



The Role of Certified Community Behavioral Health Clinics in California Advancing and Innovating Medi-Cal (CaAIM)

*Aligning federal and state initiatives to transform California's behavioral
health system*

Uplift Family Services: The Role of CCBHCs in CaAIM

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Executive Summary

There are no shortages of data documenting the need for behavioral health services. California is embarking upon an audacious plan, California Advancing and Innovating Medi-Cal (CalAIM), to transform the system that serves the most vulnerable Californians, as it is one of the remaining states to have disparate delivery systems. For decades, California has been granted a "carve-out waiver" to address long-standing challenges in utilization, access, and cost of behavioral health care. As the state moves away from the existing 1115(a) Medicaid Waiver Medi-Cal 2020 to a new 1915(b) Waiver to consolidate Medi-Cal Managed Care benefits, the Drug Medi-Cal delivery system, behavioral health reform, and sunset pilots (Whole-Person Care, Health Home Program, and Coordinated Care Initiative), California can further align federal and state initiatives with different models to integrate behavioral health services more seamlessly within a whole-person care approach. Specifically, Certified Community Behavioral Health Clinics (CCBHs) have demonstrated promising outcomes in several states (e.g., Minnesota, Illinois, etc.). CCBHs must ensure access to integrated, evidence-based addiction and mental health services, including 24/7 crisis response and medication-assisted treatment (MAT) for addiction, and meet stringent criteria regarding timeliness of access, quality reporting, staffing, and coordination with other systems (e.g., social services, criminal justice, and education systems). The following paper provides a brief description of the current context of California's behavioral health system, CalAIM, CCBHs, and demonstrates how CCBHs not only are in alignment with CalAIM but can also provide an enhanced structure for the state's future behavioral healthcare delivery system.

The Role of Certified Community Behavioral Health Clinics in California Advancing and Innovating Medi-Cal (CalAIM):

Aligning Federal and State Initiatives to Transform California's Behavioral Health System

Background

The need for coordinated and quality behavioral health care has long been established. The novel coronavirus disease-2019 (COVID-19) pandemic only highlighted and exacerbated structural inequalities in current behavioral health systems, access to and quality of care, and ultimately outcomes related to well-being.

National statistics prior to the pandemic indicated:

- 4.8 million visits were made annually to emergency departments by individuals with mental, behavioral, and neurodevelopmental disorders as the primary diagnosis.¹
- 56.8 million visits were made annually to physician offices with mental, behavioral, and neurodevelopmental disorders as the primary diagnosis.²
- One in six children ages 2-8 had a mental, behavioral, or developmental disorder (CDC, 2020).³
- One in five individuals in the general population had a mental health disorder.⁴ Low-income people of color are at greater risk of developing mental health problems and are less likely to receive appropriate and effective mental health services.^{5,6}
- Only one in 10 Americans with a substance use disorder received treatment in any given year.⁷

The COVID-19 pandemic disproportionately impacted communities of color, thereby exacerbating the disparities in behavioral healthcare and further underscoring the need for a more accessible system, as evidenced by the following:

- Increases nationally in emergency room (ER) visits for mental health concerns, suicidal risk, substance use, intimate partner violence, and child maltreatment.⁸
- Increases, nationally and across California, in homelessness rates, with a disproportionate amount being people of color.⁹ These rates were on the rise across California pre-pandemic and are projected to increase by 69% across the state and 83% in Los Angeles County by January 2023.
- Increases, nationally and across California, in the rates of mental health issues during the pandemic compared to pre-pandemic rates. The Centers for Disease Control and Prevention (CDC) have indicated that mental health issues (e.g., depression and anxiety) have increased three- to fourfold compared to rates prior to the pandemic; one in three Californians has indicated that they are dealing with symptoms of depression, anxiety or both on a regular basis, and these rates have held steady throughout the pandemic.^{10,11} Rates are disproportionately higher for young adults, people of color, LGBTQ+ community members, and those of low socioeconomic status (SES). Survey results demonstrated that among a nationally representative sample of young adults, ages 18 to 24, 56 % suffered from anxiety and/or depression during the pandemic.¹²
- Overall increases, nationally and across California, in substance use to cope with the stressors of the pandemic and overdoses, including deaths.^{13,14,15} California experienced a 50% increase in the rate of deaths due to overdose between February 2020 and February 2021.¹⁴ As with mental health issues in general, the rates of substance use were disproportionately higher among younger adults and people of color.¹³ Results of a national survey have indicated that one in four young adults, ages 18 to 24 years, has struggled with substance use during the pandemic.¹²

- Increases, nationally, in suicidal ideation.¹³ These rates are disproportionately higher among young adults and people of color; in fact, a national survey’s results indicated that one in four young adults, aged 18 to 24, experienced suicidal thoughts during the pandemic.¹²

The Quintuple Aim

The Quintuple Aim provides a framework for achieving whole-person and value-based care, as the tenets are directly in-line with both approaches to improve population health outcomes.¹⁶ CalAIM and CCBHCs are methods to improve the health care system that require simultaneous pursuit of five aims: 1) Improving *consumer health outcomes* and well-being; 2) Better *consumer satisfaction*; 3) Improving *satisfaction and work-life balance for staff* to prevent burnout; 4) Maintaining quality but lowering the *costs of services*; and 5) Addressing health disparities for *equity*.¹⁶ The Quintuple Aim is inherent to both CalAIM and CCBHC models. Both present significant opportunities to improve equity within the health care system.

California’s Fragmented Behavioral Health System

Under Medi-Cal, individuals with co-occurring behavioral health and physical health conditions experience a highly fragmented system of care that has resulted in poor health outcomes and unmet treatment needs. The wide range of services for the treatment of mental health and substance use disorders are delivered through: 1) Medi-Cal managed care plans (MMCPs); 2) County mental health plans (MHPs) that operate under a federal Medicaid Section 1915(b) freedom-of-choice waiver titled “Medi-Cal Specialty Mental Health Services;” and 3) Separate county and state programs. Beginning in 2014, the Department of Health Care Services (DHCS) required MMCPs to provide mental health services to members with ***mild to moderate*** impairment of mental, emotional, or behavioral functioning. These services are accessed through Fee-For-Service (FFS) private behavioral health providers, community clinics, and other local and county clinics. MHPs are responsible for specialty mental health services for patients with ***moderate to severe*** impairments and for emergency and in-patient behavioral health services.

In addition, counties operate Drug-Medi-Cal through a separate funding stream, which provides treatment benefits for substance use disorders (SUD). However, the limited benefits and low reimbursement rates impact quality care provision and provider experience which create significant barriers to treatment. Access to person-centered care is further hindered by the challenges in connecting the physical health (primary care), mental health, and substance use care systems that often serve the same beneficiaries.

For the over 13 million Californians that rely on Medi-Cal, this complex system results in a lack of continuity of care, the need to change providers between systems, repeating the process of recalling histories and background information, frequent “retelling” of treatment information, a lag time between appointments, and ultimately lack of trust in the system that is responsible for supporting their well-being.

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a bold multi-year initiative to transform delivery systems, program, and payment reform across California’s Medi-Cal Program, particularly for Californians who are vulnerable or have complex needs: *Individuals experiencing homelessness, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging*

population. This initiative requires a multi-level paradigm shift in how the state, counties, health plans, and providers deliver integrated whole-person care approaches to address the behavioral health, addiction treatment, and primary care needs of complex populations. Such services include non-medical services that target Social Determinants of Health (SDoH): risks related to economic stability, education, housing, health and healthcare, neighborhood and environment, and community) to reduce health disparities and inequities. The **goals** of CalAIM include:

- Matching the right patients to the right services at the right time by identifying and managing member risk and need through whole person care approaches and addressing SDoH which increases equity.
- Moving Medi-Cal from the current patchwork of programs that vary by county to a more consistent and seamless system by requiring Medi-Cal managed care plans to coordinate access to services provided by counties and community-based organization which would reduce complexity and increase flexibility.
- Improving quality outcomes, reducing health disparities and inequalities, and driving system transformation and innovation through value-based initiatives, modernization of systems and payment reform whereby physical and behavioral health providers are incentivized based on outcomes rather than services.

In essence, CalAIM advances several key priorities by leveraging Medicaid as a tool to address many of the complex challenges facing vulnerable Californians. Consequently, there are myriad of implications with the implementation of CalAIM that will have significant impact to service provision and California's infrastructure to support the new way of doing business.

Certified Community Behavioral Health Clinics: A Model Framework for CalAIM

Previous research substantiates the long-term negative consequences of pandemics, such as increases in traumatic stress and post-traumatic stress disorder (PTSD) and major depressive disorder.^{18,19,20} While COVID-19 does not discriminate in who it affects, some communities are more impacted than others. It is anticipated that there will be unforeseen consequences of COVID-19. For example, the long-term consequences of social-emotional development on youth remains to be seen. Both CalAIM and CCBHCs are uniquely positioned to help ameliorate the immediate and long-term consequences of COVID-19.

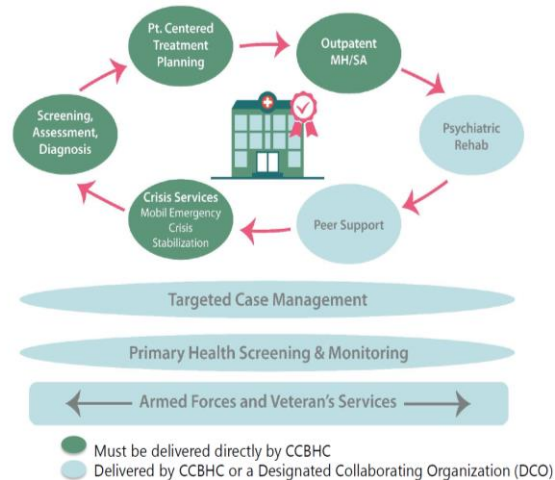
In 2014, Congress enacted the bipartisan Protecting Access to Medicare Act (PAMA) that authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration to allow states to test a model to improve the quality of addiction and mental health care and fill the gap in the unmet need for care. The **goals** of the CCBHC model are to:

- Provide comprehensive, 24/7 access to mental health, substance abuse, and physical health services in a single location.
- Provide services to any individual, regardless of their ability to pay or their place of residence, with an emphasis on those with serious mental and substance use disorders.
- Ultimately, improve care to prevent hospitalizations and reduce recidivism.
- Reduce health disparities through addressing social determinants of health.

Today, there are approximately 430 CCBHCs throughout the country. Full implementation of the model requires pivoting from business-as-usual fee-for-service models and into value-based payment systems, in which incentive payments are tied to tracking of population health outcomes. Value-based care represents a drive for improved patient experience and outcomes at lower cost, consistent with CalAIM and the healthcare industry's Quintuple Aim.

Scope of Services

CCBHs are required to offer a wide range of easily accessible, whole-person services as depicted below by the National Council for Mental Wellbeing.²¹



Program Requirements

To qualify as CCBHCs, non-profits and government behavioral health organizations are required to meet established criteria in six areas:

- 1. Staffing:** Implementation of a staffing plan based on a comprehensive needs assessment of the population served; training in cultural competence.
- 2. Availability and Accessibility of Services:** Services accessible to all at convenient times and modalities; timely access standards dependent on level of need (e.g., crisis management within 3 hours); comprehensive, regularly updated diagnostic evaluation and treatment planning.
- 3. Care Coordination:** Integrated care across full spectrum of services; health information technology to support coordination; formal agreements with other providers (e.g., primary care, inpatient, criminal justice agencies, Veterans' Administration) and tracking of discharge from programs.
- 4. Scope of Services:** Provide or partner to provide required services (see diagram above).
- 5. Quality and Other Reporting:** Report on a common set of quality measures; have continuous quality improvement (CQI) plans.
- 6. Organizational Authority, Governance, and Accreditation:** Governed by a representative board that includes more than 51% consumers or families with lived experience.

CCBHs embody SAMHSA's integrated care goals to:

- Increase access to care and quality of care and thereby improve outcomes, especially for complex, high-use patients.
- Decrease costs driven by repeated high-level care, and disjointed healthcare systems.
- Treat the whole person through a collaborative team approach to healthcare.
- Implement health information technology to share critical information across healthcare providers, while securing patient access to providers and privacy.

The table below provides a comparison of traditional behavioral health service models and CCBHCs as reported by the National Council of Mental Wellbeing, supplemented with the goals of CalAIM.²²

Comparing Traditional Behavioral Health Service Models, CCBHCs, and CalAIM

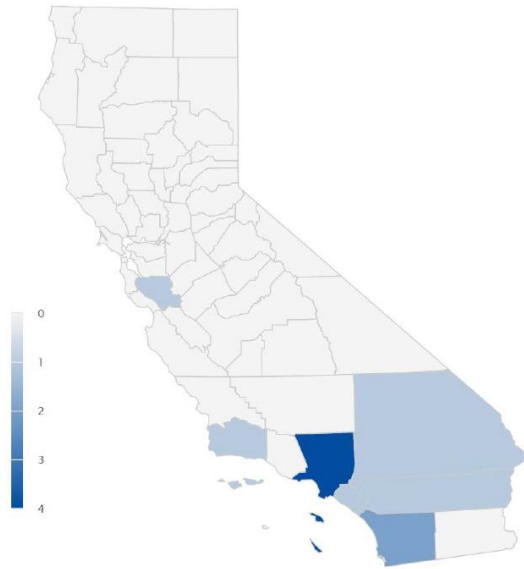
	Traditional Model	CCBHC Delivery Model	CalAIM Goals
Access to Care	Low reimbursement rates result in workforce shortages, inability to recruit and retain qualified staff, and limited capacity to meet the demand for treatment, resulting in clinics turning away patients or placing them on long waitlists.	CCBHCs are required to serve everyone, regardless of geographic location or ability to pay. Nationally, CCBHCs reported an aggregate increase of 17% in patient caseload. ²³	CalAIM seeks to improve the timeliness of access to appropriate services and address SDoH barriers that impede access. ²⁴ Similar to CCBHC models, CalAIM will take a “no wrong door” perspective. ¹⁶
Wait Times	Wait times from referral to first appointment average 48 days at community-based behavioral health clinics. ^{23,24}	Timeliness of services is a key component of CCBHCs. For routine needs, 50% of CCBHCs offer same-day access to services, 84% within one week, and 93% offer access within 10 days or less. ²⁴	While CalAIM seeks to improve timeliness of services, wait times are not explicitly addressed in current CalAIM documentation.
Quality Care	Services vary widely between clinics with little guarantee that clients will have access to high quality, comprehensive care.	CCBHCs are required to provide Evidence-Based Practices across a comprehensive array of services including 24/7 crisis services, integrated health care, care coordination, medication-assisted treatment (MAT), peer and family support and care coordination.	The move toward value-based-systems of care will stress the use of effective and efficient interventions for various populations and problem areas. ¹⁶
Quality Measures	Inconsistent quality measures across states, communities, and grant programs.	CCBHCs are required to report on standardized quality metrics.	There is a focus on quality (e.g., Quality Improvement Program) to demonstrate the value of services offered and determine how to lower the cost of services while still providing high-quality care. ¹⁶
Crisis Services	Crisis services provide necessary assessment, screening, triage, counseling, and referral services to individuals in need, but vary statewide due to limited reimbursement.	All CCBHCs offer 24/7 access to crisis care, including mobile crisis teams, ensuring individuals of all ages receive the care they need and avoid unnecessary hospitalizations; 91% engage in innovative practices in partnership with hospitals, first responders, and others. ²⁴	CalAIM seeks to increase availability and access to crisis interventions and stabilization, including enhanced call centers mobile crisis teams, and intensive outpatient services as well as acute short-term stays in psychiatric hospitals, and residential treatment and crisis stabilization settings. ¹⁶

Comparing Traditional Behavioral Health Service Models, CCBHCs, and CalAIM

	Traditional Model	CCBHC Delivery Model	CalAIM Goals
Care Coordination	Traditional reimbursement does not cover care coordination services. Integration of care is rare within traditional models of service.	CCBHCs coordinate care with hospitals, schools, criminal justice agencies and other providers to improve health outcomes and reduce use of emergency room and inpatient facilities; 95% of CCBHCs are engaged in one or more innovative practices in collaboration with law enforcement (LE) and criminal justice (CJ) agencies. ²⁴	ECM programs will connect consumers to the proper services for integrated whole-person care and create better linkages and coordination between the various health and social service systems. ¹⁶
Social Determinants and Risks	Traditional models do not necessarily work to identify and account for these factors. SDoH and risk factors are often talked about but there is no structural linkage or responsibility to incorporate factors into care model.	CCBHC models aim to develop services that account for social determinants – examine the impact that these issues have on accessing needed services. Part of the “no wrong door” philosophy; 75% of CCBHCs screen for unmet social needs that affect health. ²⁴	CS services will reduce disparities in care by identifying and addressing the social determinants that limit access to and utilization of appropriate and effective services. ¹⁶
Substance Use Services	Nationally, only 56% of substance use treatment facilities offer access to one or more types of Medication Assisted Treatment (MAT). ^{24,25}	89% of CCBHCs offer MAT, the “gold-standard” in substance use treatment, and peer support services are one of the nine required services. ²⁴	Drug Medi-Cal will be integrated into CalAIM. MAT will serve as a central evidence-based practice in the treatment of substance use. ¹⁶
Payment	Fee-for-service models pervade business as usual. Must be eligible for and enrolled in Medi-Cal or Medicare programs.	CCBHCs establish a sustainable payment model (prospective payment) that ends reliance on time-limited grants. Long-term sustainability for these models relies on eventually developing a managed care approach. However, CCBHC-Expansion grant recipients do not have this sustainable payment structure. 81% of CCBHCs are, or plan on, negotiating PPS or alternative models with private payers. ²⁴	CalAIM begins to move Medi-Cal away from fee-for-service reimbursement toward value-based arrangements with financial alignment between health plans and provider organizations. ¹⁶

CCBHCs in California

As of July 2021, there are 15 CCBHCs in California (430 total in 43 states). As illustrated below, 14 of the CCBHCs are in Southern California counties (Los Angeles County, Orange, Riverside, San Bernardino, San Diego, and Santa Barbara) and one in Northern California (Santa Clara). Additional information about the locations of organizations utilizing the CCBHC model in California and across the country can be found at [The National Council for Wellbeing's CCBHC Success Center](#).



This map does not include July 2021 Expansion Grantees

Federally Qualified Health Centers (FQHC)

[San Ysidro Health Center, Inc.](#) – San Diego
[Chinatown Service Center](#) – Los Angeles
[La Maestra Family Clinic](#) – San Diego
[South Central Family Health Center](#) – South Los Angeles
[Santa Barbara Neighborhood Clinics](#) – Santa Barbara
[Community Medical Wellness Centers USA](#) – Long Beach
[Korean Community Services, Inc.](#) – Buena Park

Community-Based Organizations (CBO)

[HealthRight360](#) – Pomona
[Behavioral Health Centers](#) – Gardena
[Los Angeles Centers for Alcohol and Drug Abuse](#) – Santa Fe Springs
[Citadel Community Care Facilities](#) – San Bernardino
[MFI Recovery Center](#) – Riverside
[Southern California Health and Rehabilitation Program](#) – Lynwood
[Tessie Cleveland Community Services Corporation](#) – Los Angeles

Consortium ((joint FQHC/behavioral health)

[Uplift Family Services/School Health Clinics/Pacific Clinics](#) – San Jose

FQHCs are community-based health care providers that receive funds from the Health Resources and Service Administration (HRSA) Health Center Program to provide primary care services in underserved areas. The majority of funding for FQHCs comes from [Medicaid \(44%\)](#) and Section 330 grants (18%). Not all CBOs are FQHCs. CBOs tend to contract with counties, or health plans for their primary revenue source and do not have Section 330 funding to cover services not allowable by other payers.

The CCBHC requirements are well-aligned with the new statewide Enhanced Care Management (ECM) benefit and Community Support (CS) services to be implemented under CalAIM. The benefit target population already includes persons with SMI, SED, and SUD with co-occurring health conditions. The CCBHC Prospective Payment System methodology is better suited to cover the wide variety of activities that are required to execute enhanced care management and population health management that are not included in the current available fee-for-service billing units. The CCBHC methodology has been implemented through managed care in other states.

"No Wrong Door" Consortium Approach: A Joint Venture for Collective Impact

Uplift Family Services (UFS) was one of five pioneering CCBHCs in California and to date, the only one in the northern region. The agency's CCBHC operates as a consortium under a joint venture agreement between UFS, School Health Clinics of Santa Clara County (SHC), and Pacific Clinics (PC). Services are available at five SHC Federally Qualified Health Centers (FQHC) across Santa Clara County. UFS and PC enhance SHC's existing primary care provision by integrating mental health, substance abuse, and care management services with the Collaborative Care Model to achieve the goal of seamless whole-person care (*Figures 1 and 2*). Collaborative Care is an evidence-based approach that aims to improve

consumer outcomes through inter-professional cooperation between Behavioral Care Managers (BCMs), consulting psychiatrists, and primary care providers who prescribe psychiatric medications. Extensive research has demonstrated that relative to usual care, the Collaborative Care Model is more effective at reducing mental health symptoms; chronic illnesses; improving functioning, quality of life, and consumer and provider satisfaction; and saving on healthcare costs.^{26,27,28}

Although Santa Clara County is home to Silicon Valley and has a relatively high median household income (\$133,076 in 2019),²⁹ income inequality and cost of living have drastically increased in recent years, exacerbated by COVID-19. The Consortium CCBHC's consumer population is considered a Medically Underserved Population for primary care by the Health Resources & Services Administration. Consumers are largely low-income, ~80% Latinx-a-o, and recent immigrants with limited English proficiency. While all ages are served, about two-thirds are youth under 18. About a third are uninsured.

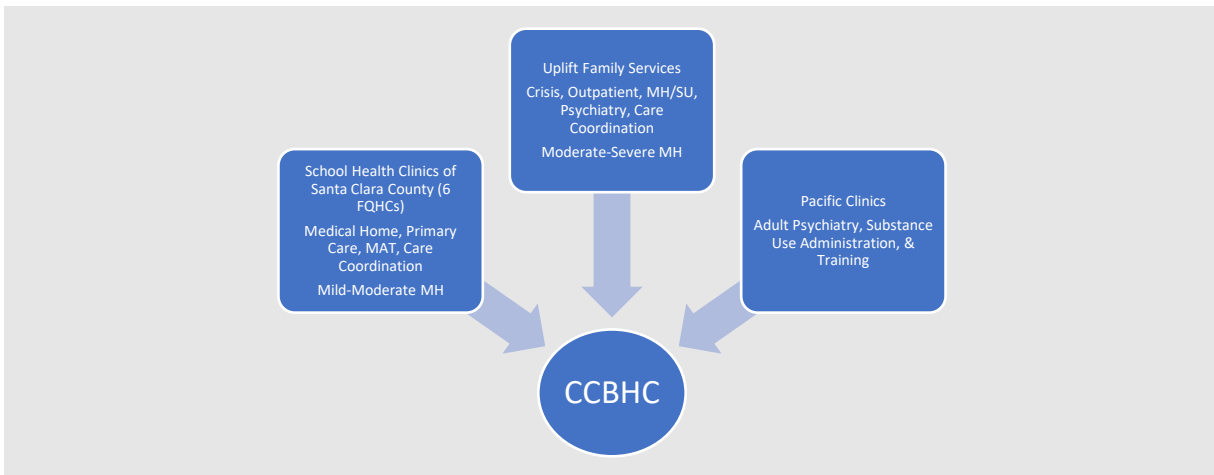


Figure 1. CCBHC consortium across three organizations with different specialties.

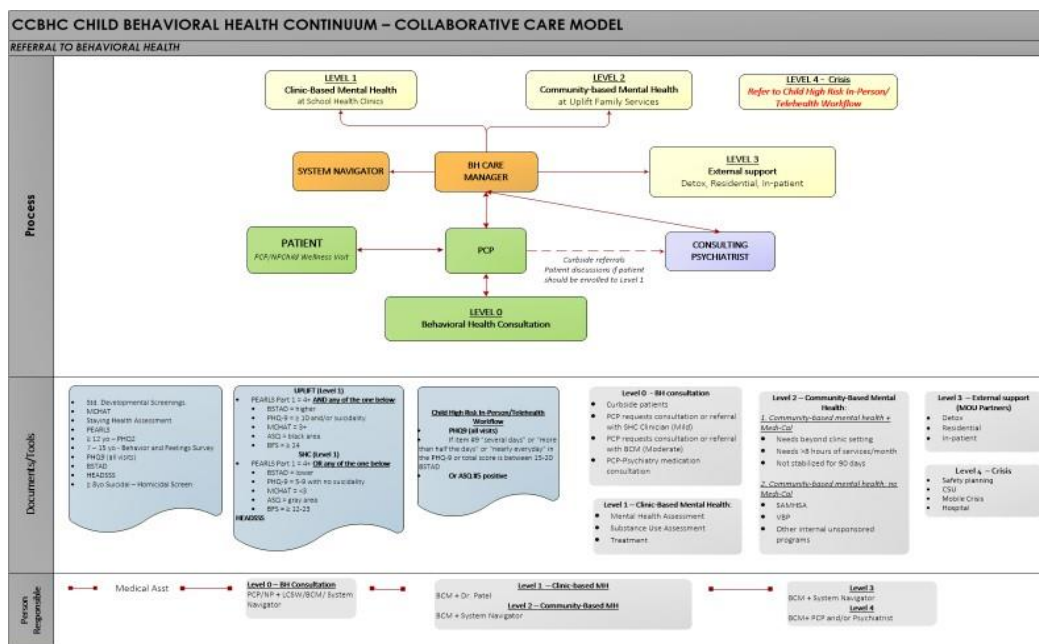


Figure 2. Example of the integrated care workflow.

Experiences in the behavioral health system: Monica is an 18-year-old Black female who has trouble concentrating, constantly feels "as if something awful might happen" and has panic attacks that result in nausea and feeling shaky and irritated. She is unable to leave home without support from a friend or her dog. She also complains of difficulty falling and staying asleep. She has experienced "constant worrying" since age 8 in response to her mother's boyfriend frequent threats to kidnap her. Her "constant worrying" increased and intensified at age 12 when her mother began to abuse substances and was incarcerated.

In the **fragmented system**, Monica seeks for help with her primary care physician (PCP) who prescribes psychotropic medication and refers her for mental health treatment. The only therapist in the clinic has a full caseload and refers her to the county system. Monica is told there is a 6 week wait for an assessment.

In the **CCBHC**, Monica is referred to mental health and psychiatry services by her PCP after screening positive for anxiety and depression. At intake, her Patient Health Questionnaire-9 (PHQ-9) score was 19 (moderately severe depression) and Generalized Anxiety Disorder-7 (GAD-7) score was 18 (severe anxiety). Her primary care physician consulted with a Behavioral Care Manager (BCM) via phone (due to COVID-19 protocols) that same day, a referral was made, and the Behavioral Care Manager (BCM), a licensed clinician contacts Monica and discusses her care with the team that include a psychiatrist and System Navigator/Rehabilitation Specialists. The next day, Monica's PCP prescribes Escitalopram (Lexapro) and she continues working with her BCM weekly to identify triggers and learning coping skills such as deep breathing exercises to help decrease her anxiety.

Within 2 weeks, Monica reports feeling less anxious as evidenced by the ability to go to a restaurant and get through a whole meal without needing to leave due to anxiety, something she was not able to do the past year. Further evidence is reflected in subsequent PHQ-9 and GAD-7 measures, which dropped to 6 (mild depression) and 7 (mild anxiety), respectively. Moreover, Monica is now able to go on walks by herself and concentrate while working on school assignments. After implementing a sleep hygiene routine, Monica now reports having an easier time falling and staying asleep. After two months of coordinated care, Monica was able to take a 10-hour train ride by herself to see family, is doing well academically and now looks forward to her job interview.

Uplift Family Services CCBHC Consortium Outcomes

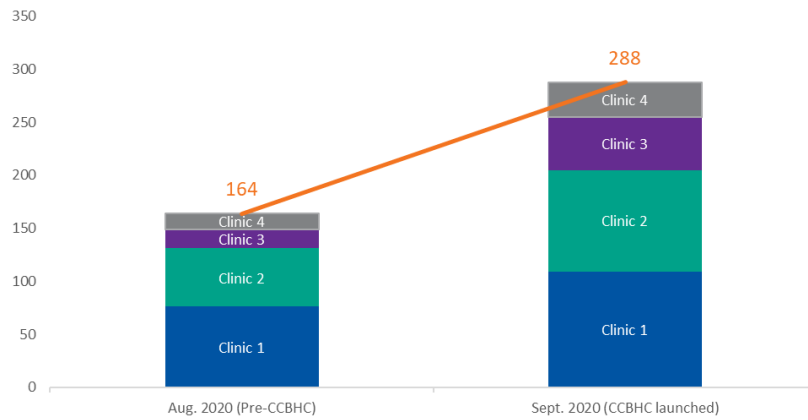
Positive evidence is emerging with CCBHC Consortium services. Within the first 12 months of operations:

- **2,943** primary care patients were **screened for behavioral health**
- Primary care providers **referred 324 (11%) patients** to behavioral health services
- **234 (72%** of referred patients) **enrolled in services**

Overall, 8.0% of screened CCBHC patients enrolled in services, a higher penetration rate than the 5.6% overall percentage of Medi-Cal beneficiaries receiving mental health services in Santa Clara County.³⁰

Integration of Physical and Behavioral Health Care

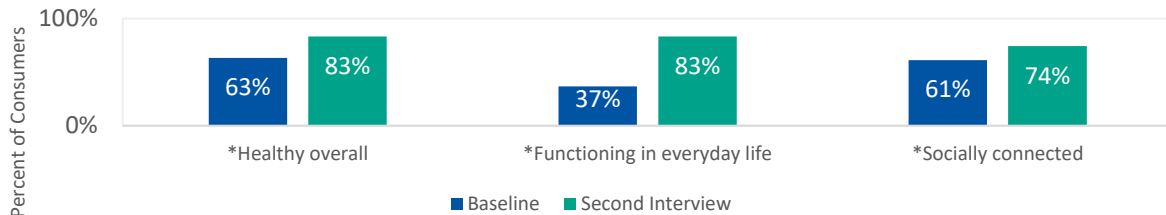
77% more primary care patients were screened for behavioral health upon CCBHC launch.



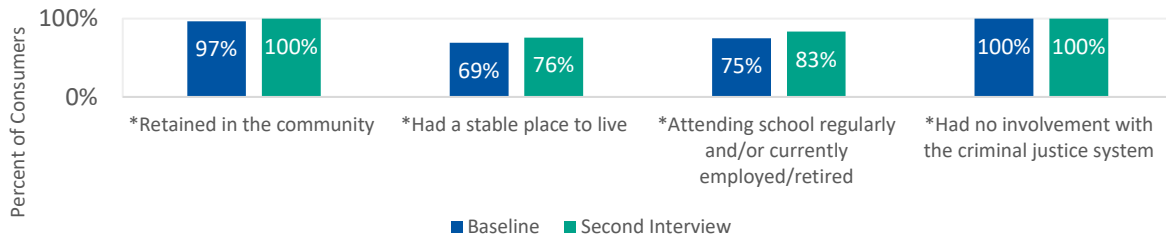
In addition, launching the CCBHC allowed for more comprehensive screening of other common behavioral health concerns, including adverse childhood experiences (ACEs), anxiety, suicidality, substance abuse, and conduct problems. In its first 12 months, the CCBHC administered 10,670 behavioral health screeners to 2,943 patients.

Clinical and Community Outcomes

CCBHC consumers reported significant improvements in health, functioning, and social connectedness.



CCBHC consumers improved or maintained their stability within the community.



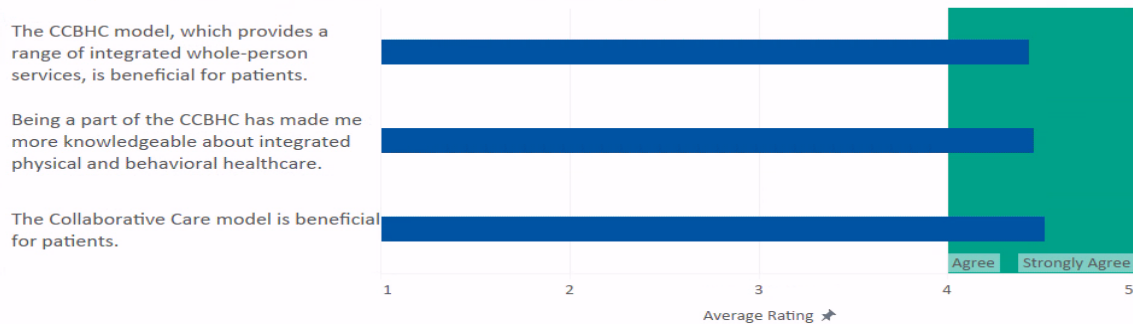
Consumer Access to Care and Satisfaction with Services

- **65%** of consumers were **contacted within 1 day or less** of their referral for behavioral health services.
- **74%** of consumers were **enrolled in services within 10 days** of their referral.
- **90%** of consumers receiving behavioral health services reported **high satisfaction**.

We love this clinic. My daughter was treated like a little princess.

Staff Satisfaction with Services

CCBHC primary care and behavioral health staff are highly satisfied with the model.



91% of CCBHC behavioral health staff reported high satisfaction with their work.

STAFF SATISFACTION: *“Working within the CCBHC has been so inspiring. Being able to reach patients in the community that have never even thought of seeking support for mental health has been my favorite part. Because of the collaboration with SHC and PC, these patients can be screened for mental health concerns and connected to the team for support within the same day.”* -Lyniece Diggs, CCBHC Clinical Program Manager and Behavioral Care Manager

Sustainability

States participating in the CCBHC demonstration grants receive Prospective Payment System (PPS) funding which provides sustainable revenue. However, California grantees have CCBHC expansion grants that do not include sustainable PPS funding. While there is immense interest among behavioral health providers to become CCBHCs, the current structure in California does not support the growth of CCBHCs among community-based behavioral health providers. Behavioral health organizations that currently meet criteria as CCBHCs are at-risk of decreasing.

The SAMHSA CCBHC-Expansion grant allows awardees the following:

- Staffing to "start-up" the CCBHC (e.g., Project Director, Evaluator) and start to provide services not previously provided (e.g., Collaborative Care, Medication Assisted Treatment) while more sustainable funding is established.
- Establish the foundation from which to expand and enhance services (e.g., develop Memorandum of Understanding with other organizations).
- One-time cost to support on-going CCBHC operations (e.g., enhancement to Electronic Health Records, equipment for telehealth).

Substantial research exists to suggest that social determinants of health, including access to housing, nutrition, and transportation, can influence health outcomes and health care use for vulnerable populations. Yet adequate, sustainable financing for interventions that improve social determinants of health has eluded most US communities. COVID-19 intensified these issues. Without sustainable funding beyond the term of the grant, the following services are potentially threatened:

- System navigation and care management for to address SDoH for populations that do not meet CalAIM criteria for ECM or CS.
- Integrated outpatient substance use services.
- Capacity building and professional development in a new CalAIM model.

- Comprehensive behavioral health services for uninsured and underinsured.

Implementation of CalAIM's ECM and CS will provide sustainable funding to support those specific populations. However, without additional funding, those in need of care management and who do not meet criteria for CalAIM will be left behind.

Call to Action

We applaud the efforts towards CalAIM. However, it is worth noting that there are populations excluded from this benefit. For example:

- Communities of color that do not meet criteria for Medi-Cal and yet have historically been impacted by an unjust system.
- Children with Autism with co-occurring mental health and substance use disorder and/or complex medical conditions.
- Young adults with multiple risk factors (e.g., history of trauma) that can be addressed in the community if such services were available to prevent frequent Emergency Department visits.

CCBHCs can be a solution to address these gaps. As illustrated above, there is a high degree of overlap and alignment between CalAIM and CCBHCs. Support of the CCBHCs would address immediate needs of populations that are not yet fully included in the initial implementation CalAIM and provide critical services to populations that will not have immediate access to ECM and CS. In essence, CCBHCs could serve as the foundation of a more robust healthcare system and immediately fill critical gaps in care as the state implements CalAIM services over time.

Below are policy recommendations in which CCBHCs can be integrated into CalAIM:

- 1. Advocate for The Excellence in Mental Health and Addiction Treatment Act** - Passage of the Excellence Act would allow California to apply to join the CCBHC Medicaid demonstration where the state would get an enhanced Medicaid match (69.34%) for those clinics included in their application for Medicaid clients. This option would result in the state saving money without changing any policies or requiring state funds from its legislature; AND/OR;
- 2. Draft a State Plan Amendment (SPA) for California's Medicaid Program- Options**
 - a. California could establish CCBHC as a Medicaid Provider Type through a State Plan Amendment (SPA). Link to examples of other state Here are links to the SPA: [Minnesota](#), [Missouri](#), [Nevada](#), and [Oklahoma](#).
 - b. **Legislative Action:** The legislature could craft legislation to mandate the state to draft the State Plan Amendment (SPA). The legislature could include a budget allocation to support the state. Examples of two states that recently passed legislation to do this: [Kansas](#) and [Illinois](#). [Maine allocated funding](#) so that the State could hire staff to think through a CCBHC SPA process. California can also utilize Mental Health Block Grant dollars for technical assistance to set-up the CCBHC model. The following is [a link to a recent letter from SAMHSA supporting such an effort](#). The benefit of this option is that the Return on Investment (ROI) impacts the non-Medicaid sectors (homeless services, criminal justice, and education), and waivers require cost neutrality within Medicaid.

- 3. Section 1115 waiver:** This waiver may be an option to allow CCBHCs to operate as a pilot. CCBHC requirements and methodology would fit as part of a full integration pilot of physical health, behavioral health, and oral health under one contracted entity in a county or region. However, the requirement for cost neutrality within Medicaid is a consideration. [Texas](#) provides an example of the waiver because it was part of their entire health care system.

In summary, delivering access to high-quality whole-person care throughout California was an imperative prior to COVID-19. The pandemic has unmasked inequities but has also been a significant accelerator of change to address the structural inequities in the healthcare system. CCBHC requirements and methodology offer California and its managed care companies a proven defined and structured process for both involving providers and the delivery of CalAIM services (e.g., ECM, CS). CalAIM is timely as it provides a means to provide life-saving services. Inclusion of CCBHCs in California's reimagined behavioral health system can be instrumental in achieving the vision for CalAIM.

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