MOVING TOWARD BEHAVIORAL HEALTH INTEGRATION

For Low-Income People in California

Vikki Wachino, Principal, Viaduct Consulting, LLC

In response to the urgent need to improve the health and well-being of people who experience behavioral health conditions, policymakers and providers are increasingly integrating the provision of physical and behavioral health care.

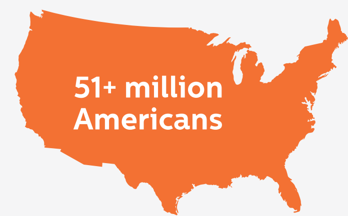
Behavioral health conditions, which include both mental health conditions and substance use disorder, are common: nearly one in five adults in the U.S. reported having experienced mental illness in 2017-2018.[1] Greater integration of physical and behavioral health services, which have historically been fragmented, may be one way to improve outcomes. State Medicaid programs have been a major focus of integration efforts. More than half of states who use managed care are integrating at least some Medicaid mental health services with their physical managed care programs.

1 in **5** adults in the U.S. reported having experienced mental illness in 2017-2018

Over time, a diverse set of stakeholders have aligned to advocate for integration of services in California's Medicaid program, Medi-Cal. There, 58 counties deliver and finance most Medicaid-covered behavioral health services, while managed care plans generally provide physical health services and limited mental health and substance use disorder services. Many stakeholders describe the current system as overly complex and fragmented. Last year, the state released a far-reaching proposal to revamp the state's Medi-Cal delivery systems, "California Advancing and Innovating Medi-Cal" (CalAIM). CalAIM included proposals to move incrementally toward integrating mental health and substance use disorder services in Medi-Cal over several years. The COVID-19 response has delayed completing this proposal, which the state plans to return to next year. This paper discusses behavioral health issues and delivery systems in California, the California behavioral health integration proposals, and the questions that the state will face when it returns to this proposal in 2021.

People in California and the U.S. face significant behavioral health challenges

The need to address behavioral health conditions is emerging as a major priority for the health system nationally. Behavioral health conditions – specifically, increasing deaths from suicide, drugs, and alcohol – were primary drivers of declining life expectancy for the three years ending in 2018.[2] Over 51 million Americans – twenty percent of the total adult population – reported having experienced a mental illness in the past year, and nearly 20 million had an SUD, according to 2019 data.[3] The COVID 19 pandemic, the prominence of inequities in our health and criminal justice systems, and a set of natural disasters across the country are increasing rates of mental health conditions and substance use in the US.[4]



20% of the total adult population reported having have experienced a mental illness in the past year

Behavioral health conditions correlate with physical health conditions. People who experience behavioral health conditions are more likely than people who do not to have a range of chronic conditions, including hypertension, cancer, diabetes, and asthma. But service delivery does not align well with this high level of need. Too often, people with mental illness or addiction go without services for physical and behavioral health conditions.[5] People with behavioral health conditions are less likely to receive preventive care.[6] Nationally, lower life expectancy and higher mortality rates for people with behavioral health needs suggest a significant need to strengthen care to improve outcomes.[7] These conditions occur in the context of a fragmented health care delivery system, and derive in part from social isolation and inequitable wealth and resource distribution among individuals and communities.[8]

BEHAVIORAL HEALTH NEEDS IN CALIFORNIA.

The behavioral health issues facing adults and children in California are significant and growing. A recent analysis found that 11 percent of adults in California experience serious psychological distress. Further, rates of serious psychological distress grew more than 40 percent between 2014 and 2018 among adults in California. Among the subgroup of adults age 18-24 rates more than doubled during that time period.[9] More than seven percent of children have serious emotional disturbance (SED).[10] People in poverty and people enrolled in public insurance are among the groups whose rates of serious psychological distress exceed statewide averages.[11] Adults and children who live in households with incomes below the poverty line are more likely to experience SMI and SED. Rates of mental illness are also higher for Black, Latinx and Native American populations than for they are for White people. Mental health issues in California and elsewhere are highly correlated with involvement with the criminal justice and foster care systems, as well as with being homeless.[12]

7+% of children have serious emotional disturbance

THE PIVOTAL ROLE OF MEDI-CAL.

Medicaid and Medi-Cal, California's Medicaid program, play a significant role in providing health and behavioral health services for low income people. Nationally, Medicaid covers more than one in every four people with serious mental illness and 17 percent of people with addiction. Along with private insurance, Medicaid is a major source of financing for behavioral health services.[13] In addition to physical health care, Medicaid covers a broad range of behavioral health services such as inpatient hospitalization, rehabilitation, targeted case management, and some residential treatment. For children and adolescents, comprehensive benefits, including those needed to diagnose, treat, and improve behavioral health conditions are available through Medicaid's pediatric benefit, the Early and Periodic Screening Diagnostic and Treatment program.

Behavioral health conditions drive not just outcomes and longevity, but spending as well. In California, which operates the largest Medicaid program in the country, 5 percent of Medi-Cal beneficiaries accounted for just over half of Medi-Cal spending in 2011. Behavioral health conditions contribute substantially to that spend: Of the 5 percent of the population associated with this high spending concentration, over half of beneficiaries had a mental health condition, often co-occurring with other health conditions.[14] Yet data suggest there is unmet need for mental health services among Medi-Cal beneficiaries: one estimate found that 6 percent or fewer Medi-Cal beneficiaries used any mental health service in fiscal years 2017-2018.[15]

MEDI-CAL BEHAVIORAL HEALTH SERVICES ARE HIGHLY FRAGMENTED.

In many parts of the US, health systems and providers that provide physical health care and those that address behavioral health care have operated separately with little coordination. Historically, states that contracted with managed care organizations to deliver care to Medicaid beneficiaries carved out behavioral health services to be provided outside of managed care or through a separate plan. Recently, seeking greater coordination, better outcomes, and cost management, more states are integrating physical and behavioral health.[16] More than half of all states cover inpatient mental health and inpatient and outpatient substance use disorder services under their physical health MCO contracts, and nearly half cover outpatient specialty mental health services through those MCOs.[17]

California has not integrated services, and its current Medi-Cal delivery system is highly fragmented. In California, four out of five Medi-Cal beneficiaries are served by Medicaid managed care organizations. There are several different models of MCOs employed across California's 58 counties, some of which are unique to California. In addition, some MCOs subcontract to managed behavioral health organizations to provide behavioral health services. Managed care organizations provide physical health services and services that address "mild-to-moderate" mental health care needs. These services include mental health evaluation and treatment, medication management, and psychiatric consultation. Counties, not the MCOs, provide specialty behavioral health services as county mental health plans under contract with the state. County alcohol and drug programs also provide services to treat substance use disorder. Total spending on community mental health services is $10 billion and counties administer $8 out of $10 public mental health dollars in the state.[18] County funding, federal Medicaid matching payments, funding from dedicated state revenue sources that were created through ballot initiatives, and limited funding from the state general fund all combine to finance county behavioral health services, including services provided outside of the Medi-Cal program.

$10 billion of total spending on community mental health services

In California, beneficiaries may navigate several different systems in order to meet their physical and behavioral health needs, including different referral processes and provider networks. The burden of navigation is particularly high for beneficiaries who have co-occurring conditions, as many do. In some places in the state, six or more systems serve the same beneficiaries.[19] In addition, spending and available services vary county to county. This fragmented system creates gaps in services and makes service coordination difficult.

Growing Interest in Integrating Physical and Behavioral Health Services in California

In recent years, some California stakeholders have advocated for greater integration of behavioral and physical health services in Medi-Cal.[20] In 2018, Well Being Trust and the California Health Care Foundation convened a working group of experts, providers, county and state officials and advocates to discuss developing an integrated system of care in Medi-Cal encompassing both physical and behavioral health care. The two philanthropies issued the "Blueprint for Behavioral Health Integration in California."[21] The report identified an opportunity to advance the health and quality of life of Medi-Cal beneficiaries through a comprehensive, statewide system of integrated care. The Blueprint established an ambitious integration goal: by 2025, all Medi-Cal enrollees should experience "high quality integrated care for physical health, mental health, and substance use needs, with all of an individual's care managed by a single entity accountable for payment, administration, and oversight." The Blueprint noted that creating an integrated system requires a major overhaul of service delivery and financing to overcome fragmentation of services for people with SMI and SUD, a multiplicity of systems that provide different levels of care, and historical divides between mental health and SUD systems.

California's proposal to advance integration as part of broader CalAIM reforms

In October of 2019, California's Department of Health Care Services (DHCS) introduced to stakeholders a major proposal, "California Advancing and Innovating Medi-Cal," (CalAIM) to strengthen Medi-Cal delivery and payment systems, including those that pertain to behavioral health. CalAIM was rooted in a goal of addressing the complex health needs and life circumstances that many low-income Californians experience, and reducing health disparities. This comprehensive proposal touched nearly every corner of the state's $99 billion, 13-million person Medicaid program, seeking to integrate delivery systems, strengthen and expand managed care, and align quality, payment and data systems to reduce fragmentation.[22] CalAIM also proposed to advance Med-Cal's ability to address social determinants of health by leveraging managed care to cover nonclinical services and expanding case management services, among other reforms.[23]

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The CalAIM proposals were developed to align with California's need to renew two longstanding Medicaid waivers, through which the federal government authorizes states to adopt policies that differ from federal law but serve the objectives of the Medicaid program. The first is California's "Medi-Cal 2020" waiver, which operates under waiver authority provided to federal Department of Health and Human Services (HHS) in section 1115 of the Social Security Act, Medicaid's authorizing law. This waiver has operated since 2010 and authorizes some managed care programs, hospital delivery system reform and payment programs, and Whole Person Care pilots. The second is the state's specialty mental health program waiver, first approved in 1995, which authorizes mental health services to be provided by county-operated plans and operates under authority provided to HHS in section 1915(b) of the Social Security Act. Both types of waivers are time-limited but subject to renewal at regular intervals. Both waivers were set to expire in 2020; prior to the onset of the COVID-19 pandemic, DHCS planned to finalize CalAIM in the spring and submit waiver extension requests to the federal government in summer 2020.

CALAIM'S APPROACH TO BEHAVIORAL HEALTH INTEGRATION.

As part of CalAIM, DHCS proposed taking specific steps toward integration. Noting Governor Newsom's commitment to behavioral health transformation, DHCS' CalAIM proposal noted that "the full needs of the Medi-Cal population are not being met, particularly with respect to improving services and access for children and other vulnerable populations." DHCS committed itself to working with the counties "to invest in and improve access to mental health and substance use disorder services for Medi-Cal beneficiaries."[24]

To respond to these challenges, DHCS proposed to move toward greater integration of behavioral health services to provide coordinated services aimed at improving outcomes. It noted the potential to reduce administrative burdens on people, providers, and counties, promote continuity of treatment, fill care gaps, make services patient-centered and promote more efficient spending.

CalAIM's behavioral health proposals constituted substantive but incremental changes to strengthen change methods of determining access to specialty mental health and substance use disorder services, change the basis of county financial contributions to behavioral health services, and promote integrated specialty mental health and substance use disorder services.[25] These changes would take effect over a five year period. Specific components of the state's approach included:

- Reforming financing and payment for behavioral health services, using rate-based methodologies and changing the basis for county financing of Medi-Cal behavioral health services from certified public expenditures to intergovernmental transfers. The state described this effort as the foundation of moving toward integration and other efforts needed to establish a continuum of care for behavioral health services;[26]
- Strengthening definitions used to determine eligibility for specialty mental health and substance use disorder services and whether services are medically necessary;
- Integrating administrative functions across separate county-based systems for specialty mental health and substance use disorder services to provide these services through one delivery system. Administrative integration would begin in 2021 and ultimately create a behavioral health plan in each county or region responsible for providing Medi-Cal mental health and substance use disorder treatment services;
- Encouraging counties to use regional contracting to pool resources and overcome administrative barriers;
- Renewing California's county-based substance use disorder program, Drug Medi-Cal ODS, and encouraging expansion of the program to the counties that have not implemented it.
- A potential waiver to cover institutional residential services for beneficiaries with serious emotional disturbance and serious mental illness.[27]

Noting that beneficiaries must navigate many different systems to obtain care, DHCS also established an intention to test using "full integration plans" that would manage all physical health, behavioral health, and dental services. DHCS planned to pilot these plans in 2024, and its plans for moving toward full integration were not specific.[28]

After the CalAIM proposal was released, DHCS began an intensive stakeholder engagement process. This process took place through existing stakeholder and behavioral health stakeholder advisory committees, and workgroups dedicated to particular topics.[29] Discussions between the state and stakeholders focused on the near term proposals to achieve greater integration rather than the longer term proposal for integration pilots. During public sessions dedicated to behavioral health reforms, stakeholders generally expressed support for the state's goals and the need for significant changes to the state's behavioral health delivery system. At the highest level, many individual organizations' feedback supported moving toward administrative and clinical integration, though no clear consensus was obtained. Beneficiary advocates described obstacles that people with co-occurring behavioral health needs face obtaining needed care and challenges providers face in operating in different systems, each with its own policies and procedures. Some also advocated for increasing accountability for outcomes, employing a "no wrong door" model of care and addressing workforce challenges. Many traced the complexity of the state's current behavioral health delivery system back to its system of financing. They also noted that moving toward integration would pose major challenges for the counties, the county workforce, and some behavioral health providers, and that in their totality CalAIM's behavioral health and other proposals would test the capacity of plans, providers, and other entities charged with implementation.[30]

The COVID-19 pandemic is driving short term innovation in California — but delaying its integration plans

In March, California, like other states, took on the unprecedented challenge of responding to the health, public health, and economic impact of the COVID-19 pandemic. The urgency of the COVID-19 response deferred California's plan to complete its CalAIM proposal and submit it to the federal government for consideration. The state pivoted to proposing to extend its existing 1115 waiver and 1915(b) specialty mental health services waiver for one year, to December 31, 2021. It intends to continue to work to develop and finalize renewal requests for its 1115 and 1915(b) waivers, and the policies in those renewals would begin in 2022, if CMS approves them.[31] Separately, a behavioral health task force, which Governor Newsom established in January to support a broad mission of improving the state's behavioral health system, is creating a 2025 behavioral health plan.[32]

COVID-19 has substantially increased the need for behavioral health services in California, as it has elsewhere. In July, 44 percent of adult Californians reported feeling symptoms associated with significant anxiety or depression, which is four times the rate that was reported early in 2020, before COVID hit. The number of young adults who reported such symptoms was significantly higher than that of other adults: more than 70 percent said that they had feelings of hopelessness, worry, or depression.[33] Nationally, rates of substance use, anxiety and depressive disorders and other behavioral health conditions are increasing.[34] Rates of mental health issues among children, including suicide risk, had increased markedly before the pandemic. Since then, economic insecurity and school disruptions are adding to children's mental health issues.[35] The summer and fall fires increased the financial and mental health stress and dislocation facing many people in California.

In July, **44%** of adult Californians reported feeling symptoms associated with significant anxiety or depression

CHANGES TO MEDI-CAL BEHAVIORAL HEALTH SERVICES AS PART OF COVID-19 RESPONSE.

California has responded to the behavioral health impact of COVID-19 on Medi-Cal beneficiaries as part of broader changes it has made to address the public health emergency. Since March, DHCS has made a suite of changes to make it easier for Medi-Cal beneficiaries to access health and behavioral health services, including expanding the use of telehealth and changing provider licensing and certification policies.[36] The state made behavioral health services available in emergency housing for people experiencing homelessness and established a new online resource, CalHOPE, that offers screening tools, a hotline, and other resources to Californians experiencing stress.[37] Many of these changes are time-limited; the authority for them is available through options that the federal government has established under temporary emergency authorities that exist only for the duration of the public health emergency.

CalHOPE offers screening tools, a hotline, and other resources to Californians experiencing stress

The future of CalAIM and Behavioral Health Integration

Next year, policymakers and stakeholders will decide whether and how to move forward with CalAIM's vision for a stronger Medi-Cal delivery system centered on beneficiaries' health and social needs. Increasing rates of poverty and loss of job-based health coverage will make Medi-Cal an even more important source of physical and behavioral health care coverage than it was pre-COVID. Medi-Cal is a primary funding source for COVID testing and treatment, as well as for longer term chronic and disabling conditions that COVID causes for some people. Moving forward with CalAIM could be part of a broader effort to strengthen California's safety net during and beyond the pandemic. But the pandemic is also driving state spending increases and revenue shortfalls in California and in other states. States have greatly diminished resources with which to finance any changes, and additional federal action to support states in addressing the significant fiscal stress brought about by COVID is uncertain. Uncertainty about the future of the Affordable Care Act, which the Supreme Court will rule on next year and which underpins significant improvements in availability of behavioral health services for both Medi-Cal beneficiaries and many people with commercial insurance, is another challenge that California and other states face.

At the same time, the pandemic is increasing the mental health challenges facing people in California and across the country. California has made incremental and temporary changes to expand access to behavioral health services during the pandemic. Some of these may lead to longer term policy changes, but the key challenge of significant fragmentation and overcoming delivery system silos will endure. In 2021, California will face the question of whether to take up the task of putting the administrative, clinical and financial pieces of the Medi-Cal behavioral health puzzle together to integrate services to try to achieve better outcomes and make it easier for people to navigate state and county systems to access needed services.

REFERENCES

1 Kaiser Family Foundation, State Health Facts Online, “Adults Reporting Any Mental Illness in the Past Year, 2017-2018,” https://www.kff.org/other/state-indicator/adults-reporting-any-mental-illness-in-the-past-year/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

2 Well Being Trust, Healing the Nation: Advancing Mental Health and Addiction Policy, January 2020, https://healingthenation.wellbeingtrust.org/assets/pdfs/Healing-the-Nation-Report.pdf. In 2019, life expectancy increased slightly for the first time in four years, and drug overdose deaths declined; O’Donnell, Jayne et al., “Life expectancy up for first time in four years while drug overdose rates drop by 4%,” USA Today, January 30, 2020. https://www.usatoday.com/story/news/health/2020/01/30/cancer-overdose-deaths-down-life-expectancy-up-again/4591717002/

3 In addition, 9.5 million people have co-occurring mental illness and substance use disorder Substance Use and Mental Health Services Administration, “Key Substance Use and Mental Health Indicators In the United States: Results from the 2019 National Survey on Drug Use and Health,” September 2020, https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf.

4 Well Being Trust and Trust for America’s Health, “Pain in the Nation Update: Alcohol, Drug and Suicide Deaths in 2018,” May 2020; and Well Being Trust, “Annual Deaths Due to Alcohol, Drugs or Suicide Exceeded 150,000, According to the Most Recent Data – And Could Get Worse Due to COVID-19,” May 21, 2020; https://wellbeingtrust.org/news/annual-deaths-due-to-alcohol-drugs-or-suicide-exceeded-150000-according-to-the-most-recent-data-and-could-get-worse-due-to-covid-19/ and Klass, Perri; “Young Adults Pandemic Mental Health Risks, New York Times, August 24, 2020 https://www.nytimes.com/2020/08/24/well/family/young-adults-mental-health-pandemic.html.

5 Kaiser Family Foundation, “Medicaid’s Role in Behavioral Health,” May 2017, https://www.kff.org/infographic/medicaids-role-in-behavioral-health/ and Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health, August 2019, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf#:~:text=Key%20Substance%20Use%20and%20Mental%20Health%20Indicators%20in,Human%20Services%20%28HHS%29%2C%20under%20Contract%20No.%20HHSS283201700002C%20with

6 California Health Care Foundation and Well Being Trust, “Behavioral Health Integration in Medi-Cal: A Blueprint for California,” February 2019, https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf

7 National Association of State Mental Health Program Directors Medical Directors Council,’ Morbidity and Mortality in People with Serious Mental Illness, October 2006; DeHert, Marc et al., “Physical Illness in patients with severe mental disorders, Prevalance, Impact of Medications, and Disparities in Health Care Care,” World Psychiatry, March 2013, https://onlinelibrary.wiley.com/doi/full/10.1002/j.2051-5545.2011.tb00014.xhttps://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08_0.pdf.

8 Well Being Trust, Healing the Nation: Advancing Mental Health and Addiction Policy, January 2020, https://healingthenation.wellbeingtrust.org/assets/pdfs/Healing-the-Nation-Report.pdf

9 D.Imelda Padilla-Frausto, et al., Serious Psychological Distress on the Rise Among Adults in California, UCLA Center for Health Policy Research, September 2020, https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/SPD-policybrief-sep2020.pdf.

10 California Budget and Policy Center, Mental Health in California: Understanding Prevalence, System Connections, Service Delivery and Funding, March 2020, https://calbudgetcenter.org/wp-content/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf

11 D.Imelda Padilla-Frausto, et al., Serious Psychological Distress on the Rise Among Adults in California, UCLA Center for Health Policy Research, September 2020, https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/SPD-policybrief-sep2020.pdf.

12 California Budget and Policy Center, Mental Health in California: Understanding Prevalence, System Connections, Service Delivery and Funding, March 2020,https://calbudgetcenter.org/wp-content/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf

13 Substance Abuse and Mental Health Services Administration, Behavioral Health Spending and Use Accounts, 2006-2015, https://store.samhsa.gov/sites/default/files/d7/priv/bhsua-2006-2015-508.pdf.

14 California Department of Health Care Services, “Understanding Medi-Cal’s High Cost Populations,” June 2015. https://dhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Enrollment%20Data/2015%20Enrollment%20Data/GI-Medi-Cal-Utilization-Data-for-Adults.pdf

15 Kim Lewis and Alexis Robles-Fradet, An Overview of Physical and Behavioral Health Integration, National Health Law Program, October 2019, https://healthlaw.org/resource/an-overview-of-physical-and-behavioral-health-integration/; Pourat

16 Michelle Herman Soper, “Integrating Behavioral Health Into Managed Care: Design and Implementation Lessons from State Innovators,” Center for Health Care Strategies, April 2016, https://www.chcs.org/media/BH-Integration-Brief_041316.pdf

17 Kathleen Gifford et al., "A View from the States: Key Medicaid Policy Changes," Kaiser Family Foundation and National Association of Medicaid Directors, October 2019, http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes.

18 Legislative Analyst's Office, "Overview of Public Community Mental Health Services Funding and the Mental Health Services Act," August 2019. Community mental health includes publicly funded outpatient and inpatient mental health services and psychotropic medications and excludes services funded by Medicare, private insurance, and provided through the Department of State Hospitals, prisons, and the K-12 educational system.

19 California Department of Health Care Services,"California Advancing and Innovating Medi-Cal," Proposal, October 2019, https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf, p. 6.

20 Kim Lewis and Alexis Robles-Fradet, An Overview of Physical and Behavioral Health Integration, National Health Law Program, October 2019; Pourat, Naderah, , et al One-Stop Shopping: Efforts to Integrate Physical and Behavioral Health Care in Five Community Health Centers, et al, UCLA Center for Health Policy Research, January 2015; http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/integrationbrief-jan2015.pdf

21 California Health Care Foundation and Well Being Trust, "Behavioral Health Integration in Medi-Cal: A Blueprint for California," February 2019, https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf

22 Total funding includes $21 billion in state general fund spending; https://lao.ca.gov/Publications/Report/3935; https://www.dhcs.ca.gov/dataandstats/statistics/Documents/County-and-4-Group-Table-Jun2020.pdf

23 California Department of Health Care Services, "California Advancing and Innovating Medi-Cal," October 2019, https://www.dhcs.ca.gov/calaim; https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

24 California Department of Health Care Services, Executive Summary, "California Advancing and Innovating Medi-Cal," Proposal October 2019, https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM-Executive-Summary.pdf

25 Ibid.

26 Ibid.

27 37 of 58 counties were implementing ODS in August 2020, See Alison Valentine et al., "How Medi-Cal Expanded Substance Use Treatment and Access to Care: A Close Look at Drug Medi-Cal Organized Delivery System Pilots," California Health Care Foundation, August 2020, https://www.chcf.org/wp-content/uploads/2020/08/HowMediCalExpandedSubstanceUseTreatment.pdf.

28 California Department of Health Care Services, Executive Summary, "California Advancing and Innovating Medi-Cal," Proposal October 2019. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf.

29 California Department of Health Care Services, Executive Summary, "California Advancing and Innovating Medi-Cal," Proposal October 2019.

30 DHCS's summaries of relevant stakeholder meetings are available at: https://www.dhcs.ca.gov/provgovpart/Documents/6422/FIP-1-31-20-Meeting-Summary.pdf; https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/BHPaymentReformMeetingSummary121319.pdf; https://www.dhcs.ca.gov/provgovpart/Documents/6422/BH-Medical-Necessity-Meeting-Summary-12-20-19.pdf; https://www.dhcs.ca.gov/provgovpart/Documents/6422/BH-Meeting-Summary-012320.pdf; https://www.dhcs.ca.gov/provgovpart/Documents/6422/BH-Integration-1-30-20-Meeting-Summary.pdf

31 The state submitted a request to extend its 1115 to CMS on September 16, 2020. DHCS Director, "Significant Updates of Interest to DHCS Stakeholders – September 18, 2020," email communication, September 18, 2020. https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal-2020-Public-Hearing-Presentation.pdf.

32 https://www.chhs.ca.gov/home/committees/behavioral-health-task-force/#august-25-2020

33 Reese, Philip, "Feeling Anxious and Depressed? You're Right at Home in California," Kaiser Health News, August 26, 2020, https://khn.org/news/feeling-anxious-and-depressed-youre-right-at-home-in-california/

34 Mark E. Czeisler et al., "Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24-30," Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, August 14, 2020.

35 California Children's Trust, "Healing Centered Schools: Financing Justice and Equity at the Nexus of Public Health and Public Education," August 2020, https://cachildrenstrust.org/wp-content/uploads/2020/08/Healing-Centered-Schools-August21_2020.pdf

36 Center for Connected Health Policy, COVID-19 Related State Actions, California, updated October 2020, https://www.cchpca.org/covid-19-related-state-actions

37 State of California, California HOPE, https://calhope.dhcs.ca.gov/

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