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-FFS verses PHIPs.

CalAIM Proposed TBL:

1) Requires an individual county or counties acting jointly, notwithstanding any other law, commencing January 1, 2027, to provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal BHDS contract, in accordance with the CalAIM T&C.

2) Requires DHCS, during the CalAIM term, in consultation with counties, to conduct any planning activities it deems necessary and issue related guidance to facilitate implementation.

3) Permits DHCS to authorize a non-county organization that it contracts to provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal BHDS contract, in accordance with the CalAIM T&C.

Policy Questions:

1) Can DHCS accomplish this proposed change administratively, or does it require a change in existing law?

2) Are there any counties that currently provide and administer covered behavioral health Medi-Cal benefits under one combined/single contract?

3) What changes would counties have to make to provide and administer covered behavioral health benefits under a single contract? For example, would they have one intake number for SMHS and SUD, and one combined contract with their contracting health care providers?

4) What is the rationale for effective date of the proposed administrative integration of 2027?

5) How would integrated county administrative structures lead to integrated care?

Witnesses:

Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Veronica A. Kelley, DSW, LCSW, Director, San Bernardino County Department of Behavioral Health, President, County Behavioral Health Directors Association

7) Behavioral Health Regional Contracting

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of SMHS. Furthermore, participating DMC-ODS counties are permitted to develop regional

delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

DHCS encourages counties to develop regional approaches to administer and deliver SMHS and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program or the local MCMC plan, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS indicates it is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under DMC might also be provided through a regional approach. DHCS states it is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

DHCS argues acting jointly through regional contracts would:

- Allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region;

- Allow for increased county administrative efficiencies;

- Give counties opportunities to share workforce and jointly invest in administrative infrastructure such as contracting, electronic health records, billing and claiming systems, and oversight/quality assurance and improvement;

- Reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes;

- Enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible, creating a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of SMHS and SUD Services proposal;

- Reduce the administrative burden of meeting state and federal Medicaid managed care requirements, such as network adequacy, quality assessment and performance improvement, beneficiary right and protections and program integrity; and,

- Better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

Timeline: DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

CalAIM Proposed TBL:

1) Requires a county, or consortium of counties in a regional model, that elects to administer, or elects to continue to administer, a DMC-ODS pilot to enter into and maintain an IGT agreement with DHCS.

2) Requires those counties to comply with all applicable CalAIM T&C and any guidance issued by DHCS as a condition of participation.

3) Requires an election by a county, or consortium of counties in a regional model, to participate as a DMC-ODS pilot to be considered voluntary for purposes of all state and federal laws.

Policy Questions:

1) Is TBL needed to authorize regional contracting?

2) Are there any financial incentives the state can offer to induce counties to enter into regional contracts or to enter into agreements with MCMC plans to offer integrated services?

Witnesses:
Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association

8) Full Integration Plans (one plan providing all Medi-Cal services, including SUD, SMHS, dental, and typical MCMC plan services)

As part of its CalAIM proposal, DHCS indicates it would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current Realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected full integration plans would go live no sooner than 2027.

CalAIM Proposed TBL: There is no proposed TBL on this CalAIM proposal.

Policy Questions:

1) Is the Administration proposing TBL on this proposal?
2) Given the complexity of financing and delivering an integrated plan and the proposed 2027 implementation date, can this proposal be deferred until a future year?

Witnesses:

Will Lightbourne, Director and/or Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Corey Hashida, Fiscal & Policy Analyst, LAO and Mark C. Newton, Deputy Legislative Analyst, LAO,
Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association

Public Comment

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[1] AB 2032 (Wood), AB 2042 (Wood), AB 2055 (Wood), SB 910 (Pan), and SB 916 (Pan).
[2] Letter to Jacey Cooper of DHCS from Anne Marie Costello, Acting CMS Deputy Administrator and Director, dated December 29, 2020 at: https://www.dhcs.ca.gov/provgovpart/Documents/CA-Medi-Cal-2020-Extension-Approval.pdf.
[3] Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs 2015 -2020, Version June 10, 2015, p. 7.
[4] Letter from Carrie Smith, Deputy Director of CMS to Jacey Cooper dated and available at: https://www.dhcs.ca.gov/Documents/CA-17-TE-Approval-12-16-20.pdf
[5] Mental Health and Substance Use Disorder Services Information Notice 16-061, issued December 9, 2016.
[6] 42 CFR, Section 438.2.
[7] The list of nearly 40 carved out psychiatric medications is in APL 17-018. DHCS indicates Health Plan of San Mateo and Kaiser Permanente in Sacramento County have these drugs carved in.
[8] Welfare and Institutions Code Section 14059.5.
[9] Title 42 of USC §1396d, Welfare and Institutions Code Section 14059.5.
[10] California Code of Regulations, Title 9, Section 1830.210.
[11] California Code of Regulations, Title 9, Section 1830.205.
[12] California Code of Regulations, Title 9, Section 1830.205.
[13] California Code of Regulations, Title 9, Section 1830.205.
[14] Mental Health and Substance Use Disorder Services Information (MHSUDS) Notice 16-061, issued December 9, 2016.
[15] California Code of Regulations, Title 9, Section 1810.370(a)(5).
[16] APL 15-007 and MHSUDS Information Notice 15-015.
[17] California Code of Regulations, Title 9, Section 1820.205.
[18] DHCS 1915(b) Waiver Standard Funding Questions, March 24, 2015.
[19] State Medicaid Director Letter # 18—011 from Mary C. Mayhew, Deputy Administrator and Director regarding Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, dated November 13, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
[20] Title 19 of the Social Security Act, Section 1905(i).
[21] Title 19 of the Social Security Act, 1905(a)(29) of the Act.
[22] Title 42 of the CFR, Section 438.6(e).