CalAIM: California Advancing and Innovating Medi-Cal

October 29, 2019

CalAIM

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CalAIM Overview

DHCS has developed a comprehensive and ambitious framework for the upcoming waiver renewals that encompasses a broader delivery system, and program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal.

Includes initiatives and reforms for:

- Medi-Cal Managed Care
- Behavioral Health
- Dental
- Other County Programs and Services

CalAIM Overview

- Medi-Cal has significantly expanded and changed over the last ten years
- Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems
- As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care.

CalAIM Overview

- Offers solutions to reinforce the stability of the Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded.

- Seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM Overview

Advances several key priorities of the Newsom Administration by leveraging Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as:

- homelessness,
- increasing behavioral health care access,
- children with complex medical conditions,
- growing number of justice-involved populations who have significant clinical needs, and
- growing aging population.

CalAIM Overview

The CalAIM package presented here is an initial set of proposals intended to drive discussion and consideration through proposed stakeholder workgroups as well as the legislative process.

Funding for CalAIM will be determined through the budgetary process which will affect which reforms proceed as well as the timeline and scope of such reforms.

CalAIM Goals

CalAIM has three primary goals:

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

Overview of CalAIM Proposals

Identify and Manage Member Risk and Need

The following proposals fall under this goal as well as incorporate the third goal of improved quality outcomes:

- Population Health Management
- Enhanced Care Management
- Mandatory Medi-Cal Application & Behavioral Health Coordination
- In Lieu of Services and Incentives
- Mental Health IMD Waiver (SMI/SED)
- Full Integration Plans
- Long-Term Plan for Foster Care

Population Health Management

Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes.

The plan shall include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Population Health Management

The population health management proposal provides information on the following topics:

- Initial Risk Assessment
- Risk Stratification
- Provider Referrals
- Actions to Address Risk and Need
  - Wellness and Prevention
  - Managing Members with Emerging Risks
  - Case Management
  - In Lieu of Services
  - Coordination between Plans and External Partners
  - Transitional Services
  - Skilled Nursing Facility Coordination
- Plan Oversight and Health Information Technology Support

Enhanced Care Management

- DHCS proposes to establish a new, statewide enhanced care management benefit.
- An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries.
- Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals.
- The proposed benefit builds on the current Health Homes Program and Whole Person Care pilots and transitions those pilots to this new statewide benefit to provide a broader platform to build on positive outcomes from those programs.

Enhanced Care Management

Target populations include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

Enhanced Care Management

DHCS is proposing statewide implementation of the enhanced care management benefit on January 1, 2021 for most mandated target populations and January 1, 2023 for individuals transitioning from incarceration.

Administered by the Medi-Cal managed care plan which will have direct responsibility for establishing model of care and contracting with public and private providers.

Enhanced Care Management

Provider types include, but are not limited to:

- Whole Person Care providers
- Health Homes providers
- Local Governmental Agencies
- Counties (public health, social services, mental health or substance use)
- Public Hospital and Health Systems
- Primary or specialty care provider/clinic
- Federally Qualified Health Center/Rural Health Center/Indian Health Provider/Community Clinics
- Community-based organizations
- Behavioral health provider

Enhanced Care Management

- Due to duplication of services and target populations and concerns from CMS regarding duplication of federal funding, DHCS will no longer allow participating Local Governmental Agencies to provide Targeted Case Management to Medi-Cal beneficiaries enrolled in managed care after January 1, 2021.
- Medi-Cal managed care plans will be required to submit a transition plan to the State by July 1, 2020 demonstrating how they will transition such existing programs into their enhanced care management and in lieu of services programs; and demonstrate a good faith effort to come into agreement with such health homes providers, Whole Person Care entities and Local Governmental Agencies already providing such services.

Mandatory Medi-Cal Application & Behavioral Health Coordination

- DHCS is proposing to mandate all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022, which would include juvenile facilities.
- The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment, receive timely access to Medi-Cal services upon release from incarceration.
- Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community.

In Lieu of Services

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health and social services to improve beneficiary health outcomes.

However, the implementation of these programs has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

In Lieu of Services

"In lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. An in lieu of service can only be covered if:

- The State determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for beneficiaries; they are not required to use the in lieu of services; and
- The in lieu of services are authorized and identified in the State's Medi-Cal managed care plan contracts.

In Lieu of Services

- Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care management benefit.
- In lieu of services may be focused on addressing combined medical and social determinants of health needs and avoiding higher levels of care.
- For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use.

In Lieu of Services

DHCS is proposing to cover the following distinct services as in lieu of service under Medi-Cal managed care. Details regarding each proposed set of services are provided in Appendix D of the CalAIM proposal.

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Nursing Facility Transition to a Home
- Personal Care (beyond In-Home Supportive Services) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers

Incentive Payments

- DHCS is proposing to establish plan incentive payments linked to delivery system transformation through an investment in enhanced care management and in lieu of services infrastructure.
- The incentive payments would also be based on quality and performance improvements and reporting in areas such as care coordination, long-term services and supports and other cross-delivery system metrics.
- The purpose of incentive payments is to drive change all the way down to the provider level
- Medi-Cal managed care plans would need to partner and share the incentive dollars with providers in the community, including our critical safety net systems such as Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital systems, and county behavioral health systems and providers

Incentive Payments

The proposed incentive payments are intended to:

- Build access to enhanced care management for medically complex children and adults to ensure they get their physical, behavioral, developmental and oral health needs met;
- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;
- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program by 2026;
- Build the necessary clinically-linked housing continuum for our homeless population;
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail; and
- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

Mental Health
IMD SMI/SED Waiver

On November 13, 2018, CMS issued a State Medicaid director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness and children with serious emotional disturbance who are enrolled in Medicaid.

Allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease.

Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries.

IMD SMI/SED Waiver

DHCS would like to collaboratively assess through the stakeholder process whether California should pursue this serious mental illness/serious emotional disturbance via a Section 1115 demonstration.

Similar to the State's existing 1115 demonstration to provide residential and other substance use disorder treatment services under Medi-Cal, county participation would be on an opt-in basis.

IMD SMI/SED Waiver

Below is a summary of key requirements that may pose feasibility challenges:

- Average Length of Stay
- Maintenance of Effort
- Readiness Requirements
- Data Collection and Required Measures
- Health Information Technology
- Staffing Considerations

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the Appendix E of the CalAIM proposal.

Full Integration Plans

- Currently, Medi-Cal beneficiaries must navigate multiple complex delivery systems in order to meet all of their health care needs.

- This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries.

Full Integration Plans

- DHCS would like to test the effectiveness of 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:
  - eligibility criteria for entities,
  - administrative requirements across delivery systems,
  - provider network requirements,
  - quality and reporting requirements, and
  - complex financial considerations including current sources of non-federal share, county/state financing and realignment/Prop 30
- Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024.

Long Term Plan for Foster Care

- DHCS proposes convening a workgroup, in 2020, of interested stakeholders to consider whether a different model of care should be implemented for children and youth in foster care, including the former foster youth program and transitions out of foster programs and services at age 26.
- DHCS would invite and encourage participation from key partners including but not limited to: the Department of Social Services; the Department of Education; child welfare county representatives and State level associations; Medi-Cal managed care plans; behavioral health managed care plans; juvenile justice and probation; foster care consumer advocates; regional centers; and judicial entities involved with matters pertaining to children who are placed into the foster care system.
- The goal of the workgroup would be to develop one or more recommendations regarding changes to the delivery systems and models of care for this population that could then be implemented in order to improve outcomes for this population

Moving Medi-Cal to a Consistent and Seamless System

The following proposals fall under this goal as well as incorporate the third goal of improved quality outcomes:

- Standardize the Managed Care Benefit
- Standardize Managed Care Enrollment
- Transition to Statewide MLTSS
- Annual Medi-Cal Health Plan Open Enrollment
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Rates for Medi-Cal Managed Care
- Behavioral Health Proposals
  - Payment Reform
  - Revisions to Medical Necessity
  - Administrative Integration Statewide
  - Regional Contracting
  - SUD Managed Care Renewal (DMC-ODS)
- Future of Dental Transformation Initiative Reforms
- Enhancing County Oversight and Monitoring
- Improving Beneficiary Contact and Demographic Information

Standardize Managed Care Benefit

- Currently Medi-Cal beneficiaries experience differences regarding which services are provided through a Medi-Cal managed care plan vs fee-for-service or another delivery system, depending on their county of residence
- CalAIM proposes to standardize the benefits that are provided through Medi-Cal managed care plans statewide, effective January 1, 2021
- Under this proposal the following changes would be made to align the managed care benefit across the state:
  - Carved Out
    - All prescription drugs and/or pharmacy services billed on a pharmacy claim (Medi-Cal Rx)
    - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties
    - Multipurpose Senior Services Program
  - Carve In
    - All institutional long-term care services
    - All major organ transplants

Standardize Managed Care Benefit

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long term care and transplant providers accept and require the Medi-Cal Managed Care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan enter into a mutually agreed upon alternative payment methodology.

This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

Standardize Managed Care Enrollment

DHCS is proposing to standardize managed care enrollment statewide, so that the same populations are mandatory or excluded from Medi-Cal managed care.

DHCS is proposing implementation of this change in two phases:

- Effective January 1, 2021, all non-dual populations will be standardized as either mandatory or excluded from plan enrollment
- Effective January 1, 2023, all dual-eligible populations will be standardized as either mandatory or excluded from plan enrollment (this aligns with the transition from Coordinated Care Initiative and discontinuation of the CalMediConnect program. See Appendix G of the CalAIM proposal for further details)

Standardize Managed Care Enrollment

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2021:

- Individuals eligible for long-term care services (includes long-term care share of cost populations)
- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage
- Beneficiaries living in rural zip codes

All dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care in 2023

Standardize Managed Care Enrollment

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment:

- Omnibus Budget Reconciliation Act: This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of cost: beneficiaries in County Organized Health Systems (COHS) and Coordinated Care Initiative counties

Standardize Managed Care Enrollment

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

Transition to Statewide Managed Long Term Services and Supports

- DHCS is proposing to discontinue the Cal MediConnect component of the Coordinated Care Initiative and begin a transition to statewide managed long-term services
- This transition includes requiring all Medi-Cal Managed Care plans to also operate Dual Eligible Special Needs Plans
- This effort builds on the successes and learnings from Cal MediConnect and the Coordinated Care Initiative, as well as promising practices from innovative managed long-term services and supports and Dual Eligible Special Needs Plan models in other States.

Transition to Statewide Managed Long Term Services and Supports

The timeline for this proposal is as follows:

- Discontinue Cal MediConnect on December 31, 2022;
- Transition the Coordinated Care Initiative through statewide integration of long-term care into managed care for all Medi-Cal populations by 2021 and requiring statewide mandatory enrollment of dual eligibles in a Medi-Cal managed care plan by 2023;
- Require Medi-Cal managed care plans operate Dual Eligible Special Needs plans as of January 1, 2023 and explore enrollment options

Annual Medi-Cal Health Plan Open Enrollment

- Currently, in counties with more than one Medi-Cal managed care plan, enrollees may change their Medi-Cal managed care plan every month. This activity limits the plans' ability to provide adequate and appropriate care coordination to their members.
- An annual Medi-Cal managed care plan open enrollment process would allow enrollees to change their Medi-Cal managed care plan only during a specified open enrollment period, however, exceptions will be allowed based on a consumer-friendly process that recognizes true needs for a change in plan.
- An annual enrollment period would be consistent with health care industry practices and align with best practices for quality health care delivery.

Annual Medi-Cal Health Plan Open Enrollment

At a minimum, the following enrollees would have the option to change their initially selected Medi-Cal managed care plan:

- During the first year of enrollment for a beneficiary whose plan was assigned through the default enrollment process;
- During the first year of enrollment for a newborn that is automatically assigned to their mother's Medi-Cal managed care plan;
- An enrollee for whom their primary care provider and/or specialists, has terminated his/her contract with the Medi-Cal managed care plan that they are enrolled in, but that provider is available in the other Medi-Cal managed care plan in the county or another provider that is preferred by the beneficiary is available in a different network than their existing plan; and
- At any time, for "good cause" as defined in regulation. Examples include, but are not limited to:
  - Transgender services not available in network;
  - HIV/AIDS services not available in network;
  - Lack of access to services covered under the contract; and
  - Conditions whose management requires coordination of multiple specialties.

Note: The option to change the initially selected Medi-Cal managed care plan would not apply to an enrollee upon a termination and reinstatement of their Medi-Cal, if such reinstatement is made within one year or is retroactive to the date of termination of their Medi-Cal eligibility

NCQA Accreditation of Medi-Cal Managed Care Plans

- DHCS recommends requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be NCQA accredited by 2025.
- This will streamline Medi-Cal managed care plan oversight and increase standardization across plans
- DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.
- Considering requiring Medi-Cal managed care plan NCQA accreditation to include the Long Term Services and Supports Distinction Survey, given movement to MLTSS.
- DHCS is also interested in discussing the addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as this could potentially maximize the opportunity for streamlining state compliance and deeming.

Regional Rates for Medi-Cal Managed Care

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program, including those proposed in CalAIM. This change is necessary to allow the capacity for the other CalAIM proposals.

Phased approach for implementation:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2021 and 2022 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2023, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

Behavioral Health Payment Reform

- As a part of CalAIM, DHCS proposes to reform the Medi-Cal behavioral health payment methodologies via a multi-phased approach
- A change is required in order to allow for the possibility to incentivize outcomes and quality as well as potential to increase reimbursement
- The first step in payment reform would be to shift away from the cost-based Certified Public Expenditure-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county non-federal share.

Behavioral Health Payment Reform

DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and substance use disorder services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding; 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 via intergovernmental transfer instead of Certified Public Expenditures, eliminating the need for reconciliation to actual costs.

Behavioral Health Payment Reform

The shift from Certified Public Expenditure to other 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;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce State and county administrative burdens and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Behavioral Health Payment Reform

- 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.
- This 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.

Revisions to Behavioral Health Medical Necessity

To ensure beneficiary behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties for providing behavioral health services, DHCS is proposing to:

- Separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services.
- Allow counties to provide and be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the mental health or substance use disorder provider determining whether the beneficiary has a covered diagnosis.

Revisions to Behavioral Health Medical Necessity

- Identify an existing or develop a new statewide, standardized level of care assessment tool – one for beneficiaries 21 and under and one for beneficiaries over 21 – that would be used by all entities to determine a beneficiary's need for mental health services and which delivery system is most appropriate to cover and provide treatment.
- Revise the existing intervention criteria to clarify that specialty mental health services are to be provided to beneficiaries who meet the eligibility criteria for specialty mental health and that services are reimbursable when they are medically necessary and provided in accordance with the Medi-Cal State Plan instead of the existing state service criteria.
- Align with federal requirements by allowing a physician's certification/recertification to document a beneficiary's need for acute psychiatric hospital services.
- Other technical corrections.

Revisions to Behavioral Health Medical Necessity

- As a part of this change, CalAIM proposes that eligibility criteria, largely driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, should be the driving factor for determining the delivery system in which someone should receive services.

- Each delivery system would then provide services in accordance with an individualized beneficiary plan, as recommended by a physician or other licensed mental health professional.

Revisions to Behavioral Health Medical Necessity

- DHCS is also proposing a no wrong door approach with children under the age of 21.
- Regardless of which delivery system a child first presents in, that system will be responsible for providing services, doing an assessment and either providing ongoing treatment or referring the child to the appropriate delivery system.
- Both the Medi-Cal managed care plan and mental health managed care plan would be reimbursed for all medically appropriate services provided to a child, even if the child ultimately moves to the other delivery system.

Administrative Behavioral Health Integration Statewide

- DHCS is proposing administrative integration of specialty mental health and substance use disorder services into one behavioral health managed care program.
- The 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.
- The result would be, by 2026, a single prepaid inpatient health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder treatment services for all Medi-Cal beneficiaries in that county or region.
- Substance use disorder fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Administrative Behavioral Health Integration Statewide

Clinical Integration	Administrative Functions	DHCS Oversight Functions
• Access Line • Intake, Screening and Referrals • Assessment • Treatment Planning • Beneficiary Informing Materials	• Contract • Data Sharing/Privacy Concerns • Electronic Health Record Integration • Cultural Competence Plans	• Quality Improvement • External Quality Review Organization • Compliance Reviews • Network Adequacy • Licensing and Certification

Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations and encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder 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.
- 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, 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 is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach.
- DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

Substance Use Disorder Managed Care Renewal

- The 30 counties that have implemented the substance use disorder managed care program (also known as DMC-ODS) have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with substance use disorder treatment needs.
- Implementation has yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.
- However, for many counties, the substance use disorder managed care model of care is still very new or hasn’t been able to be implemented.

Substance Use Disorder Managed Care Renewal

DHCS would like input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level:

- Residential treatment length-of-stay requirements
- Residential treatment definition
- Recovery services
- Additional medication assisted treatment
- Physician consultation services
- Evidence-based practice requirements
- Provider appeals process
- Tribal services
- Treatment after incarceration
- Billing for services prior to diagnosis

Future of Dental Transformation Initiative Reforms

Based on our lessons learned from the Dental Transformation Initiative, DHCS proposes the following statewide reforms:

- New dental benefits:
  - Caries Risk Assessment Bundle for young children
  - Silver Diamine Fluoride for young children and specified high risk and institutional populations
- Pay for performance initiatives:
  - Increasing the use of preventive services for children and adults
  - Establishing/maintaining continuity of care through a Dental Home

Enhancing County Oversight and Monitoring: Eligibility

Federal, State, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act have identified a number of issues that must be addressed and resolved.

- Findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing.
- Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program.

Federal audit findings have also levied fiscal penalties upon DHCS, requiring the State to repay the federal matching funds that were claimed as a result of erroneous Medi-Cal eligibility determinations.

Enhancing County Oversight and Monitoring: Eligibility

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- Reinstate county performance standards
- Develop an updated process for the monitoring and reporting of county performance standards
- Ensure DHCS/County partnership through regular meetings and open lines of communication
- Develop a tiered corrective action approach
- Incorporate fiscal penalties as part of the tiered corrective action approach
- Incorporate findings/actions in public facing report cards

For detailed timeline, see CalAIM proposal.

Enhancing County Oversight and Monitoring: CCS and CHDP

- DHCS intends to provide enhanced monitoring and oversight of all 58 counties to promote continuous and optimal care for children.
- To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program.
- Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements.
- Ongoing quality assurance and data reviews are foundational to ensuring compliance and continued improvements in program operations and beneficiary care.

Enhancing County Oversight and Monitoring: CCS and CHDP

Phase I: July – September 2020

- Review of current standards, policies, and guidelines
- Development of goals, performance measures, and metrics

Phase II: April – June 2021

- Development of auditing tools

Phase III: April – June 2022

- Evaluate and analyze findings and trends
- Identify gaps and vulnerabilities

Phase IV: October 2022- Ongoing

- Initiate Memorandum of Understanding between State and counties
- Continuous monitoring and oversight
- Continuous updates to standards, policies, and guidelines
- Shift to an automated plan and fiscal guidelines (PFG) submission

Improving Beneficiary Contact and Demographic Information

- Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries.
- This information is used by DHCS, providers, counties and Medi-Cal managed care plans, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.
- DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities, and the means to accomplish this while maintaining compliance with all applicable State and federal privacy laws.
- The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

From Medi-Cal 2020 to CalAIM: A Crosswalk

From Medi-Cal 2020 to CalAIM: A Crosswalk

The State is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for States interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years.

- The federal government no longer considers the “savings” generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers.
- CMS, in recent guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

The following slides outline the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements.

From Medi-Cal 2020 to CalAIM: A Crosswalk

Medi-Cal 2020 Waiver Component	Planned for CalAIM	Timeline
Medi-Cal Managed Care	Transition to new 1915(b) waiver.	January 1, 2021
Whole Person Care Pilots	Transition to new 1915(b) waiver.	January 1, 2021
PRIME	Transition to managed care directed payment under the Quality Incentive Program (QIP).	QIP 2.0 – July 1 – December 31, 2020 QIP 3.0 – January 1, 2021
Health Homes Program	Transition to new 1915(b) waiver.	January 1, 2021
Coordinated Care Initiative and Cal MediConnect	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	1915(b)/1115A to continue current CCI program with end date of December 31, 2022 January 2021 - Carve out MSSPs; LTC carved in January 2023 – full transition all duals into managed care statewide; all Medi-Cal managed care plans to operate DSNPs

From Medi-Cal 2020 to CalAIM: A Crosswalk

Medi-Cal 2020 Waiver Component	Planned for CalAIM	Timeline
Global Payment Program	1115 waiver renewal.	GPP program year ends June 30, 2020; renewal request to begin GPP extension on July 1, 2020.
Drug Medi-Cal Organized Delivery System (DMC-ODS)	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	Implementation continues; transition to 1915(b) waiver in January 2021
Dental Transformation Initiative	Transition authority to Medi-Cal State Plan.	January 1, 2021
Community-Based Adult Services (CBAS)	Transition to new 1915(b) waiver.	January 1, 2021
1115 Eligibility and Population Authorities	1115 waiver renewal.	January 1, 2021
Rady CCS Pilot	Not included.	Pilot expires on December 31, 2020
Designated State Health Programs (DSHP)	Not included.	Expires December 31, 2020
Tribal Uncompensated Care	Not included.	Expires December 31, 2020

Advancing Key Priorities

Advancing Key Priorities

CalAIM aligns with and advances several key priorities of the Newsom Administration.

At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings.

CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care, and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission

The following slides provide an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed

Advancing Key Priorities

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

Advancing Key Priorities

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries through a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Advancing Key Priorities

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, eligibility for, and access to integrated behavioral health care.

Advancing Key Priorities

Vulnerable Children: CalAIM would provide access to enhanced care management for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Advancing Key Priorities

Homelessness and Housing: The addition of in lieu of services would build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

Advancing Key Priorities

Justice Involved: The Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and reentry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons who are incompetent to stand trial and other forensic state-responsible populations.

Advancing Key Priorities

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component of the State's Master Plan on Aging.

Stakeholder Engagement

Stakeholder Engagement

Throughout 2019 and 2020, DHCS will conduct extensive stakeholder engagement for both CalAIM and the renewal of the 1115 and 1915b waiver(s).

DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.

Stakeholder Engagement

DHCS is undertaking a robust CalAIM workgroup process that will cover key issue areas:

- Requiring Medi-Cal managed care plans to submit **Population Health Management** strategies and moving to annual Medi-Cal managed care plan open enrollment
- Adding a new **Enhanced Care Management** benefit and a set of **In Lieu of Services**
- **Behavioral Health** payment reform and delivery system transformation
- Requiring **National Committee on Quality Assurance (NCQA) accreditation** for Medi-Cal managed care plans
- Considerations for creation of **Full Integration Plans** where one entity would be responsible for the physical, behavioral and oral health needs of their members

CalAIM Workgroups

Each CalAIM workgroup will be open to the public, so DHCS encourages interested parties to attend and/or submit written comments. Workgroup schedules, agendas, materials, and other CalAIM updates will be made available on the CalAIM webpage.

DHCS will also use the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC to provide critical updates on the CalAIM initiatives on an ongoing basis. While most aspects of CalAIM will be discussed through workgroups, it will not be possible to cover all of the topics for which we have CalAIM proposals. Updates on those proposals that are not presented in the workgroups will be provided during SAC and BH-SAC meetings in early 2020.

Stay Informed

Please subscribe to DHCS' stakeholder email service to receive CalAIM updates.

Listen-in on all workgroup meetings and attend the SAC and BH-SAC meetings.

For any other comments, questions, or concerns, please contact CalAIM@dhcs.ca.gov.

Committee Discussion