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Will Lightbourne, Director
Jacey Cooper, State Medicaid Director and Chief Deputy Director of Health Care
California Department of Healthcare Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, California 95899

Submitted via email to CalAIM@dhcs.ca.gov

Subject: Feedback on CalAIM and the 1115 Demonstration and 1915(b) Waiver

Thank you for the opportunity to provide feedback on the updated CalAIM proposal as well as the 1115 Demonstration and 1915(b) Waiver. The California Children's Trust (CCT) and the California Alliance of Child and Family Services (The Alliance) continue to support the broad goals outlined in the updated proposal. As with most large-scale systems transformations, much of the impact of these initiatives is not felt by providers and consumers until the details of an initiative's implementation are developed. Below we offer comments, some suggestions, and questions for the department that we feel are critical to answer as the state begins to shape the structure of the MediCal system of the future.

No Wrong Door:

While there is progress in advancing the relationship between MCPs and MHPs and their shared role in providing children's mental health services in either system, the creation of tools to determine the system in which services should be provided adds an administrative burden and creates a barrier to access.

The 1915(b) waiver overview (p. 27/60) emphasizes a "No Wrong Door" approach to mental health services stating: "*DHCS proposes to ensure that beneficiaries receive the care they need, no matter how they enter the system.*" The paragraphs immediately following this declaration outline multiple screening processes and the creation of four new screening tools -- two for persons seeking services for the first time (one for those under 21 and one for those over 21) and two additional age-designated tools to screen individuals transitioning between MCP and MHP services. The concept of a "no wrong door" means when you enter the door, you are served. It does not mean you are screened and sent elsewhere.

When youth or their families reach out to access behavioral health services in the public system, it has likely taken them significant emotional and psychological effort just to reach out for help. To create any additional “doors” that have to be opened to get treatment will more often than not result in them retreating from help they need.

Further, DHCS states (p. 20/60) it intends to “*streamline and simplify assessment and documentation requirements.*” The creation of four new digital screening tools will not simplify the process. They will be layered into the state’s siloed mental health system -- a system that already loses more than 40% of clinician time to documentation.

Fiscal Structure is Paramount to Success:

The 1915(b) waiver proposes moving county mental health plans from a Certified Public Expenditure (CPE) methodology to Intergovernmental Transfer (IGT)—which could increase federal revenue for counties and open up the possibility of claiming against non-federal dollars already being spent in other child-serving systems. However, there are multiple unanswered questions that prohibit us from fully evaluating the proposal. We appreciate that DHCS has listened to our concerns and pledged to address them (including modeling at the local MHP level) in advance of implementation in July 2022. Following are the questions that we see as critical to the design of the waiver:

1. Will the IGT mechanism expose MHPs to an Upper Payment Limit (UPL) calculation? We understand that the MHPs cannot be paid more than the state would pay under the state plan, which outlines the reimbursement process as it currently exists. How will this change under IGT?
2. What will the process be for setting rates? Given that rates will need to be approved by CMS, and that prior years’ cost reports will likely be used as a benchmark for determining rates under IGT, it seems imperative that a design for proposing and testing rates prior to full implementation will be essential. We would also request clarity on what efforts the state will make to ensure that there is guidance provided for MHPs on rate setting for community based organizations (CBOs). This will ensure that the payment reform efforts are felt throughout the system of care.
3. Has DHCS done a comparison of the CPT Schedule to County Cost Reports? Changing from the use of HCPCS codes to CPT codes, which create more specificity but are also not bundled as many HCPCS codes are, is one of the many significant components of the CalAIM effort. As with rate processes, the need to compare the proposed CPT Schedule with the current County Cost Reports will be critical in order to ensure that the system is adequately funded.
4. MHP’s play a number of roles outside their Pre-Paid Inpatient Health Plan (PIHP) status. Many of these roles are defined/required in Welfare and Institutions Code and other health and safety codes. How will these other functions be accounted for (e.g. detainee health, 5150 management and regulation, MHSA administration and compliance)?

5. How will the separate Federal Financial Participation (FFP) programs be handled in the shift? There are four FFP programs in the state cost report:
- Administrative
 - Utilization Review/Quality Assurance (UR/QA)
 - Mental Health MediCal Administrative Activities (MAA)
 - Direct Services

No detail is provided in the proposal about these additional service and billing codes that MHPs (and in some cases, CBOs) utilize in performing MediCal program activities. These help to fund the infrastructure and administration of the system, so understanding how these will be managed within the structure of IGT is essential.

Medical Necessity:

A core objective of CalAIM in addressing high-need individuals should be intervention early in the lives of Medi-Cal enrollees to mitigate the onset of conditions in the first place. By identifying emerging risks early in a child’s life and following up with appropriate, coordinated, and timely care and support services, Medi-Cal can contribute to setting a child’s life on a course of health and wellbeing by preventing or mitigating conditions in adulthood. For example, health systems should proactively nurture healthy relationships and resilience of young children and their families, and identify and address developmental, social-emotional, behavioral, and other related issues at the earliest stages, before they spiral into long-term, high-cost needs. *The system must shift from a diagnosis-driven system to an approach that reflects an understanding of the impact of trauma and the social determinants of health on long-term health and mental health outcomes for children and youth.*

The list of conditions on pages 24 and 25 of the proposal miss the essence of DHCS’s previous articulated statement: *“If your condition produces debilitating symptoms or side effects, then it is considered medically necessary.”* The range of circumstances that could lead someone to feel debilitated is so vast and personal, no screening tool could calculate a score. The mere act of a beneficiary seeking help should be all that is needed to deem a mental health service necessary. Beneficiaries should be able to determine whether their experiences rise to the level of needing support without the use of a rigid and often re-traumatizing screening tool.

We suggest the following changes to criteria 1 on page 25:

“Criteria 1: The beneficiary has a condition that puts the child or youth at high risk for a current or future mental health disorder due to experiencing trauma or adversity, evidenced by any of the following: beneficiary or caregiver declaration of need, or positive screen on ACES, or involvement or risk of involvement in the child welfare system, or experience or risk of homelessness.”

We also recommend clarifying that the reference to “involvement in the child welfare system” includes children currently or formerly involved in the child welfare system *or at risk of involvement*.

Criteria 2 as proposed is over complicated, lacks specificity for key definitions like “significant impairment,” and is likely to lead to confusion. While not the Department’s intent, the inclusion of the phrase “impairment level” could lead to some children being wrongfully denied SMHS as has occurred in the past. Instead, we recommend the following language be adopted:

*Criteria 2A: The beneficiary must have at least one of the following:
A reasonable probability of significant deterioration in an important area of life functioning, or
A reasonable probability a child will not progress developmentally as appropriate, or
Requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.*

We believe the above options will allow for a broad-based understanding by providers on how to determine need. Additionally, under criteria 2, when services are provided based on a suspected mental disorder, the DHCS proposal does not define if a diagnosis must be ultimately given and if so what timeframe it must be given within. We recommend that a mental health diagnosis not be required for children to continue receiving services.

Workforce:

The waivers do not address the workforce diversity or shortage problem we have in our public behavioral health system. In light of California’s behavioral health workforce shortage crisis, expanding our supply of behavioral health workers must be a top priority. We urge DHCS to keep this goal in mind when implementing CalAIM.

Medi-Cal’s unlicensed mental health provider categories such as Mental Health Rehabilitation Specialists and Other Qualified Providers, for example, offer effective mechanisms for expanding California’s behavioral health workforce. We should be expanding in particular the roles of peer support specialists, community health workers (promotores), and traditional healers. Studies demonstrate that the use of these workers in comprehensive mental health or substance abuse treatment programs helps reduce client hospitalization, improve client functioning, increase client satisfaction, alleviate depression, and diversify the workforce. Not to mention, they actually reflect the communities we are serving in California.

In addition, The Peer Support Specialist certification program authorized by SB 803, is currently structured as a county option and therefore access to these evidence-based services for parents and families will be mixed. We recommend making access to Peer Support Specialists a statewide benefit for all Medi-Cal families so that families impacted by mental health issues in a parent or child have access to this evidence-based and culturally-responsive service. Finally, investing in the state Youth Crisis Hotlines, which train and utilize peer volunteers also makes sense as they serve as a both a trusted support system and a valuable workforce pipeline (volunteers often pursue counseling and other support careers).

Drug Medi-Cal Organized Delivery System for Enrollees Under 21:

The 1915(b) Waiver Overview states that “beneficiaries under age 21 are currently, and will remain, eligible to receive DMC-ODS services without a diagnosis. Under the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) mandate, beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements. Counties are responsible for the provision of services pursuant to the EPSDT mandate”. We applaud DHCS’s confirmation that beneficiaries under the age of 21 are eligible for DMC-ODS services under EPSDT. We urge DHCS to ensure a youth-centered service delivery model and that eligible EPSDT services include outreach, screening, assessment, care coordination, family/caregiver education and support groups, mentoring, recreational therapies, and clinical supervision in addition to the current service delivery system being offered under the existing Waiver. While youth will now be guaranteed access to needed substance use disorder treatment services through the EPSDT benefit, we urge DHCS to develop accountability measures to ensure that EPSDT-eligible DMC services are available and offered consistently and in alignment to the intent of CalAIM at a statewide level.

The addition of Contingency Management services will add great value to the service delivery toolbox of DMC-ODS providers in achieving positive health outcomes. As a newly included evidence-based practice, we recommend that DHCS work with counties to provide dedicated funding for training providers in the utilization of Contingency Management and that youth Contingency Management services be tailored to youth needs and with clear protocols on definitions and feasible youth-centered target behaviors that will be reinforced.

We appreciate the proposal’s inclusion of the American Society of Addiction Medicine’s 0.5 within the Drug Medi-Cal Waiver as we believe prevention is an important piece of the continuum of care. However, as stated above, we would like to see more specificity on how youth can receive treatment under Drug Medi-Cal. In California, as many as 60% to 75% of adolescents with substance use disorders are estimated to have a co-occurring mental illness. In some cases, substance use may begin as a strategy for self-medicating to manage psychiatric symptoms. Given the need, we are concerned the proposal does not address how the CalAIM changes will provide for the needs of youth. While youth are guaranteed access to substance abuse treatment through the EPSDT benefit, data shows many have difficulty accessing these services. Currently, the American Society of Addiction Medicine’s criteria, which outlines how to uniquely support youth in recovery, is included in the DMC-ODS pilot. As such, we see an opportunity for the DMC-ODS pilot to expand services for young people. However, DMC-ODS is not statewide. DHCS should outline how it will ensure EPSDT-SUD services are available statewide through CalAIM.

We are supportive of DHCS’s proposal to remove existing limitations on residential length-of-stay for SUD treatment services. Particularly, we were heartened to see this portion of the proposal:

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.² DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements, CalAIM page 95.

We believe that linking length of stay to client needs is more appropriate.

Foundational MCP Oversight and Accountability:

The enormous changes that DHCS is proposing require a stronger level of oversight and accountability driven by DHCS when historically there has been a poor track record in overseeing the existing MCP contracts with demonstrably stagnant or declining progress on many children's indicators. We find it concerning that there is very little explicit discussion in the CalAIM proposal regarding DHCS' plans for additional managed care oversight and accountability. The upcoming re-procurement process is an important opportunity to reset MCP requirements and expectations regarding network adequacy, timely access to care, language access requirements, quality improvement and the reduction of health disparities. Performance measures and improvements should be more directly tied to plan financing, namely their capitation payments. *It will be critical to track and report on how managed care plans engage with traditional safety net providers, and how they meet the new demands the state has specified regarding population health and the social determinants of health.*

In addition, DHCS must require greater accountability and transparency from both MCPs and County Mental Health Plans (MHP) to meet the federal entitlement to behavioral health care under EPSDT. The MCP contracts should clarify that the MCP remains responsible for the provision of all medically necessary mental health services and has a case management and care coordination obligation to communicate with the County Mental Health Plan to ensure the member can access needed care without delay.

Enhanced Care Management and In Lieu of Services:

CCT and the Alliance support the core concept that Medi-Cal managed care plans and the public behavioral health plans including community-based agencies should more closely align and enter into contracts to better manage care for beneficiaries across delivery systems. We support the continuation and evolution of Whole Person Care pilots with additional Medicaid match for those services otherwise not matchable. We recommend, however, that the proposal do more to compel public behavioral health and MCP collaboration, particularly as it relates to the state's goal to target SED/SMI and SUD populations.

Given the prominent role case management plays in public behavioral health systems, and the fact that ECM would be a required benefit across the state, we believe that, at a minimum, the public behavioral health system should be core, required partners in implementing the ECM benefit which would touch public behavioral health clients. This could take the form of a requirement on MCPs to develop their population health management strategy with county and community-based partners. In fact, we are supportive of this portion of the proposal which calls

out the importance of MCPs contracting with the public behavioral health system and to provide a rationale if they do not:

If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers, CalAIM proposal page 48.

Given this existing expertise, the public behavioral health system should be provided with a first right of refusal to contract for ECM services for individuals with SED/SMI and SUD needs.

Further, the current criteria for participation in ECM as proposed is narrow and omits important categories of children and youth in need of ECM. DHCS should expand the criteria and include “proxy” criteria, such as school-related criteria, to identify eligible children. The MCP Enhanced Care Management and In Lieu of Services Contract template provisions should include community health workers in the list of provider types serving in child-serving systems of care.

Our primary concern with the ILOS proposal that we continue to raise has to do with the matching of services to target populations. In our experience providing housing supports, transitions in and out of incarceration, and managing transitions from other acute settings, including locked facilities, and in working with homeless populations, the benefits cannot and should not be limited in terms of the intensity, frequency, or duration if they are to be successfully applied in addressing the social determinants of health. Given the lack of available affordable housing options for very low-income individuals for example, combined with the relatively low education and employment levels for our county behavioral health clients, we believe the limited housing benefits envisioned under ILOS are not well targeted at high-risk beneficiaries.

Population Health Management:

CCT and the Alliance support CalAIM’s Population Health Management proposal to require health plans to conduct assessments for new members and for all members annually. We believe these plan-wide assessments can play a critical role in identifying youth with key risk factors for emerging mental health conditions. We recommend that plans be required to include in these assessments several questions concerning key Social Determinants of Health (SDOH). If the assessment indicates the youth and/or the family is experiencing one or more of these SDOH, the plan should be responsible for ensuring the family is linked with a community-based provider that is qualified to both provide a more thorough assessment and to ensure the youth receives appropriate and coordinated follow-up care.

The Alliance and CCT also support CalAIM’s Population Health Management proposal to require health plans to conduct assessments for new members and for all members annually. We applaud CalAIM’s requirement that these assessments gather SDOH, including “access to basic needs such as education, food, clothing, household goods, etc.”; “[h]ousing and housing instability assessment”; and “[u]se of community-based services and supports”. We

recommend in particular that plans be required to gather data reflecting economic distress and a youth's potential exposure to trauma, such as the following questions from the Whole Child Assessment: "On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the last year?"; and "Do you feel your child is difficult to take care of?"

We also support the requirement that plans identify members with "emerging risk" factors and provide those members case management services, including ensuring a "family-centered approach by identification of [a] member's circle of support or caregivers"; and "[d]eveloping relationships with local community organizations to implement social determinant interventions (e.g. housing supports, nutritional classes, etc.)". The Alliance and CCT believe it is critical that plans are required not only to identify members who should receive more thorough follow-up assessments, but also to ensure members actually receive those evaluations and any recommended follow-up interventions.

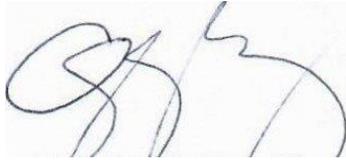
Documentation:

We remain unclear on the timeline and execution of documentation streamlining as outlined on page 26 of the CalAIM waiver overview. We reiterate our request that DHCS identify overzealous documentation requirements on counties and community-based organizations. In order for the system to be the most cost effective and streamlined and the focus to be truly on the beneficiary, this must be addressed. We understand that there are discussions and workgroups developed, we will continue to advocate for movement in this area both in documentation and administrative processes until we can identify tangible changes. Below are a few examples of burdensome requirements:

- Site certification: this process is required for any site where a provider is serving beneficiaries, even if their records are not stored on site (e.g., school site). A fire clearance and documentation of adequate space should meet the needed requirement, rather than full site reviews.
- Credentialing of staff: each MHP does this differently, with some requiring up to 10 years of addresses, work history, and a significant amount of detailed information, even if staff are already licensed with a state board. This type of additional burden is an example of requirements with MHPs that do not currently exist when contracting with MCPs.
- Clinical paperwork: statewide documentation standards need to be put in place during this process, and assurances provided to MHPs that they will not be audited outside of these required documents. The audit tool must match the actual documents and updates completed in sync between the DHCS program and audit divisions.

We appreciate this opportunity to provide comments on the department's CalAIM waiver proposals and urge the department to include our recommendations to prioritize the health and wellbeing of California's Medi-Cal children. If you have any questions, please contact Chris Stoner-Mertz at chris@cacfs.org or Alex Briscoe at alex@cachildrentrust.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Christine Stoner-Mertz', written over a light blue grid background.

Christine Stoner-Mertz, CEO
California Alliance of Child and Family Services
chris@cacfs.org | 916-956-0693

A handwritten signature in black ink, appearing to read 'Alex Briscoe', written on a plain white background.

Alex Briscoe, Principal
California Children's Trust
alex@cachildrenstrust.org | 415-629-8142