



Understanding CalAIM: Managed Care as the Center of the Medicaid Universe and a Focus on Behavioral Health Reform

Alex Briscoe, Principal, The California Children's Trust

On Monday, October 28th, the California Department of Health Care Services (DHCS) released a comprehensive plan to reform the state's medical program (MediCal). Called the California Advancing and Innovating Medi-Cal initiative, or [CalAIM](#), at 181 pages, the plan is long and contains a mix of practical and aspirational proposals that touch on many aspects of one of the largest health programs in the world. It also includes the state's strategies for renewing, reforming, and sustaining critical safety net programs administered under the 1915b and 1115 waivers.

But to see CalAIM as just a waiver renewal strategy is far too narrow an interpretation of what the state has proposed. CalAIM does not seek to end the carve-out for specialty mental health services, but it clearly doubles down on the role of managed care organizations (health plans) as central actors, brokers, care coordinators, and payors for an increasing number of MediCal's fragmented delivery and administrative systems. From mandatory enrollment for previously excluded populations to new requirements for case management, prevention services, and population health, CalAIM builds on the state's vision to use plans as the tie that binds California's struggling health and human services safety net. DHCS acknowledges that plans have struggled to play this role effectively despite its increasing reliance on them to do so—and to be fair, it is a large task. CalAIM doesn't really redraw any lines on the map, but it does seek to clarify the roles and responsibilities of various actors and it does propose fundamental payment and definitional reform of behavioral health—the focus of The Children's Trust's advocacy to date.

And while there are some proposals on county-level enrollment and eligibility reform, and some public health programs, there are just two core components of CalAIM: Managed Care Reform and Behavioral Health Reform. The mechanisms are both waivers (more 1915b than 1115) and increasingly, DHCS's strategies are based in existing administrative authority under the state plan. These focus on sustaining and institutionalizing pilots from previous waivers in the plans, applying lessons learned from the implementation of the Affordable Care Act, standardizing and improving benefits and plan performance...and yes, transforming behavioral health.

In its own words, DHCS is seeking to integrate the delivery systems and align funding,

data reporting, quality, and infrastructure to mobilize and incentivize multiple system stakeholders toward three common goals:

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

Timeline...What Happens When

CalAIM is just a proposal. DHCS plans to finalize all proposals for submission to Center for Medicaid Services between May and July 2020. The two-page timeline for the numerous workgroups and associated planning bodies is on page 113 of the proposal and worth a quick review as it will also help you understand the depth and breadth of what is happening. Again, it's a lot. It is fair to say that more than a few of us think the state does not have the capacity to execute all of it in the timelines proposed.

A Win Is a Win. Two Key Takeaways

CalAIM proposes real and substantive changes for specialty mental health. It is far and away the most ambitious and courageous action by DHCS on mental health in more than 20 years.

Despite its many flaws, missing pieces, failure to center the needs of children or name structural racism, and many unanswered questions about implementation and funding... there is a lot to like in the proposal.

There are two key takeaways from the CalAIM proposal regarding our effort to reform the children's mental health system—and they are two big wins.

First, **DHCS has proposed fundamental Behavioral Health Payment Reform in the language and form proposed by the Trust.** DHCS proposes shifting from the current practice of requiring Mental Health Plans to fully fund all services with non-federal dollars and then retroactively settle the cost with the state, feds, and their providers per minute, per service, per patient. As proposed in our [Financing Brief](#), the state has proposed moving county mental health plans from a Certified Public Expenditure methodology to Intergovernmental Transfer. See page 72 of the proposal, which says:

“This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from Certified Public Expenditure-based methodologies to other rate based/value-based structures that instead utilized intergovernmental transfers to fund the county non-federal share.”

This change will eliminate the cost settlement process and shift the state, at least initially, to a regional rate-based system. (p. 72) The state will set regional rates, which will change how services are coded and reimbursed to counties and the providers they contract with. All will shift to Current Procedural Terminology (CPT) codes. (p. 76.)

This methodological change should dramatically increase federal revenue for counties, and it opens up the possibility of claiming against non-federal dollars already being spent in other child-serving systems—which was pioneered under Whole Person Care Pilots and is a foundational concept the Trust has promoted. Many questions remain (mechanism and process, impact on budget neutrality calculation, CMS approval, among others) but this change is the win we sought on the finance side.

Second, **CalAIM proposes the removal of diagnosis as a prerequisite for access to care.** DHCS proposes shifting to a “level of impairment” model, removing diagnosis as the qualifying mechanism. Even further, the state wants to allow reimbursement to Mental Health Plans during the time it takes to decide if another delivery system is appropriate. (p 76.) CalAIM will:

“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.” (p. 74.)

And the state affirms EPSDT is different and cannot be restricted:

“DHCS believes that it is appropriate to expand the concept of medical necessity to ensure that services are reimbursable if provided in accordance with these service definitions... And for beneficiaries under the age of 21, each delivery system should provide mental health services according to the broader EPSDT guidelines.” (p. 78.)

This language is extraordinary and welcome, but falls short of our desire to redefine behavioral health as a support for healthy development and not a response to pathology—what we have sometimes referred to as breaking out of the constraints of the medical model. The plan gets fuzzy on exactly what the state will use as criteria (pp. 77-78.), and there remains obligatory language on medical necessity—the Feds do require this—as “those recommended by a physician or other licensed mental health professional.” (p. 77.)

The proposal is disjointed and contradictory at times here—both citing EPSDT (above), while also proposing a new statewide level of care tool (yet to be determined but probably the Child and Adolescent Needs and Strengths) for everyone under 21. (p. 75.)

The proposal includes a clear intention to expand access, acknowledgement of the unique nature of EPSDT, commitment to moving away from diagnosis driven reimbursement, intention to reduce administrative burdens on plans and providers and develop more consistent statewide models, and an opening of the door for increasing federal revenue via new claiming models. Yet critical questions remain about enhancing the quality of clinical programs for those who need them, and how the system will create/support the social models and peer programs that increasing evidence and patient experience data point to as essential but missing supports.

As the Buddhists say, the truth will be in the unfolding.

Other Behavioral Health Items of Note:

Beyond the two foundational changes highlighted above (transitioning from Certified Public Expenditure to Intergovernmental Transfer and shifting away from medical necessity),

CalAIM proposes a number of other important reforms relevant to behavioral health and The Children's Trust Policy Agenda:

- DHCS proposes setting **statewide rates by regions**.
- DHCS proposes the adoption of two **standardized levels of care** instruments—one for youth and young adults under the age of 21, and one for adults over 21.
- DHCS proposes the formal **administrative integration of the substance abuse and mental health** services (done in name only in some counties in the late 90's; counties including LA administer them separately). This is a massive undertaking and the rationale is clear and compelling. Plans to extend and sustain the drug MediCal waiver are also detailed.
- DHCS proposes a planning process for a **Long-Term Plan for Foster Care**.
- DHCS proposes to somehow incentivize **regional contracting** models—a clear nod to financing and administrative challenges in small counties.
- DHCS announces its intent to **explore fully integrated plans**.

Critical Parts of the Managed Care Proposals for the Coalition to Track

To repeat: It is critical to track and explore how managed care plans evolve and engage with traditional safety net actors, and how they meet the new demands the state has specified regarding population health and the social determinants of health.

The state appears to be trying to get plans out of the practice of chasing the high cost consumer and into prevention and population health. Easy things to say, harder to regulate in a very competitive health care landscape. This is the right intention, and it will be hard: Simply put, plans in California have struggled to do this, it is not their normal practice, and all the financial incentives that plans work under push them towards a focus on high-cost adult populations.

Specifically, the state will now require each Managed Care Organization to have a **Population Health Management Program** (p. 26) to actually implement **Referral Tracking** programs (p. 28). The state will require plans to submit plans showing how they will include **prevention services for children per the AAP Bright Futures Guidelines** (p. 29). It can certainly be argued that these are not new requirements.

More directly, the state has proposed a new **Enhanced Case Management benefit** (p. 31 and p. 38) and specified target populations. This will cost money, and the proposal does not specify where it will come from. Children are only included as a required population if they are high-need or medically fragile—but an important citation to note is this one regarding Case Management and Care Coordination Contracting Between MCOs and MHPs on page 38:

“For individuals with a primary serious mental illness diagnosis, children with serious emotional disturbance, or substance use disorder, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, so long as they agree to coordinate all the services (physical, developmental, oral or long-term care) needed by those target populations, not just their behavioral health needs.”

CalAIM envisions MCOs contracting directly with public system partners, and in the child

and family world, with community-based organizations that make up the vast majority of safety net providers.

The state also specifies its intention to use **In Lieu of Services** (p. 32) to sustain Whole Person Care pilot programs and encourage their adoption statewide. Such a strategy could also be used for social models, peer-to-peer programming, dyadic therapy or treatment for learning disorders—critical services that don't neatly fit in an existing payment program. The state certainly didn't intend it that way but we should track implementation with an eye for using it creatively. Like the enhanced case management benefit, "in lieu of services" offers a new mechanism (payor) for community-based child and family service providers to engage with MediCal—albeit via Managed Care Organizations (public and private plans) that have been notoriously difficult to engage and who have limited experience partnering with child-serving systems.

Finally, DHCS teases a future community health record of some kind with its statement of resources and commitment to a **Health Information Technology for Integrated Care** (p. 35). Clearly, existing Electronic Health Records are not viable for community-based providers or linkages to non-clinical care and support. This offers promise for professionals across child-serving systems, and for families and advocates to directly engage in care coordination and management.

Conclusion:

The state has proposed fundamental payment reform consistent with major tenets of the Trust's Policy Agenda. Critical reform proposals include fundamental reform of what is eligible for reimbursement and how the reimbursement will be administered and documented. The proposal does not do enough to center racial justice, or properly or effectively clarify how it will promote or incentivize delivery system reform and child-serving system integration and expansion.

It will be critical to track these discussions as the CalAIM workgroups and planning process launch. We intend to do so, and track the work of many colleagues and partners who are working on these issues.

Here is a link to the [FULL CalAIM PROPOSAL](#).

And here is a link to the Stakeholder Advisory Committee [Summary PowerPoint](#).

I look forward to continuing the conversation.

Alex Briscoe
alex@cachildrenstrust.org

The CCT Policy Agenda targets systems change based on three areas of advocacy that center Equity and Justice 1) Redefine Behavioral Health as a Support for Healthy Development 2) Restructure Systems 3) Improve and Expand Public Financing.