CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00472/9 and 21-W-00080/9

TITLE: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration

AWARDEE: California Department of Health Care Services

Under the authority of the Section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable the California Department of Health Care Services (referred to herein as the state or the State) to operate the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration. These waivers are effective beginning January 1, 2025 through December 31, 2029 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the BH-CONNECT Section 1115(a) Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program and Children's Health Insurance Program (CHIP) expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 1, 2025 through December 31, 2029.

1. **Statewide Operation** **Section 1902(a)(1)**

   To enable the state to operate the demonstration on a county-by-county basis.

   To enable the state to provide services to individuals who are primarily receiving treatment for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD) on a geographically limited basis.

   To enable the state to cover Community Transition In-Reach Services only for those members receiving services through participating Behavioral Health Plans (BHPs).

   To enable the state to provide peer support services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis.

To enable the state to provide supported employment within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis. This authority is effective the date SPA 24-0051 is implemented.

To enable the state to provide enhanced community health worker services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis. This authority is effective the date SPA 24-0052 is implemented.

2. **Comparability/Amount, Duration, and Scope Section 1902(a)(10)(B) and 1902(a)(17)**

To enable the state to provide services to individuals who are primarily receiving treatment for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD) that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the State to cover Community Transition In-Reach Services for qualifying Medi-Cal members with significant behavioral health needs that are otherwise not available to all members in the same eligibility group.

To enable the state to provide peer support services within electing Drug Medi-Cal State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide supported employment within electing Drug Medi-Cal State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group. This authority is effective the date SPA 24-0051 is implemented.

To enable the state to provide enhanced community health worker services within electing Drug Medi-Cal State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group. This authority is effective the date SPA 24-0052 is implemented.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00472/9 and 21-W-00080/9

TITLE: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration

AWARDEE: California Department of Health Care Services

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by California for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from January 1, 2025 through December 31, 2029, unless otherwise specified, be regarded as expenditures under the state's title XIX and XXI plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable California to operate the above-identified section 1115(a) demonstration.

1. **Access, Reform and Outcomes Incentive Program.** Expenditures for incentive payments to BHPs that meet defined criteria as outlined in Section 5 of the STCs to strengthen access to behavioral health services and improve health outcomes among Medi-Cal members living with significant behavioral health needs.

    a. Time limited expenditure authority is granted until two years following the conclusion of the approval period for the Access, Reform and Outcomes Incentive Program, in order for the state to pay close-out costs of operating the program, and incentive payments associated with periods of performance within the approval period for the Access, Reform and Outcomes Incentive Program.

    b. This expenditure authority does not entitle uninsured individuals to any benefits under the demonstration.

2. **Workforce Initiatives.** Expenditures for workforce initiatives that meet the criteria specified in Section 6 of the STCs.

    a. Time limited expenditure authority is granted until four years following the end of the demonstration (December 31, 2033), in order for the state to pay close-out administrative costs of operating the programs and monitoring service commitments.

3. **Activity Funds Initiative.** Expenditures for payments to organizations for specified services or items for children and youth enrolled in Medi-Cal that meet the criteria in Section 7 of the

STCs with a behavioral health condition or at high risk of a behavioral health condition who are involved in the child welfare system. The services or items will be prescribed in an individual's clinical record, resulting in improved behavioral health outcomes**.**

4. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

5. **Community Transition In-Reach Services**. Expenditure authority for Community Transition In-Reach Services, provided by community-based transition teams, as described in these STCs, for qualifying Medi-Cal members with significant behavioral health needs experiencing or at risk of experiencing extended lengths of stay of 120 days or more in inpatient, subacute, and residential facilities, including in facilities that meet the definition of an Institution for Mental Diseases (IMD), for up to 180 days prior to discharge. Payments will not be made to facilities where the beneficiary resides.

6. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, described in these STCs (Section 11), which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. This authority is contingent upon adherence to the requirements within STC Section 12 Provider Rate Increase, as well as all other applicable STCs.

7. **Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 10. This expenditure authority is contingent upon compliance with Section 12, as well as all other applicable STCs.

Title XIX Requirements Not Applicable to the HRSN Expenditure Authorities

Statewideness **Section 1902(a)(1)**

To enable the state to provide short-term rental assistance services only in certain geographic areas where Medi-Cal managed care plans elect to offer these services, unless and until the state requires all Medi-Cal managed care plans to cover short-term rental assistance.

Comparability; Amount, Duration and Scope; Provision of Medical Assistance
Section 1902(a)(10)(B), and
Section 1902(a)(17)

To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section 10 of the STCs.

Title XXI Expenditure Authority:

8. **Activity Funds Initiative.** Expenditures for payments to organizations for specified services or items for children and youth enrolled in CHIP that meet the criteria in Section 7 of the STCs with a behavioral health condition or at high risk of a behavioral health condition who are involved in the child welfare system. The services or items will be prescribed in an individual's clinical record, resulting in improved behavioral health outcomes**.**

9. **Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 10. This expenditure authority is contingent upon compliance with Section 12, as well as all other applicable STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00472/9 and 21-W-00080/9

TITLE: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration

AWARDEE: California Department of Health Care Services

1. PREFACE

The following are the Special Terms and Conditions (STC) for the "Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment" (BH-CONNECT) section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the California Department of Health Care Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The periods for each Demonstration Year (DY) will be as follows:

- DY 1: January 1, 2025 through December 31, 2025
- DY 2: January 1, 2026 through December 31, 2026
- DY 3: January 1, 2027 through December 31, 2027
- DY 4: January 1, 2028 through December 31, 2028
- DY 5: January 1, 2029 through December 31, 2029

The STCs related to the programs for those populations affected by the demonstration are effective from January 1, 2025 through December 31, 2029**,** unless otherwise specified.

The STCs have been arranged into the following subject areas:

10	Health-Related Social Needs (HRSN) Services
11	DSHP
12	Provider Rate Requirements
13	State Commitments to Provider Rates
14	Monitoring and Reporting Requirements
15	Evaluation of the Demonstration
16	General Financial Requirements
17	Monitoring Budget Neutrality for the Demonstration
18	Monitoring Allotment Neutrality
19	Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	Access, Reform and Outcomes Incentive Program Protocol
Attachment D	Reserved for SMI Implementation Plan and Financing Plan
Attachment E	Reserved for Monitoring Protocol
Attachment F	Reserved for Evaluation Design
Attachment G	HRSN Services Protocol
Attachment H	HRSN Services Matrix
Attachment I	HRSN Implementation Plan
Attachment J	DSHP List
Attachment K	Provider Rate Increase Attestation Table

2. PROGRAM DESCRIPTION AND OBJECTIVES

The BH-CONNECT demonstration aims to strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs, inclusive of mental health conditions and substance use disorders (SUDs). The demonstration builds on the success of California's previous section 1115 demonstrations and 1915(b) waiver to improve health outcomes and reduce health disparities for the Medi-Cal population in the state.

The BH-CONNECT section 1115 demonstration authorizes:

- A Workforce Initiative to invest in a highly qualified, diverse behavioral health workforce to support Medi-Cal members and uninsured populations living with behavioral health needs.
- Federal funding for Designated State Health Programs (DSHP), which California will use to support the Workforce Initiative.
- Activity Funds to ensure children and youth involved in child welfare have access to activities that support health and wellbeing.
- The Access, Reform and Outcomes Incentive Program to incentivize county behavioral health delivery systems to improve access to behavioral health services; improve

outcomes among Medi-Cal members living with significant behavioral health needs; and make targeted behavioral health delivery system reforms.
- Services for eligible individuals with a serious mental illness during short-term stays in Institutions for Mental Diseases (IMDs), consistent with the requirements outlined in SMDL #18-011.
- Community transition in-reach services to support individuals with significant behavioral health conditions who are experiencing long-term stays in institutions in returning to the community.
- Short-term rental assistance for a limited time-period for eligible beneficiaries.

Through the BH-CONNECT demonstration, California aims to:
- Expand the continuum of community-based behavioral health services and evidence-based practices (EBPs) available through Medi-Cal.
- Strengthen family-based services and supports for children and youth living with significant behavioral health needs, including children and youth involved in child welfare.
- Invest in statewide practice transformations to better enable county behavioral health delivery systems and providers to support Medi-Cal members living with significant behavioral health needs.
- Strengthen the workforce needed to deliver community-based behavioral health services and EBPs to Medi-Cal members.
- Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness.
- Reduce use of institutional care by those individuals most significantly affected by significant behavioral health needs.
- Shorten lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration.
- Promote improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.

Throughout these STCs, the term behavioral health plans (BHPs) is defined as including three types of Prepaid Inpatient Health Plans regulated under 42 CFR Part 438: (1) mental health plans (MHPs) that are responsible for Specialty Mental Health Services (SMHS), (2) Drug Medi-Cal Organized Delivery Systems (DMC-ODS) that are responsible for providing specialty substance use disorder (SUD) services, and (3) Integrated Prepaid Inpatient Health Plans that are responsible for providing both SMHS and DMC-ODS.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either

through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other

contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. **Eligibility Groups Affected by the Demonstration.** There is no change to Medicaid or CHIP eligibility and the standards and methodologies for eligibility remain set forth under the Medicaid or CHIP state plans and are subject to all applicable Medicaid and CHIP laws and regulations.

5. ACCESS, REFORM, AND OUTCOMES INCENTIVE PROGRAM

A key goal of this section 1115 demonstration is to improve access and quality for Medi-Cal members living with significant behavioral health needs. The state is eligible to receive $1,900,000,000 total computable over 5 years contingent on it meeting the requirements below. Under this demonstration, the state is providing incentive payments to participating behavioral health plans that demonstrate improvements in access to behavioral health services and outcomes among Medi-Cal members living with behavioral health needs.

5.1. **Description.** The state will implement the Access, Reform and Outcomes Incentive Program as a pilot in a select number of counties where funding is most needed to improve performance in this program's focus areas of access, outcomes and delivery system reform. Within participating counties, BHPs will receive incentive payments for demonstrated improvements in access to behavioral health services and outcomes among Medi-Cal members living with behavioral health needs. Additional program criteria and measurement areas will be further specified in the Access, Reform and Outcomes Incentive Program Protocol, hereafter referred to as the Incentive Program Protocol.

a. In this program, the state will pay BHPs solely based on achieving goals and the corresponding progress as measured by performance on identified measures as further described in these STCs and the Incentive Program Protocol.

b. DHCS will administer the Access, Reform and Outcomes Incentive Program and distribute incentive payments to BHPs that meet participation requirements described in STC 5.2 and meet performance targets on the measures outlined in these STCs and the Incentive Program Protocol.

c. DHCS will determine the amount of funding that each BHP can earn in each demonstration year using the methodology described in these STCs and the Incentive Program Protocol.

d. Access, Reform and Outcomes Incentive Program funding will not supplant funding provided by other Federal, state or local funding sources for behavioral health services. Incentive payments will not be used to reduce payment amounts otherwise payable to and by BHPs for Medi-Cal activities.

e. Access, Reform and Outcomes Incentive Program funding will not reward BHPs for improvements that are already being incentivized by another state program.

f. BHPs must use any earned incentive payments to support and expand Medi-Cal services and activities that benefit Medi-Cal members served by the behavioral health delivery system. However, this funding will not be used to supplant funding for existing benefits.

5.2. **Participation Requirements.**

a. The Access, Reform and Incentive Program is limited to a pilot of up to 80 percent of counties as specified in the Incentive Program Protocol. The state will select counties where the funding is most needed to improve performance on the access, outcomes and delivery system reform measures specified in the Incentive Program Protocol described in STC 5.13. Within participating counties, BHPs will be eligible to earn incentive payments if they meet the following participation requirements:

   i. BHPs must complete a self-directed assessment with the National Committee for Quality Assurance (NCQA) on NCQA's Managed Behavioral Healthcare Organization (MBHO) standards on a timeline specified by DHCS. The assessment will evaluate BHPs' performance on managed care, quality improvement, and care coordination capabilities.

   ii. To be eligible to earn incentive payments for selected measures related to the implementation of key evidence-based practices (EBPs), BHPs must complete the assessment described in STC 5.2(a), and cover and implement Assertive Community Treatment (ACT), Forensic ACT, Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), the Individual Placement and Support model of Supported Employment, Clubhouse Services, Enhanced Community Health Worker Services, and/or Peer Support Services, including a forensic specialization, as specified by DHCS.

   iii. On at least an annual basis, BHPs must submit reports and data to DHCS to allow the state to determine whether the county BHP is meeting reporting or

performance requirements. Failure to adequately report on milestones and performance metrics may preclude receipt of future Access, Reform and Outcomes Incentive Program funding.

b. The state has the discretion to remove a county from participation in the Access, Reform and Outcomes Incentive Program due to poor performance or non-compliance with program requirements.

5.3. **Program Areas of Focus.** Progress towards achieving the goals specified above will be assessed by specific measures in three focus areas as outlined below. Both these measures, as well as the methodology for determining whether the goals and targets associated with these measures are being met, will be specified in the Incentive Program Protocol described in STC 5.13. Measures must have the potential to demonstrate improvements over the demonstration period, and measures submitted for each calendar year should reflect data from that calendar year; any exceptions must be documented and approved in the Incentive Program Protocol. Participating BHPs will be eligible to earn incentive payments in the following areas of focus:

a. **Focus Area 1.** Improve Access to Behavioral Health Services: Up to $777,750,000 total computable will be available for incentive payments related to improved access to behavioral health services.

b. **Focus Area 2.** Improve Health Outcomes and Quality of Life: Up to $714,000,000 total computable will be available for incentive payments related to improved health outcomes and member-reported quality of life among Medi-Cal members with behavioral health needs.

c. **Focus Area 3.** Targeted Behavioral Health Delivery System Reforms: Up to $236,000,000 total computable will be available for incentive payments related to targeted behavioral health delivery system reforms.

d. The Incentive Program Protocol will outline the measures for which participating BHPs must meet specified performance targets to earn incentive payments in the Access, Reform and Outcomes Incentive Program. For participating BHPs that do not have adequate sample size to report on select measures, funding may be re-distributed to other measures or Areas of Focus. To the extent sample sizes are sufficiently large, participating BHPs will be required to stratify data based on the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

5.4. **Baseline data.** Where possible, the state must use existing plan data accumulated prior to implementation to identify performance goals for participating BHPs. If data prior to implementation is not available, the state will establish baseline data in initial demonstration years. The state's plan for baseline data for each metric will be provided in the Incentive Program Protocol.

5.5. **Additional Terms and Operations of the Access, Reform and Outcomes Incentive Program.** The following will apply:

a. DHCS will distribute incentive payments earned in the measure areas described in STC 5.3 to BHPs based on its review and assessment of data on BHP performance. Payments will be made on at least an annual basis. The distribution methodology for the incentive payments will be outlined in the Incentive Program Protocol.

b. DHCS will submit summaries of BHP performance annually to CMS in the Monitoring Reports. The summaries should include an assessment of progress towards each of the focus areas, the relevant measurement periods, and any mid-course corrections the state may be considering.

c. DHCS will monitor BHP participation in the Access, Reform and Outcomes Incentive Program and related payments to ensure compliance with program requirements and applicable statutory and regulatory requirements, and to prevent fraud, waste and abuse.

5.6. **Federal Financial Participation (FFP) for the Access, Reform and Outcomes Incentive Program.** The state may claim, as authorized expenditures under the demonstration, up to $1,900,000,000 total computable over 5 years, for performance-based incentive payments to BHPs participating in the Access, Reform and Outcomes Incentive Program across three areas of focus, as specified in Table 1 below. Payments are an incentive for successfully meeting specified targets on measures associated with access to care, quality of care, and health outcomes rather than payment of claims for the provision of behavioral health care.

a. Access, Reform and Outcomes Incentive Program payments are not direct reimbursement for expenditures of payments for services. Such payments are intended to support and reward BHPs for strengthening access to behavioral health services and improving health outcomes among Medi-Cal members living with significant behavioral health needs. Such payments are not considered patient care revenue.

b. The state may claim FFP for Access, Reform and Outcomes Incentive Program payments for one measure in Demonstration Year 1 as described in STC 5.12.

c. With the exception of the measure described in STC 5.12, the state may not claim FFP for Access, Reform and Outcomes Incentive Program payments until after CMS has approved the Incentive Program Protocol. Once approved, the state may receive FFP for expenditures beginning January 1, 2026.

d. The state may not claim FFP for Access, Reform and Outcomes Incentive Program payments in each year until the state has concluded whether or not the BHPs have met the performance standard for each payment. BHPs must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to approved Access, Reform and Outcomes Incentive Program activities.

e. The state must inform CMS of the funding of all Access, Reform and Outcomes Incentive Program payments to BHPs annually through Monitoring Reports submitted to CMS as required by STC 14.6.

Table 1. Access, Reform and Outcomes Incentive Program Funding by Demonstration Year ($ in thousands)

Area of Focus	DY 1	DY 2	DY 3	DY 4	DY 5
Maximum Incentive Program Expenditure Authority	$210,000	$285,000	$ 385,000	$ 510,000	$ 510,000
Program Accountability Percent	0%	0%	5%	10%	20%
Program Accountability Dollars	N/A	N/A	$19,250	$51,000	$102,000
Maximum Funds Net Program Accountability	$210,000	$285,000	$365,750	$459,000	$408,000
Improved Access to Behavioral Health Services	$60,000	$185,000	$175,750	$189,000	$168,000
Improved Health Outcomes and Quality of Life	$60,000	$60,000	$152,000	$234,000	$208,000
Targeted Behavioral Health Delivery System Reforms	$90,000	$40,000	$38,000	$36,000	$32,000

f. Within each area of focus, DHCS will determine the initial allocation of incentive funds available to be potentially earned by each participating BHP for each demonstration year in accordance with a methodology, to be detailed in the Incentive Program Protocol, that may be based on the following factors:

   i. Total number of participating BHPs;

   ii. Total Medi-Cal member enrollment in the county;

   iii. County-level indicators of social and health-related risk based on data such as the Healthy Places Index (HPI) percentile data; and

   iv. Minimum and maximum allocation limits per county.

g. Authorized expenditure amounts for one demonstration year cannot be carried, shifted or otherwise transferred across demonstration years in any circumstances; however, earned incentive payment based on one demonstration year may be paid in a subsequent demonstration year against the expenditure limit for the demonstration year on which the incentive payment is based, as necessary pursuant to operational processes to determine the final incentive payment amount.

5.7. **High-Performance Pool.** The state will create a high-performance pool to redistribute incentive funds that are unearned by BHPs in DY 1 – DY 5. To the extent unearned incentives remain after the annual performance period, any remaining funds will be used for incentive payments for BHPs meeting higher standards of access and outcome improvements in the same performance period, based on a subset of measures to be defined in Incentive Program Protocol. The high-performance pool will be made up only with unearned incentives for the BHPs and the state will not withhold any amounts to increase it. The parameters to earn this funding will be outlined in the Incentive Program Protocol. Unearned funding for Incentive Program Accountability, described in STC 5.11, is not available for the high-performance pool.

a. To be eligible to participate in the high-performance pool, the BHP must achieve prerequisite targets on a set of measures from the three focus areas as specified in the Incentive Program Protocol. These targets should be based on national data from the same year, if available, and otherwise compared to data submitted by all participating BHPs during that year. These targets will be specified in the Incentive Program Protocol.

b. A BHP which has met the above prerequisites may receive a high-performance payment based on tiered measure performance on a set of measures from the three focus areas, where plans which achieve higher percentile performance receive relatively higher incentive payments, in accordance with the High-Performance Pool earning and funding methodology described in the Incentive Program Protocol.

5.8. **Budget Neutrality Treatment for Access, Reform and Outcomes Incentive Program.** The expenditure authority for the Incentive Program must be supported out of budget neutrality savings.

5.9. **Federal Matching Rate for Access, Reform and Outcomes Incentive Program.** All expenditures for the Access, Reform and Outcomes Incentive Program must be claimed as administrative on the applicable CMS 64.10 waiver forms(s). The state must ensure that Access, Reform and Outcomes Incentive Program expenditures described in STC 5 (this STC) are not factored into payment rates, and that there is no duplication of funds.

5.10. **Claiming Process.** The state is required to report expenditures for the program on the CMS-64 as prescribed within these STCs and follow applicable timely filing rules.

a. The state will incur administrative costs related to implementing and overseeing the Access, Reform and Outcomes Incentive Program for the entirety of the

demonstration period, but also related administrative closeout costs that may be claimed for up to two years following the conclusion of Demonstration Year 5.

b. The state may only distribute incentive payments associated with Demonstration Years 1-5.

5.11. **Incentive Program Accountability.** A share of total Access, Reform and Outcomes Incentive Program funding will be at risk if the participating BHPs fail to demonstrate progress toward meeting a set of accountability measures, to be defined and approved by CMS in the Incentive Program Protocol. The percentage at risk will gradually increase from 5 percent in DY 3 to 20 percent in DY 5. The state must propose 3-5 accountability measures with at least one measure pertaining to each focus area of the incentive program. These measures must be able to be calculated and aggregated across all participating counties and have the potential to demonstrate improvement over the demonstration period.

a. Program accountability is applied prior to calculation of individual plan performance, so any reductions from program accountability apply to the global amount of funding from which BHP payments may be made, described in STC 5.3 above.

b. The accountability measures submitted for each calendar year should reflect data from that calendar year; any exceptions must be documented and approved in the Incentive Program Protocol. Where possible, the state must use data from before demonstration implementation as a baseline to inform the program accountability calculation. If data prior to implementation is not available, the state will establish baseline data in DY1.

c. The program accountability calculation will be based on achievement of or improvement towards performance goals across all BHPs participating in the Access, Reform and Outcomes Incentive Program. The targets for each measure used in the program accountability calculation, as well as the methodology for determining progress towards those targets (including relevant baseline data), will be specified in the Incentive Program Protocol.

d. Each accountability measure will be assigned a weight for each performance year. Aggregated participating BHP performance in each component will be multiplied by the associated weight, and then summed together to create an aggregate score, which will be the state's Accountability Score. The state will report its Accountability Score to CMS in the Monitoring Report once it is available, with supporting documentation showing the calculation of the score. If the state is unable to provide this in the Monitoring Report, it should indicate in the Incentive Program Protocol its preferred submission timeline for CMS's approval. The score will then be used by the State and CMS to determine whether the state's Access, Reform and Outcomes Incentive Program expenditure authority will be reduced for the relevant demonstration year. The maximum amount of funding at risk for program accountability is described in Table 1, and the actual amount of any reduction for a

year will be determined according to the methodology agreed upon by the state and CMS in the Incentive Program Protocol.

e. Participating BHP performance is assessed individually by BHP and by measure to determine whether the BHP has met the established targets for incentive payments.

f. Expenditure limit reductions for the state are forfeited and cannot be earned back in subsequent demonstration years. However, an earned incentive payment based on one demonstration year may be paid in a subsequent demonstration year against the expenditure limit for the demonstration year on which the incentive payment is based, as necessary to determine the final earned incentive payment amount.

5.12. **Requirements for Demonstration Year 1.** In the first year of the demonstration, the state may receive FFP for a measure related to Focus Area 3: Targeted Behavioral Health Delivery System Reforms. The state shall include narrative documentation in its first Annual Monitoring Report showing that it met this requirement. Additionally, the state will submit in the Monitoring Report baseline data for the accountability metrics, as appropriate.

5.13. **Access, Reform and Outcomes Incentive Program Protocol (Incentive Program Protocol).** The state must submit a proposed Incentive Program Protocol for CMS approval. With the exception of the measure described in STC 5.12, the state is at risk for all incentive payments until the Incentive Program Protocol is approved. FFP will be available retroactively to the beginning of DY 2 for approved elements of the Incentive Program Protocol, should the state make qualifying expenditures prior to the Protocol's approval. The Incentive Program Protocol will be appended to these STCs as Attachment C. The Incentive Program Protocol must include the following information (in addition to what is described elsewhere in these STCs):

a. Description of the statewide approach to improve access to behavioral health services and outcomes among Medi-Cal members living with behavioral health needs, including the relationship between the accountability measures and the interventions at the health system level.

b. Description of how its analysis (including the NCQA MBHO assessments) identified areas for improvement across the Focus Areas and led to the selection of the proposed measures for the three focus areas as well as the program accountability measures and interventions.

c. Description of how the state will select which counties participate in the Access, Reform and Outcomes Incentive Program based on identifying counties with the greatest need, including how it will consider both the NCQA MBHO assessments as well as other factors in its selection process.

d. Selected measures, both at the individual BHP level as described in STC 5.3 and the aggregated accountability level as described in STC 5.7, and their technical specifications for the Access, Reform and Outcomes Incentive Program. The state must have written permission from measure stewards to use their measures prior to

program implementation, as applicable. Validated and tested measures from nationally recognized measure stewards should be prioritized for selection; if such measures do not address certain program goals, additional measures may be selected or developed as specified in the Incentive Program Protocol. In the event that a measure is retired by a measure steward for any reason, the state must replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within California (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the finding from analysis and/or NCQA MBHO assessment.

e. Goals/targets for the above measures, as well as the methodology for determining whether the measure is making progress toward or achieving the goal, including how the measures will be compared to baseline data and whether any statistical testing will be applied to determine significance of observed trends.

f. Targets for the high-performance pool, such that higher performing plans receive larger payments from the high-performance pool.

g. Description of the earning and distribution methodology for incentive funding at the BHP level described in STC 5.3, program accountability level described in STC 5.11, and high-performance pool level described in STC 5.7.

h. Description of how the state will convene participating plans and engage stakeholders to facilitate the sharing of best practices, including the sharing of implementation successes as well as discussion of strategies to address challenges.

6. WORKFORCE INITIATIVES

To support workforce recruitment and retention and to promote the increased availability of behavioral health care practitioners who serve Medi-Cal members and uninsured individuals, the state shall implement five statewide workforce initiatives: 1) Medi-Cal Behavioral Health Student Loan Repayment Program; 2) Medi-Cal Behavioral Health Scholarship Program; 3) Medi-Cal Behavioral Health Recruitment and Retention Program; 4) Medi-Cal Behavioral Health Community-Based Provider Training Program; and 5) Medi-Cal Behavioral Health Residency Training Program. Funding for these workforce initiatives must not supplant state and federal funding or duplicate existing workforce programs. The state will consult with the Health Resources and Services Administration (HRSA) as it works on these programs. The aim of these workforce initiatives is to address shortages in qualified practitioners serving Medi-Cal members and uninsured individuals who are living with or at-risk for behavioral health conditions.

6.1. **Terms and Conditions Applicable to Each Workforce Initiative.** The following shall apply to each of the five workforce initiatives detailed in this section of the STCs:

a. Full-time service commitments for workforce initiative participants must be fulfilled in safety net settings defined as:

i. Federally Qualified Health Centers (FQHC),

ii. Community Mental Health Centers (CMHC),

iii. Rural Health Clinics (RHC), or

iv. Settings with the following payer mix:

1. Hospitals with 40 percent or higher Medicaid and/or uninsured population,
2. Rural hospitals with 30 percent or higher Medicaid and/or uninsured population, or
3. Other behavioral health settings with 40 percent or higher Medicaid and/or uninsured population.

b. To fulfill the full-time service commitment, qualified practitioners may work at a single organization, or hold part-time positions across multiple provider organizations, so long as all organizations meet the safety net setting definition in STC 6.1(a).

c. The state shall develop a process for ensuring that practitioners remain in compliance with program requirements and meet the qualifying service commitments. If the service commitment is not met, except in extraordinary circumstances as determined by the state (e.g., disability or death), the state shall not make further payments and the state shall recoup all payments made on behalf of the program participant. In the case of recoupment, regardless of whether the state is able to recover the payments made on behalf of the program participant, the state shall return the federal share of those payments to CMS within 1 year of the breach in the service commitment. Suspension or revocation of a professional license does not constitute an extraordinary circumstance for purposes of not meeting the service commitment. Program participants must pass required professional state licensing or certification examinations and obtain requisite licensure or certification no later than 1 year of completing the degree or certificate programs and meeting clinical hour requirements pursuant to state law, except in extraordinary circumstances as determined by the state (e.g., disability or death). Failure to obtain requisite licensure or certification will constitute a breach in the service commitment requirement.

d. The state may have multiple rounds/cohorts of disbursements (i.e., awards to new recipients) each year for workforce initiatives, so long as it does not extend beyond the applicable authorized level of funding for each program over the course of the demonstration period or demonstration year, as applicable.

e. The state will define application and eligibility criteria and select awardees through a competitive process that will allow the state to evaluate the applicants relative to the criteria established. The state may prioritize applicants with cultural and linguistic competence that reflect and respond to the needs of the Medi-Cal population. The criteria must comply with federal civil rights law and not impermissibly discriminate based on race, ethnicity, national origin, sexual orientation, gender identity, disability or any other federally protected classes or characteristics.

f. The state must ensure all education and training programs are certified or accredited by the state or organizations recognized by the state. If no certification or accreditation is available, education and training programs must meet widely recognized guidelines outlining the core roles and skills considered standard for that discipline and be approved by the state.

g. The state must ensure that if an individual participates in one of the workforce programs described in STC Section 6, the individual is ineligible to participate in another workforce program funded under STC Section 6 until their service obligations are fulfilled, with the exception of the Behavioral Health Residency Training Program participation and enrollment in the Behavioral Health Student Loan Repayment Program as described in STC 6.7(a).

h. The state must conduct oversight of provider organizations and educational institutions receiving workforce funding. At a minimum, provider organizations and educational institutions must submit annual reports detailing the use of workforce funding to the state.

6.2. **Medi-Cal Behavioral Health Student Loan Repayment Program.** The state will make available student loan repayments for behavioral health practitioners specified in STC 6.2(a).

a. Eligible behavioral health practitioners and loan repayment amounts include:

i. Up to $240,000 per licensed practitioner with prescribing privileges and individuals in training to be a licensed practitioner with prescribing privileges, including but not limited to: Psychiatrists, Addiction Medicine Physicians, and Psychiatric Mental Health Nurse Practitioners.

ii. Up to $180,000 per non-prescribing licensed or associate level pre-licensure practitioner, including but not limited to: Psychologists, Clinical Social Workers, Professional Clinical Counselors, Marriage and Family Therapists; Occupational Therapists, and Psychiatric Technicians.

iii. Up to $120,000 per Alcohol or Other Drug Counselors, Community Health Workers, Peer Support Specialists, Wellness Coaches, and other non-prescribing practitioners meeting the provider qualifications for Community Health Worker services, Rehabilitative Mental Health Services, Substance Use Disorder Treatment Services, and Expanded Substance Use Disorder Treatment Services in the California Medicaid State Plan.

b. Recipients who are eligible behavioral health practitioners defined in STC 6.2(a)(i) and (ii) commit to practicing full-time for four years in safety net settings meeting the definition in STC 6.1(a).

c. Recipients who are eligible behavioral health practitioners defined in STC 6.2(a)(iii) commit to practicing full-time in a safety net setting as defined in STC 6.1(a), as follows:

i. For loan repayments of $20,000 and greater, practitioners must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).

ii. For loan repayments of $10,000 and up to $20,000, practitioners must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).

iii. For loan repayments less than $10,000, practitioners must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).

d. Loan repayments must be made directly to the student loan servicer either by the state or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.

e. The state may only repay an amount up to the student loan amount owed by the practitioner. The state may not pay an amount that exceeds an individual practitioner's student loan. Only the student loans for educational costs associated with the course of study that led to the highest degree or certificate earned as a pre-requisite to obtaining the relevant practitioner credential may qualify for reimbursement under the program.

6.3. **Medi-Cal Behavioral Health Scholarship Program.** The state will make available scholarship payments while participants receive their education. To participate in the program, individuals must be pursuing behavioral health degrees or certifications specified in STC 6.3(a).

a. Eligible participants and scholarship amounts include:

i. Up to $240,000 per licensed practitioner with prescribing privileges and individuals in training to be a licensed practitioner with prescribing privileges, including but not limited to: Psychiatrists, Addiction Medicine Physicians, and Psychiatric Mental Health Nurse Practitioners.

ii. Up to $180,000 per non-prescribing licensed or associate level pre-licensure practitioner, including but not limited to: Psychologists, Clinical Social Workers, Marriage and Family Therapists, Professional Clinical Counselors, Occupational Therapists, and Psychiatric Technicians.

iii. Up to $120,000 per Alcohol or Other Drug Counselors, Community Health Workers, Peer Support Specialists, Wellness Coaches, and other non-prescribing practitioners meeting the provider qualifications for Community Health Worker services, Rehabilitative Mental Health Services, Substance Use Disorder Treatment Services, and Expanded Substance Use Disorder Treatment Services in the California Medicaid State Plan.

b. Recipients who are eligible behavioral health practitioners defined in STC 6.3(a)(i) and (ii) commit to practicing full-time for four years in safety net settings meeting the definition in STC 6.1(a).

c. Recipients who are eligible behavioral health practitioners defined in STC 6.3(a)(iii) commit to practicing full-time in a safety net setting as defined in STC 6.1(a), as follows:

    i. For scholarships of $20,000 and greater, practitioners must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).

    ii. For scholarships of $10,000 and up to $20,000, practitioners must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).

    iii. For scholarships less than $10,000, practitioners must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).

d. Scholarship program eligible participants include individuals who are in a course of study leading toward the qualifying degree or certification required as a pre-requisite to obtaining the relevant provider credential to be licensed and non-licensed practitioners listed in STC 6.3(a).

e. Scholarship payments must be made directly only to the educational institution by either the state or a procured vendor. Funds will not be provided to individual participants.

f. The state must require that all Medi-Cal Behavioral Health Scholarship Program participants, make application to the Free Application for Federal Student Aid (FAFSA) and Cal Grant program. The state or intermediary may not make scholarship payments on behalf of a program participant until both the FAFSA and Cal Grant applications have been submitted and a determination has been made on the amount of grant funding that will be received by the program participant.

6.4. **Medi-Cal Behavioral Health Recruitment and Retention Program.** The state will establish a program to provide recruitment and retention bonuses, supervision support for pre-licensure and pre-certification practitioners, and certification/licensure and training supports with the aim of recruiting and retaining behavioral health practitioners to serve the Medi-Cal population. The state will develop a process to identify provider organizations to receive Recruitment and Retention Program funding, however, funding for payments to the provider organizations described in STC 6.4(a)-(c) must go to the behavioral health practitioners. The Medi-Cal Behavioral Health Recruitment and Retention Program will include:

a. Up to $20,000 per practitioner for recruitment bonuses and up to $4,000 per practitioner for retention bonuses to provider organizations meeting the safety net setting definition in STC 6.1(a). Provider organizations must make these recruitment

and retention bonus payments to licensed behavioral health practitioners and non-licensed practitioners listed in Section 6.2(a)(i)-(iii).

i. For recruitment bonuses of $20,000, practitioners must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).

ii. For recruitment bonuses of $10,000 and up to $20,000, practitioners must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).

iii. For recruitment bonuses less than $10,000, practitioners must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).

b. Up to $50,000 per individual for recruitment bonuses to provider organizations meeting the safety net setting definition in STC 6.1(a) to support individuals pursuing behavioral health related associate's degrees, bachelor's degrees, master's degrees, or doctorate programs who are completing required training in advance of their final year of education. Participants must commit to practicing full-time, upon graduation and upon certification or licensure, at safety net settings as defined in STC 6.1(a).

i. For recruitment bonuses of $20,000 and greater, recipients must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).

ii. For recruitment bonuses of $10,000 and up to $20,000, recipients must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).

iii. For recruitment bonuses less than $10,000, recipients must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).

c. Up to $1,500 per practitioner for achieving or maintaining licensure or certification to provider organizations that are safety net settings as defined in STC 6.1(a) to support practitioners pursuing or maintaining licensure or certification for a behavioral health profession, including but not limited to costs of study material, examination costs, and licensing and certification fees. Recipients commit to practicing full-time, upon licensure or certification, for two years at the provider organization making the licensure and certification payments.

d. Up to $35,000 per demonstration year to provider organizations that are safety net settings as defined in STC 6.1(a) to support the supervision hours of pre-licensure or pre-certificate behavioral health practitioners training to gain the required hours to qualify for licensure or certification at the provider organization.

e. Backfill for licensed or certified practitioners who attend training to provide key evidence-based practices, specifically Assertive Community Treatment (ACT),

Forensic ACT, Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), the Individual Placement and Support model of Supported Employment, Clubhouse Services, Multisystemic Therapy, Functional Family Therapy, Parent-Child Interaction Therapy, High Fidelity Wraparound, Community Health Worker Services, and Peer Support Services. To avoid reduced access to care when a practitioner is in training for these key evidence-based practices during practitioner working hours and recognizing the absence requires a temporary or covering worker to perform duties, the state may use funds to pay the provider organization to backfill the practitioner. Backfill costs must not exceed the following rates and no more than 5 days per week for participants in the following programs:

i. $750 per day for practitioners with prescribing privileges as defined in STC 6.2(a)(i).

ii. $500 per day for non-prescribing licensed practitioners, as defined in STC 6.2(a)(ii).

iii. $250 per day for other non-prescribing behavioral health practitioners, as defined in STC 6.2(a)(iii).

f. A practitioner awarded a recruitment bonus under this program is not eligible to receive a retention bonus until the practitioner has fulfilled their recruitment bonus service commitment.

6.5. **Medi-Cal Behavioral Health Community-Based Provider Training Program.** The Behavioral Health Community-Based Provider Training Program is designed to build up the workforce of Alcohol or Other Drug Counselors, Community Health Workers and Peer Support Specialists by funding training and education in order to create a healthcare workforce pipeline to address community-based workforce shortages throughout the state. Participation in the program will be conditioned on a three-year full-time commitment of service in safety net settings as defined in STC 6.1(a).

a. The state may pay training programs up to $10,000 per practitioner participating in this program. Funds may only be used for the following activities:

i. Program tuition and required program fees for course curriculums necessary to achieve the professional titles of Alcohol or Other Drug Counselor, Community Health Worker or Peer Support Specialist.

ii. Textbooks and supplies as required by the educational program curriculum.

iii. Professional exam fees and certification or licensure costs.

b. Payments must be made directly only to the training program on behalf of the practitioner. Funds will not be provided to individual participants.

6.6. **Medi-Cal Behavioral Health Residency Training Program.** The state will provide up to $250,000 per residency and fellowship slot per demonstration year to allow safety net settings to support new or expanded residency and fellowship slots during the

demonstration period. The state may adjust the individual awards as necessary to reflect the impact of inflation, subject to the total funding for the initiative detailed in STC 6.8. Awards may be made only to safety net settings meeting the definition in STC 6.1(a). Eligible recipient organizations must demonstrate significant training experience and infrastructure, and must align programs with established standards for residency and fellowship training programs to meet a baseline of quality and standardization. The training programs must be certified or accredited by the state or organizations recognized by the state. Residency and fellowship funding is limited to additional slots for the following accredited or certified professional programs:

a. Psychiatry Residency

b. Child Psychiatry Fellowship

c. Addiction Psychiatry/Addiction Medicine Fellowship

6.7. **Additional Terms and Operations of the Behavioral Health Residency Training Program.** For the demonstration behavioral health residency grant program, the following shall apply:

a. The state will enroll practitioners filling the residency and fellowship slots into the Behavioral Health Student Loan Repayment Program in STC 6.2. During the residency or fellowship training, the state will make loan repayment awards on behalf of the practitioner, in accordance with the Student Loan Repayment Program requirements. Practitioners must fulfill the Student Loan Repayment Program service commitments at safety net settings defined in STC 6.1(a) following completion of the residency or fellowship program.

b. To receive funds through the Behavioral Health Residency Training Program, organizations must include a sustainability plan for future years past the funding period. All residency fellowship programs must also gain approval from American College of Graduate Medical Education for new or expanded slots and that process also includes a review of sustainability.

c. Residency payments may be made directly only to the safety net settings by either the State or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.

    i. For each yearly issuance of funding for the residency training program, the managing vendor will make a single payment to each safety net setting covering one year's residency slot costs. The state will ensure that the amount of the award does not exceed the cost of operating the slots; if the award exceeds the cost of the residency slots, the award will be reduced so that it matches the cost of the slots.

d. The state may only claim FFP for expenditures associated with residency and fellowship slots that are filled by qualifying providers. In the event that an individual residency or fellowship slot is not filled for the entirety of a year, the slot

payment is pro-rated for the portion of the year that the slot was occupied. If the payment is made at the start of the year and the slot becomes unfilled mid-year, the state will provide for recoupment and return of FFP if the slot is not re-filled within one month.

6.8. **Workforce Initiatives Funding.** Table 2 below shows the maximum amount of funding for each workforce initiative program (including 15 percent administrative costs) by demonstration year.

Table 2. Workforce Initiatives Funding by Demonstration Year

Program	DY 1	DY 2	DY 3	DY 4	DY 5	Total
Behavioral Health Scholarship Program	$33,000,000	$81,000,000	$81,000,000	$24,000,000	$15,000,000	$234,000,000
Behavioral Health Student Loan Repayment Program	$106,000,000	$106,000,000	$106,000,000	$106,000,000	$106,000,000	$530,000,000
Behavioral Health Recruitment and Retention Program	n/a	$231,000,000	$231,000,000	$231,000,000	$273,000,000	$966,000,000
Behavioral Health Community-Based Provider Training Program	$10,000,000	$15,000,000	$20,000,000	$20,000,000	$20,000,000	$85,000,000
Behavioral Health Residency Program	$17,000,000	$17,000,000	$17,000,000	$17,000,000	$17,000,000	$85,000,000
Total	$166,000,000	$450,000,000	$455,000,000	$398,000,000	$431,000,000	$1,900,000,000

a. Subject to the total funding for each program in STC 6.8, the state may carry forward prior year unused workforce initiatives expenditure authority from one year to the next. The state must notify CMS of any updates to annual amounts in the annual monitoring reports.

b. After DY 2, the state may redistribute up to 30% of Workforce Initiatives funding in table 2 among the workforce programs without submitting an amendment pursuant to STC 3.7. The state must use initial program results (e.g., participation rates, success rates, challenges) to support redistribution of funds. The state must notify CMS of any redistribution of funds in the annual monitoring reports.

c. Time-limited expenditure authority is granted from January 1, 2030 until December 31, 2033, to allow the state to pay close-out administrative costs of operating the workforce initiative programs and monitoring remaining service commitments. The state must adhere with federal timely filing requirements during this time-limited expenditure authority period. The expenditures will continue to be claimed on the CMS 64 on the specified waiver lines if the date where claims are made go beyond the demonstration period as part of this demonstration period. No payments for student loans, scholarships, retention and recruitment activities, educational and training activities, including residency and fellowship slots, may be made following the demonstration period's expiration (December 31, 2029).

d. The state must follow all federal statutes, regulations, and policies regarding individual eligibility requirements for Federal educational funding support.

e. All expenditures for workforce initiatives are only matchable as administrative expenditures. The state must ensure that the workforce initiatives funding expenditures are not factored into managed care capitation payments and that there is no duplication of funds.

7. ACTIVITY FUNDS INITIATIVE

The state will provide to Medicaid and CHIP enrolled individuals Activity Funds for services and items that support an eligible member's (child or youth as described in STC 7.1) inclusion in the community and promote improved behavioral health outcomes.

7.1. **Eligibility.** To qualify for the Activity Funds Initiative, a member must be enrolled in Medicaid or CHIP and meet criteria under 7.1(a) and 7.1(b) below.

a. Meet one of the following criteria:

i. Are under age 21 and are currently involved in the child welfare system in California;

ii. Are under age 21 and previously received care through the child welfare system in California or another state within the past 12 months;

iii. Have aged out of the child welfare system up to age 26 (having been in foster care on their 18th birthday or later) in California or another state;

iv. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or

v. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

b. Meet one of the following clinical criteria:

i. Have a diagnosed behavioral health condition.

ii. At high risk for a behavioral health condition that is still being assessed through the diagnostic process, but who have been determined to need the service by a licensed behavioral health professional through clinical assessment.

7.2. **Service Description.** Activity Funds are for items or services that support an eligible member's inclusion in the community and promote improved physical and behavioral health outcomes. These items or services are designed to help participants find a form of expression beyond words or traditional therapies in an effort to reduce anxiety, aggression, and other clinical issues.

a. Activity funds may be used for the following, as indicated in a member's clinical record by a provider described in 7.3:

i. Physical wellness activities and goods that promote a healthy lifestyle (e.g., sports club fees and gym memberships; bicycles, scooters, roller skates and related safety equipment); and

ii. Strengths-developing activities (e.g., music lessons, art lessons, therapeutic summer camps).

b. Activity Funds must be used to support items and services that:

i. Promote inclusion in the community; and/or

ii. Increase the eligible member's safety in the home environment.

iii. Facilitate the eligible member's age-appropriate participation or autonomy in making decisions that improve physical or behavioral health outcomes.

c. The items and services provided under the Activity Funds Initiative must clearly link to an assessed need established in an eligible member's clinical record and must be determined to meet member need by a provider as described in STC 7.3.

d. Activity Funds may only be available when the item or service is not available through another source as indicated in STC 7.5(c).

e. Activity Funds are additive to, and do not duplicate, what is available to an individual under the Medicaid State Plan.

f. Activity Funds cannot be used to support:

i. Items used solely for entertainment or recreational purposes;

ii. Tobacco or alcoholic products;

iii. Items of the same type for the same member unless there is a documented change in the member's need that warrants replacement; and

iv. Activities that are illegal or otherwise prohibited through federal or state regulations.

7.3. **Service Delivery.** A provider will document the need for these services in an individual's clinical record and coordinate delivery of the activity in collaboration with the member, their caregiver(s) and social worker, as appropriate, including the following:

a. Assessment of beneficiary need;

b. Identification of appropriate activities for eligible members;

c. Documentation of the identified activity in the member's clinical record; and

d. Connecting the eligible member with an available activity provider.

7.4. **Administration and Payment.** The Activity Funds Initiative will be administered by DHCS and may be distributed in partnership with the California Department of Social Services (CDSS). DHCS will be responsible for overseeing Activity Funds.

a. DHCS may enter into an inter-agency agreement with CDSS that specifies the roles of each Department in administering Activity Funds and allows for the exchange of data between the two Departments, as needed.

b. DHCS may contract with a third-party administrator (TPA) to disburse Activity Fund payments. No funds shall be disbursed directly to a child, youth, or family member. DHCS, or the TPA acting on its behalf, will be responsible for collection and submittal of documentation and paying the activity provider for approved activities.

c. DHCS will develop and maintain a list of allowable activity types consistent with those listed in 7.2, as well service delivery provider types, to support providers in identifying services available under this initiative.

7.5. **Funding.** Other sources of federal funding for the items or services described in the Activity Fund Initiative must be exhausted prior to the state paying for them with Medicaid or CHIP funding. Medicaid and CHIP are payors of last resort.

8. SERIOUS MENTAL ILLNESS (SMI) PROGRAM AND BENEFITS

8.1. **Behavioral Health Plan Participation.** Under this demonstration, FFP for services provided in IMDs pursuant to STCs 1.1-1.6 is available for beneficiaries in participating behavioral health plans (BHPs) that agree to certain conditions and are approved by DHCS. To participate, a BHP must:

a. Cover all of the following evidence-based practices on a timeline specified by DHCS: Assertive Community Treatment (ACT); Forensic ACT; Coordinated Specialty Care for First Episode Psychosis; Supported Employment; Enhanced Community Health Worker Services; and Peer Support Services, including a forensic specialization; and

b. Reinvest FFP received for services provided in IMDs to support services and activities that benefit Medi-Cal members served by the BHP.

8.2. **SMI Program Benefits.** Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI Program, to be monitored pursuant to the SMI Monitoring Plan as outlined in STCs 8.5 – 8.7 below.

8.3. **SMI Implementation Plan.**

a. The state must submit the SMI Implementation Plan within 90 calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within 60 calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under expenditure authority until CMS has approved the SMI Implementation Plan and the SMI financing plan described in STC 8.3(e). After approval of the required Implementation Plan and Financing Plan, FFP will be available prospectively, but not retrospectively.

b. Once approved, the SMI Implementation Plan will be incorporated into the STCs as Attachment D, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI Program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 14.2.

c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and

either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g.,

with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;
3. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the person was were referred to;
4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers); and
5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide updates on how it has increased the availability of mental health services in every Annual Monitoring Report);
2. Commitment to implementation of the SMI financing plan described in STC 8.3(e). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.6;
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible; and
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association [e.g., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment and Increased Integration.

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI in treatment sooner, including through supported employment and supported education programs;
2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI conditions sooner and improve awareness of and linkages to specialty treatment providers; and
3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI.

d. **SMI Health Information Technology (Health IT) Plan.** The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure "ecosystem" at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the

demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 8.3[c]), to develop the infrastructure/capabilities of the state's health IT infrastructure.

i. The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment D) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

ii. The state will include in its Monitoring Plans (see STC 14.5) an approach to monitoring its SMI Health IT Plan which will include performance metrics to be approved in advance by CMS.

iii. The state will monitor progress, each DY, on the implementation of its SMI Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 14.6).

iv. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications'[1] (ISA) in developing and implementing the state's SMI Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

v. Where there are opportunities at the state- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care Organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B "Standards and Implementation Specifications for HIT". If there is no relevant standard in 45 CFR 170 Subpart B, the state should review the Office of the National Coordinator for Health Information Technology's Interoperability Standards Advisory (https://www.healthit.gov/isa/) to locate other industry standards in the interest of efficient implementation of the state plan.

vi. Components of the Health IT Plan include:

    1. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

[1] Available at: https://www.healthit.gov/isa/sites/isa/files/inline-files/2022-ISA-Reference-Edition.pdf

2. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.
3. In developing the Health IT Plan, states should use the following resources:

    - States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

    - States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

    - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

e. **SMI Financing Plan.** As part of the SMI implementation plan referred to in STC 8.3(d), the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment D and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

    i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;

8.4. **Maintenance of Effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.6.

8.5. **Availability of FFP for the SMI Services Under Expenditure Authority #11.** Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

8.6. **Unallowable Expenditures Under the SMI Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

9. COMMUNITY TRANSITION IN-REACH SERVICES

9.1. **Overview of Community Transition In-Reach Services and Program Objectives.** The state is authorized to implement Community Transition In-Reach Services for qualifying Medi-Cal members in participating counties that are approved by DHCS to offer the services starting no sooner than January 1, 2025. Counties will have the option to establish community-based, multi-disciplinary care transition teams that provide intensive pre- and post-discharge care planning and transitional care management services to support individuals with significant behavioral health conditions who are experiencing or at-risk for long-term stays in institutional settings in returning to the community.

9.2. **County Participation.** BHPs may opt to cover Community Transition In-Reach Services if they meet the following criteria and are approved by DHCS:

a. Submit a plan to DHCS to describe how they will assess availability of mental health and/or substance use disorder (SUD) services and housing options, and ensure that an appropriate behavioral health continuum of care is in place within the county so that more Medi-Cal members can live in and receive behavioral health care in community-based settings, rather than institutional settings. The plan should also include the process for how the assessment will inform any needed action steps based on the outcome of the assessment.

b. Track and report, on a cadence established by DHCS, data and trends in the number and utilization of beds across inpatient, subacute, and residential facilities (including Institutions for Mental Diseases) in which the county places members. This data and information will additionally serve to inform monitoring and evaluation efforts undertaken by the state.

c. Provide Assertive Community Treatment (ACT), Forensic ACT, the Individual Placement and Support model of Supported Employment, and Peer Support Services, including a forensic specialization, within the county and/or ensure these services are covered by the BHP in the county where a member receiving Community Transition In-Reach Services will ultimately reside upon discharge from a qualifying facility.

9.3. **County Readiness.** DHCS will establish a process to assess the availability of mental health and/or SUD services and housing options available in counties that opt to cover Community Transition In-Reach Services. A BHP may only participate in this initiative upon approval by DHCS that the appropriate continuum of care is in place for the county. Updates on county readiness must be included in the narrative portion of the monitoring reports, described in STC 14.6**.**

9.4. **Eligibility Criteria.** To qualify to receive Community Transition In-Reach Services, a Medi-Cal member must:

a. Be enrolled in Medi-Cal.

b. Be aged 21 years or older or an emancipated minor, as defined by California Family Law Code (Div. 11, Part 6, Ch. 1, §7002).

c. Meet the Specialty Mental Health Services (SMHS) Program access criteria, as defined in the California state guidance.

d. Receive care covered by a BHP that has opted to provide Community Transition In-Reach Services regardless of whether the member resides in an in-county or out-of-county facility.

e. Be experiencing or at risk of experiencing an extended length of stay of 120 days or more in a qualifying facility.

    i. "Individuals at risk of experiencing extended length of stay" is defined as individuals in inpatient, residential, or subacute settings with lengths of stay shorter than 120 days but who have clinical presentation and progress similar to the patient profiles of individuals whose lengths of stay exceed 120 days. Patient profiles may include but are not limited to the following: previous inpatient or residential stays, difficulty with adherence to prescribed medication, co-occurring disorders, both behavioral and physical, few or limited family/friend supports in the community, civil commitment, guardianship/conservatorship status, experience of homelessness prior to hospitalization, and/or exhibits severe functional impairment based on clinical evaluation.

9.5. **Qualifying Facilities.** In qualifying counties, Community Transition In-Reach Services may be provided in inpatient, residential, or subacute settings, including Institutions for Mental Diseases (IMDs).

9.6. **Scope of Community Transition In-Reach Services.** Community Transition In-Reach Services to support care transition and discharge planning include transitional care management services that include, but are not limited to:

a. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

    i. Taking client history;

    ii. Identifying the individual's needs and completing related documentation; and

    iii. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

b. Developing a comprehensive individualized care plan that is based on the information collected through the assessment that:

i. Specifies the self-determined goals and actions to address the medical, social, educational, and other services needed by the individual;

ii. Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals and a plan for achieving those goals that reflect the individual's preferences with regard to services and support and types of housing they many need to help them successfully transition out of institutions and into living and engaging in their communities; and

iii. Identifies a course of action to respond to the assessed needs and preferences of the eligible individual.

c. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

d. Monitoring and follow-up activities:

i. Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

1. Services are being furnished in accordance with the individual's care plan;

2. Services in the care plan are adequate to support them to live in stable housing and engage in their communities; and

3. Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

e. Identifying and addressing other system barriers, including social and financial issues, and facilitating linkages to social supports necessary to support successful reintegration of Medi-Cal members into their communities.

9.7. **Duration of Community Transition In-Reach Services.** Community Transition In-Reach Services are available for up to 180 days prior to discharge. If an individual is not discharged after 180 days, in-reach services are no longer eligible for FFP.

9.8. **Community Transition In-Reach Teams.** Community transition teams will be multi-disciplinary and, at a minimum, they must include the following practitioner types for

purposes of providing in-reach and post-discharge care planning, transitional care management, and community re-integration services:

a. A licensed mental health professional as a team lead;

b. A certified Peer Support Specialist or other Specialty Mental Health Services practitioner with lived experience of recovery from a significant behavioral health condition;

c. An occupational therapist (if not serving as team lead), unless the BHP meets the following exemption:

    i. The BHP submits documentation, in accordance with DHCS standards, that demonstrates:

        1. Workforce shortages for qualified occupational therapists in the county and that the Community Transition In-Reach Teams in the county can perform their required functions without an occupational therapist; and

        2. A plan to expand the availability of occupational therapists in the licensed mental health professional provider network.

d. At least one additional Specialty Mental Health Services practitioner.

e. Access to a prescriber for the purpose of coordinating medication management throughout the care transition.

9.9. **Availability of FFP for the Community Transition In-Reach Services Under Expenditure Authority #5.** Federal Financial Participation is only available for Community Transition In-Reach Services provided to beneficiaries who are residing in an inpatient, residential or subacute setting, including IMDs, when the beneficiary meets eligibility criteria described in 9.4. The state may claim FFP for Community Transition In-Reach services furnished to beneficiaries during IMD stays for up to 180 days prior to discharge. Payments will not be made to facilities where the beneficiary resides.

9.10. **Unallowable Expenditures Under the Community Transition In-Reach Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for inpatient, residential or subacute treatment service providers, including those that are IMDs, unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

10. HEALTH-RELATED SOCIAL NEEDS (HRSN) SERVICES

10.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 10.2 and Attachment G, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX and Title XXI, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary's receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 10.8 (Service Delivery) and Attachment G.

10.2. **Allowable HRSN services.** The state may cover the following HRSN services:

a. Housing Interventions, including:

i. Room and board-only supports (also referred to as "rent-only" supports or interventions), limited to a clinically appropriate amount of time, including:

1. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

10.3. **HRSN Intervention Duration and Frequency.**

a. Subject to STC 10.3.b., housing interventions that are classified as room and board-only support, as described in STC 10.2.a.i.1, may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.

b. Multiple HRSN housing interventions can be covered for qualifying beneficiaries across all of California's section 1115(a) demonstrations; provided however that CMS will apply a total combined cap of 6 months for all HRSN housing interventions that include room and board supports, per beneficiary, in any rolling 12-month period.

i. The state may only offer room and board-only supports to beneficiaries who qualify for other HRSN housing interventions if they have not reached the 6-month global cap, within any rolling 12-month period, for HRSN housing

interventions that include room and board supports across all of California's section 1115(a) demonstrations.

ii. If the beneficiary received additional HRSN housing interventions providing room and board supports under another one of California's section 1115(a) demonstrations, the state may only provide the remaining balance of month(s) under the 6 month global cap for HRSN housing interventions that include room and board supports within any rolling 12-month period.

10.4. **Excluded HRSN Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (bricks and mortar);

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 10.2 and 10.3;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except case management of HRSN services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States;

g. Expenditures that supplant services and/or activities funded by other state and/or federal governmental entities;

h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

i. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping space are not available to residents 24 hours a day, and facilities without private sleeping space.

10.5. **Covered Populations.** Expenditures for HRSN services may be made for the populations of focus specified in Attachment G, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid or CHIP (or Medicaid demonstration)-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described STC 10.1, to address the documented

need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment G. Attachment H, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state anticipates incorporating into Attachment G at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment H reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the and social risk factors outlined in Attachment H. Additionally, the state can later include additional clinical and social risk factors in compliance with STC 10.6 and 10.7.

10.6. **Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected in Attachment H must be effectuated through the process indicated in STC 10.7. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment G.

If the state adds new HRSN services beyond those specified in STC 10.2 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol must include the following information:

a. A list of the covered HRSN services (not to exceed those allowed under STC 10.2), with associated service descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

    i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

    ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

10.7. **Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services:**

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachment G and Attachment H. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in Attachment H, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN services or qualifying criteria change in Attachment G by the following process:

    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.

    ii. The state must provide public notice.

    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment H, the state must follow the process below to update the protocol:

    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing

so would not require an increase to the amount of the state's HRSN expenditure authority in Table 13.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 10.7.b.

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC 10.7.b. This restriction is not applicable to the process and scope of changes outlined in STC 10.7.a.

10.8. **Service Delivery.** HRSN services will be provided in the managed care delivery system(s) and delivered by HRSN service providers. Terms applicable to all HRSN services:

a. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the following terms will apply:

i. HRSN services can be provided by managed care plans and paid on a non-risk basis and must be appropriately included in contracts. This can be accomplished by either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of "non-risk contract" at 42 CFR § 438.2) or as an amendment to a state's existing risk-based managed care plan contract to include a non-risk payment. The state must take measures to ensure there is no duplication of payments for either the delivery of such service or the administrative costs of delivering such services.

ii. For a non-risk contract or a non-risk payment, the managed care plan is not at financial risk for changes in utilization or for costs incurred under the contract or payment that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HRSN services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

iii. When the state includes non-risk payments in a risk-based contract, the state must ensure all non-risk payments are separate and apart from risk-based payments and clearly define what services/populations are covered under non-risk payments versus included in risk-based capitation rates. All of the costs of delivering services under a non-risk payment must be excluded from the development of the risk-based capitation rates for the risk-based contracts. Specifically, the costs of delivery the services as well as any costs of administering the non-risk payment must be excluded from the development of the risk-based capitation rates.

iv. Prior written CMS approval pursuant to STC 10.9 is required before the state moves to incorporate the HRSN services into the risk-based capitation rates in

Medicaid managed care. When the state incorporates the HRSN services into the risk-based capitation rates in Medicaid managed care, the state must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and may no longer utilize non-risk payments for the services included in risk-based capitation rates.

v. Any applicable HRSN services that are delivered by managed care plans in a risk arrangement, must be included in the risk-based managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a).

vi. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.

vii. All expenditures for HRSN services delivered under non-risk contracts must be excluded from MLR reporting. When HRSN services (i.e. HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5) are included in capitation rates paid to managed care plans under risk-based contracts, and only then, should HRSN services be reported in the medical loss ratio (MLR) reporting as incurred claims.

viii. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure, as applicable, will be identified and reported in the MLR as non-claims costs.

b. CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in managed care. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology codes that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 10.17.

10.9. **Requirements for HRSN Services prior to being delivered in risk-based managed care.** The state's plan to incorporate HRSN into risk-based managed care contracts must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation

rates. At least 6 months prior to moving HRSN services approved under these STCs into risk-based Medicaid managed care contracts, the state must submit to CMS, for review and written prior approval, documentation that details the following information:

a. Each HRSN service defined in STC 10.2 and each covered population that will receive each HRSN service defined in STC 10.5 where the state is seeking CMS written approval to be delivered through one or more risk-based managed care program(s). The applicable managed care program(s) for each service and population should also be specified.

b. If the HRSN service will be offered in all regions under each risk-based managed care program or if the offerings will be limited geographically.

c. The first rating period the state is seeking to start offering the HRSN service(s) through risk-based managed care. If the HRSN services will be delivered through risk-based managed care on a rolling basis, provide the timeline for each service and/or population.

d. The state's timeline to complete a readiness review pursuant to 438.66(d). Implementation may only begin when each managed care plan has been determined by the state to meet certain readiness and network requirements, including providing any documentation specified by CMS.

e. A transition of care plan that provide continuity of care for beneficiaries transitioning from another delivery system (e.g. FFS) or non-risk contracts into risk-based contracts.

f. A description of base data that the state and its actuary plan to use for capitation rate setting process to develop both the benefit and non-benefit costs, including the types of data used (FFS claims data, managed care encounter data, managed care plan financial data, etc.) and the data source(s) that will be used for capitation rate development. Consistent with Medicaid managed care rate development requirements under 42 CFR 438.5(c), CMS requires at least 3 years of encounter data or similar data (e.g. cost reports, claims data) for the HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5 that will be incorporated into risk-based managed care. CMS will consider exceptions to the requirement for 3 years of base data for periods impacted by COVID-19.

g. The methodology the state's actuary will use in the capitation rate setting process. This includes, but is not limited to, any trend factors and adjustments to the data the state and its actuary will apply to the base data in the capitation rate setting process. The methodology should also include information on the approach the actuary will take to incorporating the HRSN service(s) into capitation rate development (for example, if the actuary will create an add-on that will be applied to some or all existing rates cells, creating a separate rate cell, or some other method) and any changes to or new risk adjustment or acuity adjustments applied due to the inclusion

of the HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5.

h. If the state is planning to delegate risk for the delivery of HRSN services to clinical providers, community organizations, and/or subcontractors for specific HRSN services, the capitation rate setting plan should include a description of these proposed delegated arrangements and/or sub-capitated payment arrangements that the state intends to use in the delivery of any HRSN services defined in STC 10.2 for covered populations outlined in STC 10.5.

i. Identification of any in-lieu of services (ILOS) the state currently offers through its managed care programs and if there will be changes to those ILOS as a result of the state moving these HRSN service(s) into risk-based managed care contracts.

j. Because of the uncertainty associated with HRSN services and in alignment with past guidance about situations with high levels of uncertainty, CMS is requiring the State to implement a 2-sided risk mitigation strategy (such as a 2-sided risk corridor) to provide protection for state and federal governments, as well as managed care plans. The HRSN capitation rate setting plan should provide a description of the risk mitigation mechanism(s) that will be used in the transition of HRSN services to risk-based managed care. As part of plan to incorporate HRSN into risk-based managed care, the State will also need to develop an MLR monitoring and oversight process specific to HRSN services. This process must specify how HRSN services will be identified for inclusion in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs, as applicable, will be identified and reported by managed care plans as non-claims costs.

k. All state directed payments the state plans to implement for any HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5 that will be provided under risk-based contracts must comply with all applicable federal requirements, including but not limited to 438.6(c). The state should submit this information to establish compliance for any state-directed payments for HRSN services to CMS at statedirectedpayment@cms.hhs.gov.

10.10. **Phased In Implementation of HRSN Services.** As further discussed in the state's Implementation Plan, the state will phase in their HRSN service, short-term rental assistance, on the following schedule:

a. No sooner than July 1, 2025, short-term rental assistance will be an optional service for managed care plans to provide.

b. No sooner than January 1, 2026, and as specified in Attachment G and H and consistent with STC 10.5 and 10.6, short-term rental assistance will be a mandatory service for managed care plans to provide for eligible individuals who meet the access criteria for Medi-Cal SMHS, DMC, or DMC-ODS as specified in Attachment G and Attachment H. Short-term rental assistance will be an optional service for

managed care plans to cover for additional eligible populations as specified in Attachment G and H and consistent with STC 10.5 and 10.6.

c. No sooner than January 1, 2027, short-term rental assistance will be a mandatory service for managed care plans to provide for all eligible populations as specified in Attachment G and H, consistent with STC 10.5 and STC 10.6.

10.11. **Contracted Providers.** Managed care plan contracts must provide, applicable to all HRSN services:

a. Managed care plans will contract with providers to deliver the HRSN services authorized under the demonstration and included in the managed care contract.

b. Managed care plans must establish a network of providers and ensure the HRSN service providers have sufficient experience and training in the provision of the HRSN services being offered. HRSN service providers do not need to be licensed, however, staff offering services through HRSN service providers must be licensed when applicable (i.e., when the staff member is performing activities for which a licensure requirement applies in the state).

c. The managed care plan and contracted providers will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements. Any state direction of managed care plan expenditures under risk-based contract(s) and risk-based payments would only be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

10.12. **Provider Network Capacity.** Managed care plan contracts must ensure the HRSN services authorized under the demonstration are provided to qualifying beneficiaries in a timely manner and shall develop policies and procedures outlining the managed care plan's approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

10.13. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulation.

10.14. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each individual receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan must be reviewed and revised as appropriate at least every 12 months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

10.15. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

10.16. **CMS Approval of Managed Care Contracts.** As part of the state's submission of associated managed care plan contracts to implement HRSN services through managed care, the state must include contract requirements including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize beneficiaries' access to covered services.

ii. Beneficiaries always retain their right to receive covered service on the same terms as would apply if HRSN services were not an option.

iii. Beneficiaries who are offered or who utilize an HRSN retain all rights and protections afforded under 42 CFR 438.

iv. Managed care plans are not permitted to deny a beneficiary ma m covered service on the basis that the beneficiary is currently receiving HRSN services, have requested those services, has previously qualified for or received those services, or currently qualifies or may qualify in the future for those services.

v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.

b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, these encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement

efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state or another legally authorized oversight body to aid in on-going evaluation of the HRSN services initiative or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing resources and to avoid duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

10.17. **HRSN Rate Methodologies.** For FFS payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR Part 447, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 7. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable FFS payment rates or methodologies for HRSN and maintain documentation of these FFS payment rates or methodologies on its website described in 42 CFR 447.203. The state may receive FFP for HRSN service expenditures authorized under this demonstration upon implementation of the FFS payment rates and/or methodologies for which it has conducted prior public notice and may begin claiming for this FFP (for dates of service no earlier than the effective date of approval for the relevant expenditure authority) no earlier than the date of submission of the payment rates and/or methodology to CMS for approval. However, any FFS payments to providers or claims for FFP prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved FFS payment rate and/or methodology within one year of CMS's approval. All requirements for timely filing of claims for FFP continue to apply.

For managed care payments and rates (including capitation rates, non-risk payments, and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs. As applicable, the state must also notify CMS at least 60 days prior to intended implementation if it intends to direct its managed care plans on how to pay for HRSN services (i.e., state directed payments).

All rates/payment methodologies for HRSN services, for both FFS and managed care delivery systems, must be submitted to CMS for review and approval, including but not limited to fee-for-service payments as well as managed care capitation rates, any state directed payments that require prior written approval, and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, for both FFS and managed care delivery systems, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public

comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

10.18. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan required by STC 10.21 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.6, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

10.19. **Partnerships with State and Local Entities.** To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other state or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the beneficiary's care plans, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 14.6, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

10.20. **Provider Payment Rate Increase.** As a condition of the HRSN services expenditure authorities, California must comply with the provider rate increase requirements in Section 12 of the STCs.

10.21. **HRSN Implementation Plan**

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STC regarding implementation of demonstration policies that are outlined in the STC. The state must submit the MOE information required by STC 10.18 no later than 90 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan as initiatives

are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment I.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent.

c. The Implementation Plan must include information on, but not limited to, the following:

    i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

    ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

    iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision;

    iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing assistance programs, relative to the number of total eligible beneficiaries in the state (including those who are eligible but unenrolled);

    v. An implementation timeline and evaluation considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;

    vi. Information as required per STC 10.18 (MOE); and

    vii. Information as required per STC 10.19 (Partnerships with State and Local Entities).

11. DESIGNATED STATE HEALTH PROGRAMS

11.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs (DSHP), subject to the limits described in this Section 11. DSHP are specific state programs that: (1) are population- or public health-focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the DSHP will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. This DSHP authority will enable the state to use state dollars that it otherwise would have spent on the DSHP specified in the Approved DHSP List (Attachment J), for which it may use as non-federal share as specified in Section 11. DSHP Funded Initiatives, on demonstration expenditures to support DSHP-funded initiatives, as described in STC 11.3(c).

a. The DSHP will have an established limit in the amount of $1,615,000,000 total computable expenditures, in aggregate, for DY 1 - DY 5.

b. The state may claim FFP for up to the annual amounts outlined in the table below, plus any unspent amounts from prior years. In the event the state does not claim the full amount of FFP for a given demonstration year, the unspent amount, available for claiming, will roll over to one or more demonstration years not to exceed the total for this demonstration period. The total amount of DSHP FFP that the state may claim in DY 1 - DY 5 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives.

	Table 3. Annual Limits of Total Computable Expenditures for DSHP				
	DY 1	**DY 2**	**DY 3**	**DY 4**	**DY 5**
Total Computable Expenditures	$323,000,000	$323,000,000	$323,000,000	$323,000,000	$323,000,000

c. The state must contribute $142,500,000 to add in original, non-freed up DSHP funds, for the remaining demonstration period towards its initiatives described in STC 11.3. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of nonfederal share, which may be subject to CMS financial review.

e. The Approved DSHP List is limited to programs that are: (1) population- or public heath- focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the program will impede the primary objective of Medicaid to provide coverage for services for low-income; and (3) vulnerable populations, and serve a community largely made up of low-income individuals. The Approved DSHP List is Attachment J. Any changes the state wants to make to its DSHP program will require an amendment as specified in STC 3.7.

11.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, or the Centers for Disease Control and Prevention) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 5 percent of total provider expenditures or claims through DSHP identified as described in STC 11.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the Approved DSHP List (Attachment J). Therefore, the state can claim up to the program limits in the Approved DSHP List.

c. In addition to 11.2(a), the following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

i. Bricks and mortar;

ii. No shelters, vaccines, and medications for animals;

iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

iv. Revolving capital funds; and

v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

11.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs, for which the state may claim FFP in accordance with STC 11.1 and 11.2 to fund the DSHP-funded initiatives as specified in STC 11.3(c).

b. **Requirements.** CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

    i. Workforce Initiatives;

11.4. **DSHP Claiming Protocol.** The state will develop a DSHP Claiming Protocol, which the state will make available to CMS upon request. State expenditures for the DSHP must be documented in accordance with the protocol.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

    i. Certification or attestation of expenditures.

    ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 11.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

11.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS, upon request. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of nonfederal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the state's DSHP Claiming Protocol.

11.6. **DSHP Sustainability Report.** The DSHP Sustainability Report will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. As part of the monitoring reports, the state shall submit the DSHP Sustainability Report section in its annual report.

12. PROVIDER RATE REQUIREMENTS

12.1. The provider payment rate increase requirements described hereafter are a condition for the DSHP and HRSN expenditure authorities, as referenced in expenditure authorities 6 and 7.

12.2. As a condition of approval and ongoing provision of FFP for the DSHP and HRSN expenditures over this demonstration period of performance, DY 1 through DY 5, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.

12.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

12.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

12.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. For behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 14.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

12.6. To establish the state's ratio for each service category identified in STC 12.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 12.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 12.5(b) using Medicaid managed care provider payment rate and utilization data.

12.7. In determining the ratios required under STC 12.5 and 12.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

12.8. If the state is required to increase provider payment rates for managed care plans per STC 12.2 and 12.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

12.9. For the entirety of DY 3 through DY 5, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 1, and such rate will be in effect on the first day of DY 3. A required payment rate increase shall apply to all services in a service category as defined under STC 12.4.

12.10. If the state uses a managed care delivery system for any of the service categories defined in STC 12.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 3 through DY 5, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 1 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 12.4.

12.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 3 (or, as applicable, the first day of the first rating period that starts in DY 3), the state will provide an alternative effective date and rationale for CMS review and approval.

12.12. California will provide the information to document the payment rate ratio required under STC 12.5 and 12.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

12.13. For demonstration years following the first year of provider payment rate increases, if any, California will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

12.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 12.5 and 12.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment K.

Table 4. California DSHP and HRSN Related Provider Payment Increase Assessment – Attestation Table.

The reported data and attestations pertain to DSHP and HRSN related provider payment increase requirements for the demonstration period of performance DY 1 through DY 5.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 12.5(a) or STC 12.5(b)]	[insert approach, either ratio derived under STC 12.6(a) or STC 12.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Obstetric Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 12.5(a) or STC 12.5(b)]	[insert approach, either ratio derived under STC 12.6(a) or STC 12.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Behavioral Health Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system

		for applicable covered service categories]
	[insert approach, either ratio derived under STC 12.5(a) or STC 12.5(b)]	[insert approach, either ratio derived under STC 12.6(a) or STC 12.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]

In accordance with STCs 12.1 through 12.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on [*insert date*], and will not be lower than the highest rate for that service code in DY 1 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 12.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]

☐a. The effective date of the rate increases is the first day of DY 3 (January 1, 2027) and will be at least sustained, if not higher, through DY 5 (December 31, 2029).

☐b. California has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY 3 (January 1, 2027). California will effectuate the rate increases no later than the CMS approved date of January 1, 2027, and will sustain these rates, if not made higher, through DY 5 (December 31, 2029).

California *[insert does or does not]* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care. For any such payments, as necessary to comply with the DSHP and HRSN STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]. California *[insert does or does not]* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the DSHP and HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 12.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than [*insert date*].
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 12.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
California further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 12.
I, *[insert name of SMD or CFO (or equivalent position)] [insert title],* attest that the above information is complete and accurate. [*Provide signature*_____*] [Provide date*_____*]* *[Provide printed name of signatory]*

13. STATE COMMITMENTS TO PROVIDER RATES

13.1. The provider access and rate increase requirements described hereafter are a condition to receive FFP for expenditures under the BH-CONNECT demonstration. These requirements are only in effect for a demonstration year to the extent that the state collects more revenue applicable to a demonstration year from its Managed Care Organization Provider Tax than would be otherwise be permitted through the CMS-approved December 15, 2023 tax waiver of the broad-based and uniformity requirements. Should the state

experience extenuating economic conditions or circumstances that result in an inability to meet this requirement, the state can request specified relief subject to CMS approval.

13.2. The following requirements in STCs 13.3 through 13.9 apply to Medi-Cal Managed Care plans. These requirements do not apply to Specialty Mental Health Services plans or Drug Medi-Cal Organized Delivery System plans.

13.3. Effective January 1, 2024, California implemented fee-for-service (FFS) and managed care provider payment rate increases for primary care, maternal (obstetrical and doula) care, and outpatient (non-specialty) mental health care to 87.5 percent of Medicare. The state will maintain at least 87.5 percent of Medicaid to Medicare provider rate ratios for these services for the duration of the BH-CONNECT demonstration period (the entirety of DY 1 through DY 5).

13.4. This commitment is aligned with the requirements in the access rule and managed care rule for states to publicly compare fee-for-service payment rates and managed care plans' payment rates for primary care, obstetrical care, and outpatient mental health and substance use disorder services to Medicare rates and the implementation of the managed care rule provisions pertaining to appointment wait time standards for primary (adult/pediatric), obstetrical and gynecological, and outpatient mental health and substance use disorder services (adult/pediatric). California will conduct enhanced transparency for the services specified in STC 13.3 for calendar years 2025 and 2026. The state will provide to CMS an annual payment analysis for Medi-Cal Managed Care plans' payment rates for the services specified in STC 13.3, consistent with the requirements outlined in 42 CFR § 438.207(b)(3) for calendar years 2025 and 2026.

a. For calendar year 2025, California will submit this analysis no later than June 30, 2026.

b. For calendar year 2026, California will submit this analysis no later than June 30, 2027.

13.5. In addition, California will collect and report to CMS an annual payment analysis for Medi-Cal Managed Care plans' payment rates for calendar years 2025 and 2026, beyond the required evaluation and management codes identified in 42 CFR § 438.207(b)(3), on all other current procedural terminology codes not reported in STC 13.4, but that are listed in Table 5. This reporting must be consistent with the requirements outlined in 42 CFR § 438.207(b)(3) but applied to all other current procedural terminology codes not reported in STC 13.4, but that are listed in Table 5.

a. For calendar year 2025, California will submit this analysis no later than June 30, 2026.

b. For calendar year 2026, California will submit this analysis no later than June 30, 2027.

13.6. As California moves forward with implementing the required appointment wait time standards for Medi-Cal Managed Care plans under 42 CFR § 438.68(e) in calendar year

2028, California will ensure that any network adequacy exceptions granted under 42 CFR § 438.68(d) are carefully evaluated using the criteria specified in 42 CFR § 438.68(d). By June 30, 2027, California will provide to CMS the standard operating protocol for network adequacy exceptions granted by the state under 42 CFR § 438.68(d) and a description of the process for monitoring network adequacy exceptions.

13.7. In addition to the provider payment rates described in STC 13.3, California will increase payment levels for the primary care and specialty providers described in Table 5. By December 31, 2026, these payment increases are expected to achieve a Medicaid to Medicare provider payment ratio specified in Table 5 for each provider type. The state will (at least) subsequently sustain the provider payment levels to meet the requirements in this STC through the end of the BH-CONNECT period (the entirety of DY 3, DY 4 and DY 5).

13.8. Of the allowable streamlined eligibility and enrollment strategies outlined to continue in the CMCS Informational Bulletin (CIB) "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes"[2], California will maintain strategies to streamline income and resource verification during the ex parte renewal process at the time of demonstration approval through June 30, 2025. The State Medicaid Agency will complete an ex parte renewal when no data sources return income information (Zero-Dollar and 100 percent FPL Income strategies) in accordance with the parameters outlined in the CIB and will document the continued use of these strategies in their verification policies and procedures.

Table 5. Provider Payment Levels by December 31, 2026

Provider	Medicaid to Medicare provider payment ratio
1. Evaluation & Management Codes for Office Visits, Preventive Services, and Care Management	90%
2. Obstetric Services	90%
3. Non-Specialty Mental Health Services (mild and moderate mental health services provided by managed care plans)	87.5%
4. Vaccine Administration	87.5%
5. Evaluation & Management Codes for ED Physician Services	90%
6. Other Procedure Codes commonly utilized by Primary Care, Specialist, and ED Providers	80%

13.9. By June 30, 2027, the state will provide to CMS a letter signed by the State Medicaid Director, describing the payment increases required by STC 13.7 and affirming that as a result of the provider payment increases, the state met the expectations of Medicaid to Medicare provider reimbursement ratios in Table 5.

[2] https://www.medicaid.gov/federal-policy-guidance/downloads/cibe1411142024.pdf

13.10. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this section.

14. MONITORING AND REPORTING REQUIREMENTS

14.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due, if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted due to being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps that the state has taken to address such issue, and state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

14.2. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 for services rendered in IMDs will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

14.3. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs. The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

14.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

14.5. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol addressing components of the demonstration within 150 calendar days after approval of the demonstration amendment. The state must submit a revised Monitoring Protocol within 60 days after receipt of CMS's comments, if any. Once approved, the Monitoring Protocol will be incorporated into the STCs as Attachment E. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment, as applicable. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and

Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 14.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the SMI component, the Monitoring Protocol must include an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas; a description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 14.6; and a description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and target will be benchmarked against performance in best practice settings.

For the qualitative elements (e.g., operational updates as described in STC 14.6.a), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Monitoring Reports.

14.6. **Quarterly and Annual Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The monitoring reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed.

b. **Performance Metrics**. Per applicable CMS guidance and technical assistance, the performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on beneficiaries' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, and grievances and appeals.

a. Specifically, the state must undertake reporting on categories of metrics including, but not limited to: enrollment, utilization of services, and quality of care and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies, objectives, and populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography/county), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

i. For the SMI component, the state's monitoring must cover metrics including, but are not limited to, screening of beneficiaries admitted to psychiatric hospitals or residential treatment facilities, mental health services utilization (e.g., inpatient and outpatient), and average length of stay in IMDs and the demonstration's four milestones as outlines in the SMDL dated November 13, 2018 (SMDL #18—011).[3]

ii. For the Access, Reform and Outcomes Incentive Program, the state should include a summary of implementation updates, plan performance on the incentive measures outlined in STC 5.3 for each focus area, and payment of incentive funds to plans, as well as the results of any future MBHO NCQA assessments. In addition, the program accountability measures described in STC 5.11 will be submitted annually for CMS review via the Monitoring Reports, unless otherwise described in the Incentive Program Protocol.

iii. For the Community Transition In-Reach Services, the state must provide updates on county readiness in the monitoring reports, as well as data and trends in utilization of beds across inpatient, subacute, and residential facilities (including Institutions for Mental Disease), as described in STCs 9.2 and 9.3.

[3] SMDL #18—011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

Additionally, the state must report on metrics related to discharge from residential settings into community/outpatient settings and readmissions to acute levels of care.

iv. For the Workforce Initiatives, the state must report on the student loan repayment, scholarship, recruitment and retention, training, and residency activities in the Monitoring Reports. The state must provide details in the narrative section of the Monitoring Reports regarding program recruitment, participation, completion, residency slots and program types, and status of service commitments. The state must submit annually the number and amount of recruitment and retention bonuses awarded to the provider organizations and the behavioral health practitioners. The state is required to provide details regarding the types of provider organizations and the behavioral health practitioners who receive the awards.

v. In order to ensure a link between DSHP-funded initiatives and improvements in health equity and beneficiary health outcomes, CMS and the state will coordinate to use the critical set of disparities-sensitive metrics described above, with applicable demographic stratification.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements, Section 16 of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly, and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. **Evaluation Activities and Interim Findings**. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

14.7. **SMI Mid-Point Assessment.** The state must contract with an independent entity to conduct a Mid-Point Assessment by three years after the demonstration approval date. This timeline will allow for the Mid-Point Assessment to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care plans, health care providers (including SMI treatment providers), beneficiaries, community groups, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after three years after the demonstration approval date. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment with 60 calendar days after receipt of CMS's comments, if any.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the SMI Implementation Plan for ameliorating these risks. Modifications to any of these plans or protocols are subject to CMS approval. Elements of the Mid-Point Assessment must include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI Implementation Plan, the SMI Financing Plan, and toward meeting the targets for SMI performance measures as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI Implementation Plan or SMI Financing Plan or to other pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

14.8. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

d. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 14.1.

14.9. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

14.10. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its Annual Monitoring Report.

14.11. **Corrective Action Plan Related to Demonstration Monitoring**. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15. EVALUATION OF THE DEMONSTRATION

15.1. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

15.2. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 14.1.

15.3. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

15.4. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than one hundred eighty (180) calendar days after the approval date of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-indifferences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of an independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 15.7 and 15.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment components. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

15.5. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

15.6. **Evaluation Questions and Hypotheses.** Consistent with attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing must include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures must be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Consumer Assessment of Health Care Providers and Systems (CAHPS), the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and

experience with the various demonstration policy components. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Hypotheses must cover all policies and goals of the demonstration and should be crafted to not only evaluate whether overall demonstration goals were achieved but also the extent to which each component contributed to outcomes. Where demonstration components offer tailored service to specific populations, evaluation hypotheses must include an assessment of whether these programs improved quality of care outcomes and access to health care for the targeted population while also promoting the desired administrative and fiscal efficiencies.

a. The state's evaluation efforts must develop hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing services to address behavioral health.

b. For the Workforce Initiatives, the state must develop hypotheses and research questions to evaluate the effects of the initiatives on improvements in overall staffing levels, long-term effects of the workforce programs on retention, and improvements in access to and utilization of behavioral healthcare for Medicaid beneficiaries. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention. Because these initiatives may affect a small number of providers, the state is strongly encouraged to use a mixed-methods approach that would incorporate qualitative data sources, including interviews and/or focus groups with participating providers, and a beneficiary experience survey.

c. The evaluation must also include an assessment of the Access, Reform and Outcomes Incentive Program. Hypotheses should address the impacts of the program on beneficiary access to behavioral health care, beneficiary health outcomes, and delivery system reforms. The evaluation should also cover implementation challenges, successes, and other lessons learned from the program, including at the plan-level.

d. Hypotheses for the SMI component of the demonstration must relate to, for example, utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, increases in the availability of crisis stabilization services, and improved care coordination.

e. The Evaluation Design must also include hypotheses and research questions related to the Community Transition In-Reach Services such as how the program may lead to an increase in discharges from residential settings into community/outpatient settings, reduce readmissions to acute levels of care, and increase beneficiary access to care and improve care coordination. The evaluation should also investigate to what extent factors such as length of stay, diagnosis, treatment adherence, co-occurring physical health conditions, and/or homelessness are targeted for the provision of Community Transition In-Reach Services, as well as how health outcomes may vary by these factors. The evaluation should also incorporate insights on beneficiary experience and self-reported outcomes. As part of the evaluation strategy for this program, the state is required to submit a rapid-cycle assessment to cover the first year of program implementation, which will be due to CMS one-and-a-half years after the program is implemented unless otherwise agreed upon by CMS and the state. The rapid-cycle report should include both quantitative and qualitative analysis and cover, to the extent possible, implementation data, utilization of the services within this program, and preliminary data on the health outcomes listed above. Plans for the rapid-cycle assessment should be included in the state's Evaluation Design. CMS will provide the state with technical assistance regarding the rapid-cycle assessment.

f. Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest to the extent data are available (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography/county). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

As noted above, for any amendment to the demonstration, the state will be required to update the approved Evaluation Design or submit a new Evaluation Design to accommodate the amendment component, as appropriate.

15.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report must be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report must discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state is not requesting an extension for the demonstration, the draft Interim Evaluation Report is due one (1) year prior to the end of the demonstration.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

15.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

15.9. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report. Presentations may be conducted remotely.

15.10. **Public Access**. The state must post the final documents (e.g., Implementation Plan, Monitoring Protocol, Close Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

15.11. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of deliverables, CMS must be notified prior to presentation of these reports or their findings, including in related publications (for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS must be provided a copy including any associated press materials. CMS must be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

15.12. **Corrective Action Plan Related to Evaluation**. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A correction action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16. GENERAL FINANCIAL REQUIREMENTS

16.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

16.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

16.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section

1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

16.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries.

Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

16.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

16.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

16.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration

approval. This deliverable is subject to the deferral as described in STC 14.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

16.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 17:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

16.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles

and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

16.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 6. Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Workforce Initiative	Main			X	All expenditures for the Workforce Initiatives described in Section 6.
DSHP	Main			X	All expenditures for DSHP described in Section 11.
Access, Reform and Outcomes Incentive Program	Main			X	All expenditures for the Access, Reform and Outcomes Incentive Program described in Section 5.
SMI	Hypo 1	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment described in Section 8.
Community Transition In-Reach Services	Hypo 2	X		X	All expenditures for services provided as Community Transition In-Reach Services described in Section 9.
Activity Funds	Hypo 3	X		X	All expenditures for the Activity Funds Initiative described in Section 7.
HRSN Services	SHAC		X	X	All expenditures for HRSN initiatives described in Section 10.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

16.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00472/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 17, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 14, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 7. MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Workforce Initiative	Report all expenditures for the Workforce Initiatives described in Section 6.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29
DSHP	Report all expenditures for DSHP described in Section 11.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29
ARO Incentive Program	Report all expenditures for the Access, Reform and Outcomes Incentive Program described in Section 5.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29
SMI	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment described Section 8.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29
Community Transition In-Reach Services	Report all expenditures for the Community Transition In-reach Services described in Section 9.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29

Activity Funds	Report all expenditures for the Activity Funds Initiative described in Section 7.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	1/1/25	12/31/29
HRSN Services	Report all expenditures for HRSN initiatives described in Section 10.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/1/25	12/31/29
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

16.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 8. Demonstration Years		
Demonstration Year 1	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 2	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 3	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 4	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 5	January 1, 2029 to December 31, 2029	12 months

16.13. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section 17. CMS will provide technical assistance, upon request.[4]

16.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

16.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base

[4] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

16.16. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 16.16.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

17. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

17.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, Hypothetical Budget Neutrality Tests, and a Supplemental HRSN Aggregate Ceiling (SHAC) Budget Neutrality Test as described below. CMS's assessment of the state's compliance with these tests will be based on the

Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

17.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 6, Master MEG Chart and Table 7, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

17.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

17.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the SHAC Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the SHAC amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both." Accrued savings from the California Advancing and Innovating Medi-Cal (CalAIM) demonstration shall be included when calculating the Main Budget Neutrality limit. For the current demonstration period, $5,415,000,000 will be transferred from the CalAIM demonstration to the BH-CONNECT demonstration.

Table 9. Main Budget Neutrality Test								
MEG	**PC or Agg ***	**WOW Only, WW Only, or BOTH**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**
ARO Incentive Program	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Workforce Initiative	Agg	WW Only	N/A	The state must have savings to offset these expenditures.				
DSHP	Agg	WW Only	N/A	The state must have savings to offset these expenditures.				

*PC = Per Capita, Agg = Aggregate

17.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

17.6. **Hypothetical Budget Neutrality Test 1:** SMI (Expenditure Authority #4) The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit

from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10. Hypothetical Budget Neutrality Test 1								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**
SMI	PC	Both	5.0%	$11,078.11	$11,632.02	$12,213.62	$12,824.30	$13,465.52

17.7. **Hypothetical Budget Neutrality Test 2:** Community Transition In-Reach Services (Expenditure Authority #5). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11. Hypothetical Budget Neutrality Test 2								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**
Community Transition In-Reach Services	PC	Both	5.0%	$2,845.00	$2,987.25	$3,136.61	$3,293.44	$3,458.11

17.8. **Hypothetical Budget Neutrality Test 3:** Activity Funds (Expenditure Authority #3). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 12. Hypothetical Budget Neutrality Test 3								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**
Activity Funds	PC	Both	4.7%	$83.33	$87.25	$91.35	$95.64	$100.14

17.9. **Supplemental HRSN Aggregate Ceiling (SHAC) Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 10), CMS considers these expenditures to be "supplemental HRSN aggregate ceiling (SHAC)"" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-ceiling of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects SHAC expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the ceiling for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's SHAC spending exceeds the SHAC Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the ceiling to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the SHAC.

17.10. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset

by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 13. SHAC Budget Neutrality Test							
MEG	**Agg**	**WOW Only, WW Only, or Both**	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**
HRSN Services	Agg	Both	$244,242,000	$514,194,000	$541,257,000	$569,744,000	$599,731,000

17.11. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

17.12. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 1, 2025 to December 31, 2029. If at the end of the demonstration approval period the Main Budget Neutrality Test or a SHAC Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

17.13. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 14. Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

18. MONITORING ALLOTMENT NEUTRALITY

18.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. **Premiums.** Any premium contributions collected under the demonstration must be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within

two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

18.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state must separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

18.3. **Title XXI Administrative Costs.** All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

18.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 4 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

a. **Exhaustion of Title XXI Funds for CHIP Population.** If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

19. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 15. Schedule of Deliverables for the Demonstration Period

Date	Deliverable	STC
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after demonstration approval	SMI Implementation Plan (including Health IT Plan)	STC 8.3 (a)
60 calendar days after receipt of CMS comments	Revised SMI Implementation Plan (including Health IT Plan)	STC 8.3 (a)
90 calendar days after approval of the extension	Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services	
9 months after the approval of the extension	HRSN Implementation Plan	STC 10.21 (a)
At least 60 days prior to intended implementation	Provider Payment Methodologies for HRSN	
Prior to claiming FFP in DY2 through DY5	Incentive Program Protocol	STC 5.13
150 calendar days after demonstration approval	Monitoring Protocol	STC 14.5
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 14.5
180 calendar days after demonstration approval	Draft Evaluation Design	STC 15.4
60 days after receipt of CMS comments	Revised Evaluation Design	STC 15.5
One and a half years after implementation of the Community Transition In-Reach Services	Rapid Cycle Assessment (Community Transition In-Reach Services)	STC 15.6 (e)
No later than 60 calendar days after three years after the demonstration approval date	SMI Mid-Point Assessment	STC 14.7
60 calendar days after receipt of CMS comments	Revised Mid-Point Assessment	STC 14.7
One year prior to the demonstration expiration date, or with renewal application	Draft Interim Evaluation Report	STC 15.7 (c)
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 15.7 (d)

Table 15. Schedule of Deliverables for the Demonstration Period

Date	Deliverable	STC
Within 18 months after the demonstration expiration date	Draft Summative Evaluation Report	STC 15.8
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 15.8 (a)
Monthly Deliverables	Monitoring Calls	STC 14.9
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 14.6
	Quarterly Expenditure Reports	STCs 14.6 (c) and 16.2
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 14.6

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

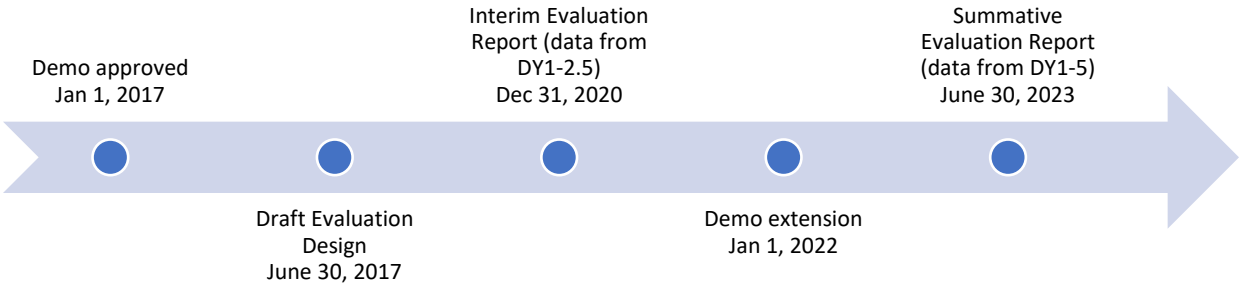
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

- General Background Information
- Evaluation Questions and Hypotheses
- Methodology
- Methodological Limitations
- Attachments

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. **General Background Information**. In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5. Describe the population groups impacted by the demonstration.

B. **Evaluation Questions and Hypotheses.** In this section, the state should:

1. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3. Identify the state's hypotheses about the outcomes of the demonstration:

4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. **Methodology**. In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1. Evaluation Design. Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2. Target and Comparison Populations. Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. Evaluation Period. Describe the time periods for which data will be included.

4. Evaluation Measures. List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing;

and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

b. Qualitative analysis methods may be used and must be described in detail.

c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5. Data Sources. Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    a. *If primary data (data collected specifically for the evaluation):* The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6. Analytic Methods. This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

    b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

7. Other Additions. The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table 16. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome Measures Used to Address the Research Question	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. **Methodological Limitations.** This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1. When the state demonstration is:

    a. Long-standing, non-complex, unchanged, or

    b. Has previously been rigorously evaluated and found to be successful, or

    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

    a. Operating smoothly without administrative changes; and

    b. No or minimal appeals and grievances; and

    c. No state issues with CMS-64 reporting or budget neutrality; and

    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments.

1. Independent Evaluator. This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

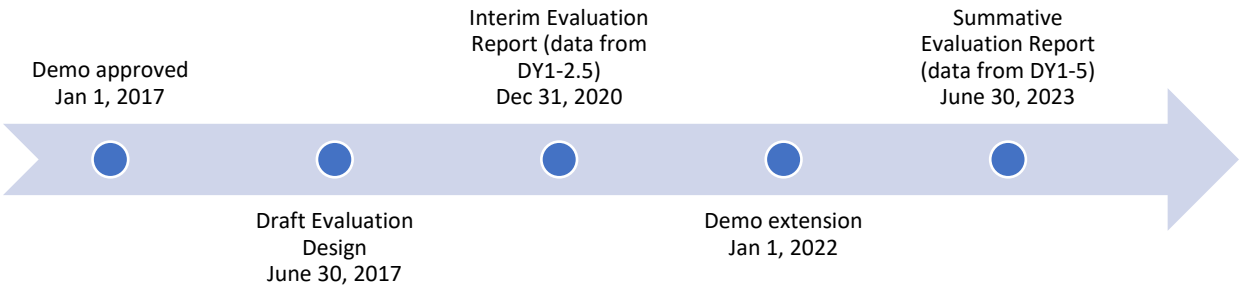
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary
B. General Background Information
C. Evaluation Questions and Hypotheses
D. Methodology
E. Methodological Limitations
F. Results
G. Conclusions
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS, pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. **Executive Summary.** A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration.** In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5. Describe the population groups impacted by the demonstration.

C. **Evaluation Questions and Hypotheses.** In this section, the state should:

1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2. Identify the state's hypotheses about the outcomes of the demonstration;

    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;

    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and

    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. **Methodology**. In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design. Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?

2. Target and Comparison Populations. Describe the target and comparison populations; include inclusion and exclusion criteria.

3. Evaluation Period. Describe the time periods for which data will be collected

4. Evaluation Measures. What measures are used to evaluate the demonstration, and who are the measure stewards?

5. Data Sources. Explain where the data will be obtained, and efforts to validate and clean the data.

6. Analytic Methods. Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7. Other Additions. The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations.** This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results.** In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration

results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. **Conclusions.** In this section, the state will present the conclusions about the evaluation results.

    1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

    2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

        a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives.** In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. **Lessons Learned and Recommendations.** This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

    1. What lessons were learned as a result of the demonstration?

    2. What would you recommend to other states which may be interested in implementing a similar approach?

F. **Attachment: Evaluation Design.** Provide the CMS-approved Evaluation Design.

ATTACHMENT C

Reserved for Access, Reform and Outcomes Incentive Program Protocol

ATTACHMENT D

SMI Implementation Plan and Financing Plan

State		California
Demonstration Name		The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration
Approval date		
Approval period		January 1, 2025 – December 31, 2029
Implementation date		January 1, 2025

Pleases see below for contact information for the State's point of contact for this demonstration implementation plan:

Name and Title: Tyler Sadwith, State Medicaid Director, Department of Health Care Services

Telephone Number:

Email Address: tyler.sadwith@dhcs.ca.gov

Introductory Note:

The Department of Health Care Services (DHCS) issues behavioral health information notices (BHINs) to provide guidance about and interpretation of changes in policy or procedures that impact specialty behavioral health delivery systems. Specialty behavioral health delivery systems include county mental health plans (MHPs) and Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS) counties. Specialty behavioral health delivery systems are required to implement mechanisms to assure compliance in accordance with BHINs. Pursuant to the State's Welfare and Institutions section 14184.102, subdivision (d), DHCS has authority to implement through BHINs the CalAIM Act (Article 5.51) and CalAIM terms and conditions, as defined, without issuing formal regulations. The CalAIM Act encompasses the BH-CONNECT demonstration, making it possible to use BHINs as authoritative guidance that imposes official, enforceable requirements on behavioral health plans (BHPs)[1] as a formal regulation would do. In the future, DHCS may also issue formal regulations to complement guidance issued via a BHIN related to the milestones in this plan. Although they are not formal regulations, BHINs are developed through an intensive process in which DHCS crafts policy with review by multiple internal state agencies and divisions, including our Office of Legal Services, among others, and then issues a draft of the BHIN for public comment. After receiving public comment, DHCS reviews and revises the policy as needed and re-issues the BHIN. If there are significant comments, DHCS may choose to issue an updated draft of a BHIN for further public comment prior to finalization.

DHCS maintains a multifaceted system to ensure oversight and accountability to licensing requirements, contractual requirements and regulations set forth in BHINs, which is deployed to monitor all aspects of compliance. All requirements set forth in certification or licensing, including in statute, regulations, and BHINs, are monitored by the Licensing and Certification Division. Elements set forth within BHP contracts, statute, regulations, and BHINs are monitored by the Medi-Cal Behavioral Health Oversight and Monitoring Division. These bodies collect, track and validate requirements according to existing protocols, provide technical assistance as needed, and issue Corrective Action Plans and/or sanctions. In other words, when this implementation plan references BHINs as the vehicle for implementing policy and procedural changes, it means that the full oversight and enforcement authority used by DHCS to officially set forth requirements for BHPs and licensed or certified providers, and oversee and enforce compliance with those requirements, will be utilized to ensure those changes are implemented and complied with. In addition, DHCS will require any BHP that wants to opt into receiving Federal Financial Participation (FFP) for qualified stays in qualified Institution for Mental Disease (IMD) settings to submit an implementation plan for how it will comply with the requirement applicable to an opt-in county. These include meeting the standards discussed in this Implementation Plan for CMS, as well as providing a specified set of community-based evidence-based practices, as discussed in detail in the BH-CONNECT application. BHPs will be required to monitor facility compliance with the terms of the demonstration, and DHCS will in turn monitor BHP compliance.

Upon approval of the BH-CONNECT demonstration, DHCS plans to issue one or more BHINs within 3-6 months that establish requirements for counties and Participating Psychiatric Settings that opt to participate in BH-CONNECT. These BHIN(s) will provide guidance on all requirements that must be met prior to claiming FFP for services provided during short-term stays to Medi-Cal members in those facilities. The BH-CONNECT BHINs will include information related to changes arising from all CMS milestones described in this Implementation Plan including:

- Accreditation requirements (Milestone 1.a);
- Requirements to screen members for co-morbid physical health conditions, SUDs, and suicidal ideation (Milestone 1.e);

[1] Throughout this Implementation Plan, the term behavioral health plans (BHPs) is defined as including three types of Prepaid Inpatient Health Plans regulated under 42 CFR Part 438: (1) mental health plans (MHPs) that are responsible for Specialty Mental Health Services (SMHS), (2) Drug Medi-Cal Organized Delivery Systems (DMC-ODS) that are responsible for providing specialty substance use disorder (SUD) services, and (3) Integrated Prepaid Inpatient Health Plans that are responsible for providing both SMHS and DMC-ODS.

- Requirements for intensive pre-discharge planning that includes community-based providers in care transitions (Milestone 2.a);
- Requirements to assess beneficiaries' housing situations and coordinate with housing services providers when needed and available (Milestone 2.b);
- Requirements to contact beneficiaries and community-based providers through the most effective means possible, within 72 hours post discharge (Milestone 2.c); and
- Requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay (Milestone 3.d).

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals, and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status.* Milestone partially achieved. There are three types of hospitals and residential treatment settings in the State that primarily provide mental health treatment to individuals living with SMI or SED and may be IMDs in counties that opt to participate in the BH-CONNECT waiver opportunity (hereafter, "Participating Psychiatric Settings"). DHCS recognizes that while Freestanding Acute Psychiatric Hospitals and select Psychiatric Health Facilities meet criteria for Inpatient Psychiatric Services for Individuals under Age 21, Mental Health Rehabilitation Centers do not. DHCS is not requesting expenditure authority under BH-CONNECT for individuals under age 21 in any such facilities that do not meet criteria for Inpatient Psychiatric Services for Individuals under Age 21. DHCS is not requesting expenditure authority for any Qualified Residential Treatment Programs (QRTPs). • **Mental Health Rehabilitation Centers (MHRC)** provide intensive support and rehabilitative services in a residential setting to persons with mental disorders who otherwise would have been placed in a state hospital or another mental health facility. They assist persons in developing skills to become self-sufficient and capable of increasing levels of independence and functioning. MHRCs are licensed by DHCS.[2]

[2] Cal. Welf. & Inst. Code § 4080.

Prompts	Summary
	• **Psychiatric Health Facilities (PHF)** provide 24-hour inpatient psychiatric care for mentally disordered, incompetent, or other persons as described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code. PHFs are licensed by DHCS.[3] • **Freestanding Acute Psychiatric Hospitals (APH)** provide 24-hour inpatient acute psychiatric services as special services in accordance with a general acute care hospital and all structures, equipment, and services**.** APHs are licensed by the California Department of Public Health. All three Participating Psychiatric Settings described above are licensed or otherwise authorized by the State to primarily provide mental health treatment. BHPs are required to inform the State of any accreditation from a private independent accrediting entity for all three Participating Psychiatric Settings. None of the Participating Psychiatric Settings are required to be accredited as a condition of licensure or Medi-Cal certification, but many are currently accredited by a nationally recognized accreditation entity.
	Future Status The State will require that all participating residential treatment facilities (MHRCs) and inpatient, non-hospital treatment facilities that are not certified as meeting the conditions of participation in 42 CFR Part 482 (PHFs) that wish to receive federal financial participation (FFP) for stays in IMDs of no more than 60 days to obtain accreditation prior to the State claiming FFP for services provided to Medi-Cal members residing in those facilities. The State will fully and expressly capture this requirement for participating residential treatment facilities (MHRCs) and inpatient, non-hospital treatment facilities that are not certified as meeting the conditions of participation in 42 CFR Part 482 (PHFs) as part of a BH-CONNECT BHIN. DHCS will leverage the compliance monitoring systems described above to ensure oversight and accountability to licensing requirements.

[3] Cal. Welf. & Inst. Code § 4080.

Prompts	Summary
	DHCS will also update the contracts the state holds with each BHP for counties participating in BH-CONNECT to include the requirement that any IMD facility for which FFP is claimed must be accredited. The state will leverage existing processes for ensuring BHPs are in compliance with BHINs with active engagement by the Medi-Cal Behavioral Health Oversight and Monitoring Division, per the discussion in the Introductory note to this Implementation Plan.
	Summary of Actions Needed Specifically, the State will issue a BHIN for counties and participating residential treatment settings (MHRCs) and inpatient, non-hospital treatment facilities that are not certified as meeting the conditions of participation in 42 CFR Part 482 (PHFs) that opt to participate in BH-CONNECT to require accreditation by a nationally recognized accreditation entity prior to receiving FFP for services provided to Medi-Cal members residing in those facilities. DHCS intends to issue this guidance in Q1 2025, pending demonstration approval by CMS. The state will not permit facilities to receive Medicaid funding for services delivered in IMDs until they meet accreditation requirements. (Timeline: Within 3-6 months of demonstration approval). As described above, DHCS also plans to amend county behavioral health plan contracts to reflect new requirements related to BH-CONNECT, consistent with existing practices to update contracts as the new policy is promulgated. (Timeline: 3-24 months). In support of counties understanding new requirements, DHCS will offer open webinars and publish Frequently Asked Questions to ensure clarity of expectations and mandates. Further, DHCS will ensure that BHPs understand they may leverage administrative funds allocated within their plan to support providers in meeting the standards. BHPs will be required to demonstrate their capacity to meet the requirements as part of the submission of a county-level implementation plan, which will be reviewed and approved by the state prior to service commencement. As described above in the Introductory Note, participating BHPs will be required to monitor compliance with demonstration terms for facilities in their networks (including but not limited to compliance with accreditation requirements), and DHCS will monitor and enforce BHP compliance with demonstration terms.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status.* Milestone achieved. All Participating Psychiatric Settings are subject to oversight and auditing, including unannounced visits, to ensure compliance with the State's licensing and certification requirements. **Facility Licensure Oversight by DHCS and CDPH** • **MHRC** licensing is based on application approval and on a site review(s) conducted by the DHCS, within 30 calendar days following the MHRC applicant receiving written notification of approval of the application from the Department. Subsequently each MHRC has an annual licensing survey.

Prompts	Summary
	• **PHF** licensing inspection is conducted by DHCS to approve licensure of the facility. Every PHF and program for which a license has been issued must be periodically inspected by a multidisciplinary team appointed or designated by the DHCS. The inspection must be conducted no less than once every two years and as often as necessary to ensure the quality of care provided. • **APHs** require an annual license renewal application submitted to CDPH to renew the license. APH are subject to relicensing surveys once every three years. **SMHS Oversight by BHPs: Continued SMHS Compliance for County and Contracted Providers** To receive Medicaid funding, all Participating Psychiatric Settings must enter into a contract or payment agreement with a BHP. The BHP is then responsible for additional oversight consistent with the terms of its Medi-Cal contract. BHPs must conduct review of each provider for continued compliance with SMHS standards at least once every three years.[4] BHPs are also responsible for conducting onsite review of contracted providers (with limited exceptions) at least once every three years.[5] County owned and operated providers are subject to onsite review conducted by DHCS.[6] The BHP contract also requires BHPs to develop and maintain a compliance program to monitor network providers on an ongoing basis and specifies an auditing process that includes unannounced visits at any time by the State, CMS, federal agencies, state agencies, or their duly authorized representative. Authorized representatives may visit any contracted facility at any time to evaluate performance under contractual requirements, including the quality, appropriateness, and timeliness of services provided and inspect any and all records, documents, and facility premises.
	Future Status The State and BHPs will continue to provide oversight (including unannounced visits) to ensure compliance with all applicable licensing, certification, and accreditation requirements.
	Summary of Actions Needed None.
1.c Utilization review process to ensure beneficiaries have access	*Current Status.* Milestone achieved.

[4] MHP Contract Ex. A, Attachment 8, Section 8.A
[5] MHP Contract Ex. A, Attachment 8, Section 8.L
[6] MHP Contract Ex. E, Section G(1)

Prompts	Summary
to the appropriate levels and types of care and to provide oversight on lengths of stay	Services delivered in all Participating Psychiatric Settings will be provided through BHPs. The State's contracted BHPs are required to conduct utilization review to ensure the medical necessity and appropriateness of all covered services delivered to Medi-Cal members. BHPs are subject to detailed and robust requirements for concurrent review and authorization processes for psychiatric inpatient and residential level of care services. Among other requirements, BHPs must maintain telephone access to receive authorization requests 24 hours a day and 7 days a week; ensure that authorization decisions are overseen by a health care professional that has appropriate clinical expertise; include in the authorization communication the amount, scope, and duration of treatment authorized by the BHP; and make an authorization decision as expeditiously as possible but no later than 72 hours after receipt of the request for services. Authorization procedures and utilization management criteria are based on medical necessity and consistent with evidence-based clinical guidelines, principles, and processes, and BHPs must demonstrate that they have mechanisms in place to ensure consistent application of review criteria for authorization decisions.
	Future Status The State will continue to require BHPs to conduct utilization review of all covered services, including those delivered in Participating Psychiatric Settings, to ensure that members have access to the appropriate levels and types of care and to provide oversight on lengths of stay.
	Summary of Actions Needed None.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status.* Milestone achieved. Implementation and oversight of State and federal Medicaid program integrity requirements is provided by the State's Medicaid Provider Enrollment Division (PED) and Audits and Investigations (A&I) Division. PED oversees risk-based screening of all newly enrolling providers, revalidates existing providers pursuant to the rules in 42 CFR Part 455, and ensures that treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107. A&I manages other types of compliance and enforcement efforts, including conducting audits and investigations to ensure adherence to program integrity requirements related to overpayment and fraudulent billing.
	Future Status The State will continue its program integrity processes for Participating Psychiatric Settings.
	Summary of Actions Needed

Prompts	Summary
	None.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status.* Milestone partially achieved. The State's requirements for psychiatric settings for adults (as listed in 1a) do not yet fully meet this milestone.
	Future Status As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure all Participating Psychiatric Settings screen members for co-morbid physical health conditions, SUDs, and suicidal ideation, and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers). Methods for substantiating this requirement will be outlined in the BHIN and may include DHCS review of policies and procedures, attestations, report submissions and/or client chart reviews. In addition, any BHP that elects to participate in the option to draw down FFP in qualified circumstances for short-term IMD stays must submit an implementation plan subject to review and approval by DHCS. This plan will require BHPs to establish how they ensure Participating Psychiatric Settings have met the requirements to provide screening for beneficiaries for co-morbid physical health conditions, SUDs and suicidal ideation, and facilitate access to treatment for those conditions. BHPs will be required to monitor facility compliance, and BHP compliance (including review of BHP policies, provider subcontracts, provider manuals, and other BHP records) will be monitored by the Medi-Cal Behavioral Health -- Oversight and Monitoring Division, in partnership with DHCS' Audits and Investigations Division.
	Summary of Actions Needed The State will develop and issue one or more BHINs that outlines requirements for BHPs to ensure Participating Psychiatric Settings meet this requirement (Timeline: 3-6 months). Accompanying the BHIN, the state will offer webinars and draft Frequently Asked Questions guides as needed to ensure facilities and BHPs have the information and tools necessary to achieve and maintain compliance. BHPs, in turn, will be able to utilize DHCS guidance to provide ongoing technical assistance and training to their network providers and ensure all requirements are met, and continued compliance can be supported, prior to commencement of services. Some BHPs may take longer than others to meet the requirements established in the BHIN, but, there is no deadline for opting-in to receive FFP for short-term IMD stays, making it possible for BHPs that need more time to meet the standards to do so. Note that all BHPs seeking to take up the IMD option must submit an implementation plan to DHCS for review and approval prior to beginning to claim FFP for short-term IMD stays; DHCS will ensure that BHPs have met the requirements of this section before finalizing approval of the BHP implementation plan. As noted above, BHPs will be subject to ongoing DHCS monitoring of their compliance with the terms of the BH-CONNECT demonstration as outlined in the BHP contract and applicable BHINs.

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	*Current Status* Milestone achieved. The State has established a number of requirements designed to ensure quality of care in Psychiatric Settings. These include: • Revisions to the **informed consent requirement** for anti-psychotic medications to permit verbal consent. • A requirement that SUD recovery or treatment facilities **offer medications for addiction treatment** (MAT) or have effective referral processes in place for this purpose. • Establishment of **Psychiatric Residential Treatment Facilities** (PRTFs) as a new category of residential health facilities licensed by DHCS. • **Improved quality standards** for certain residential psychiatric settings that serve children and youth.
	Future Status The State will maintain existing requirements/policies designed to ensure quality of care. In addition, as part of the BH-CONNECT demonstration the State has proposed to establish the Access, Reform, and Outcomes Incentive Program to incentivize BHPs to improve performance on quality measures and reduce disparities in behavioral health access and outcomes, with a focus on members living with SMI/SED and/or SUD who are otherwise at risk of hospitalization or other significant adverse health outcomes. The State will also explore opportunities to implement policies that will further reduce the use of seclusion and restraint in inpatient and residential treatment settings.
	Summary of Actions Needed None.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	*Current Status.* Milestone partially achieved. Many Psychiatric Settings are subject to discharge planning requirements. Section 1262 of the California Health and Safety Code requires that any mental health patient being discharged from a psychiatric setting, including all three Participating

Prompts	Summary
	Psychiatric Settings shall be given a written aftercare plan prior to the patient's discharge from the facility. The written aftercare plan shall include, to the extent known, all of the following components: • The nature of the illness and follow-up required. • Medications including side effects and dosage schedules. If the patient was given an informed consent form with their medications, the form shall satisfy the requirement for information on side effects of the medications. • Expected course of recovery. • Recommendations regarding treatment that are relevant to the patient's care. • Referrals to providers of medical and mental health services. • Other relevant information. No current policies fully and expressly capture the requirement to involve community-based providers in transition efforts. Other state initiatives, however, support this requirement. Under the CalAIM Population Health Management initiative, Medi-Cal Managed Care health plans (MCPs)[7] are accountable for providing strengthened Transitional Care Services (TCS) – which includes enforcing Admissions, Discharge, and Transfer (ADT) notifications and discharge planning for members in acute care hospitals (including inpatient psychiatric facilities), emergency departments, and skilled nursing facilities – until members have been successfully connected to all needed services and supports – beginning as of January 1, 2023, and fully implemented for all members by January 1, 2024 across all settings and delivery systems. While BHPs are primarily responsible for coordination of care with the member upon discharge from psychiatric settings, under DHCS' Memoranda of Understanding (MOUs) between MCPs and BHPs, MCPs are required to develop a joint process with BHPs to coordinate TCS for members. MCPs are also required to assign or contract with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services.
	Future Status As part of one or more BH-CONNECT BHINs, as well as a forthcoming BHIN regarding CalAIM Behavioral Health Data Sharing Policy, the State will fully and expressly capture the requirement for all Participating Psychiatric Settings to carry out intensive pre-discharge planning and include community-based providers in care transitions. This may include policies such as: • **Assertive discharge planning** after psychiatric hospitalization with a risk of death by suicide. This person-centered, focused effort tailored to specific support needs will be highly participatory and may include immediate access to structured clinical interventions within a step-down level of care, appointments with primary care or other medical

[7] MCPs are responsible for covering physical health services, and Non-Specialty Mental Health Services, for their enrolled Medi-Cal members and for ensuring their Network Providers coordinate care for Members as provided in the applicable Medi-Cal Managed Care Contract, and coordinating care from other providers of carve-out programs, services, and benefits, including Specialty Mental Health Services. MHPs are responsible for providing or arranging for the provision of Specialty Mental Health Services.

Prompts	Summary
	follow up, arranged access to prescription medications, family and support system engagement and psychoeducation, peer support engagement, vocational or educational support, crisis response planning, risk factor analysis and safety contracting, strategies to address social determinants of health, and articulated preferred methods for proactive system outreach within the first hours or days following discharge, • Compliance with standards and specifications associated with **Electronic Notification requirements** in accordance with 42 CFR 482.61(f), as specified in the CMS Interoperability and Patient Access final rule. This requirement will also be reinforced in a separate forthcoming BHIN on the CalAIM Behavioral Health Data Sharing Policy slated for release during or prior to Q1 2025. • Coordination of behavioral health services to include admission, discharge, and transfer (ADT) notifications from acute care hospitals, psychiatric hospitals, state hospitals, and skilled nursing facilities, and data sharing between Medi-Cal Partners, defined as any person or organization that provides Medi-Cal reimbursable health and social services to Medi-Cal members, including BHPs and MCPs.[8] The State will also consider how providers can initiate services with a community-based provider while a member is still residing in an inpatient/residential facility and explore options for implementation. As outlined in the BH-CONNECT Addendum Request (submitted to CMS in July 2024), DHCS is seeking expenditure authority for **Community Transition In-Reach** services as part of the continuum of care established by BH-CONNECT. Through this option, BHPs can establish community-based, multi-disciplinary care transition teams that provide intensive pre- and post-discharge care planning and transitional care management services to support individuals with significant behavioral health conditions who are experiencing or at risk for long-term stays in institutional settings in returning to the community. These care transition teams will deploy an in-reach model for individuals who are experiencing or at risk of experiencing extended lengths of stay (120 days or more) in inpatient, residential, or subacute settings (including IMDs) to support reintegration into the community. The Community Transition In-Reach Services will be Specialty Mental Health services that BHPs can opt in to cover.
	Summary of Actions Needed As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure all Participating Psychiatric Settings carry out intensive pre-discharge planning, and include community-based providers in care transitions. (Timeline: 3-6 months). Additionally, DHCS will issue a Data Sharing BHIN (Timeline: 3-6 months).
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries'	*Current Status.* Milestone partially achieved.

[8] DHCS CalAIM Data Sharing Authorization Guidance: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf

Prompts	Summary
housing situations and coordinate with housing services providers when needed and available	The State has established requirements for some types of psychiatric hospitals and residential settings to address housing challenges for members, and state law also establishes specific requirements for homeless individuals in certain settings, but gaps remain. While this milestone is not achieved in full for all Participating Psychiatric Settings, many Psychiatric Settings do assess members' housing situations and coordinate with housing services providers when needed and available, however, for residential settings, regulations do not specify requirements for transitions connecting those in the community for persons who are homeless or have unsuitable or unstable housing. Inpatient hospitals are specifically required to inquire about a patient's housing status and identify post-discharge destinations for individuals experiencing homelessness. Under Senate Bill 1152 (Chapter 981, Statutes of 2018) acute psychiatric hospitals (along with general acute care hospitals and special hospitals) must comply with a particularly robust set of discharge planning requirements for homeless patients. Specifically, state law provides that these facilities must identify a post discharge destination for any homeless patient at either a social services agency or provider that has agreed in advance to the placement; a dwelling place identified by the homeless patient as their residence; or an alternative location indicated by the homeless patient and documented in his or her record. The facility must prioritize placing the patient at a sheltered location with supportive services. In addition, the hospital must develop a written plan (to be updated annually) for coordinating services and referrals with the county behavioral health agency, health care and social services agencies, health care providers, and nonprofit social service providers, as available. The plan must include a list of local homeless shelters and their hours of operations, admission procedures and requirements, client population served, scope of services available; the hospital's procedure for homeless patient discharge referrals; and training protocols for discharge planning staff. In addition, the State has developed and is seeking to implement several policies designed to address the housing needs of individuals with SMI/SED including: • **Behavioral Health Bridge Housing (BHBH),** which will provide $1.5 billion in funding through June 30, 2027 to county behavioral health agencies and Tribal entities to operate bridge housing settings to address the immediate and sustainable housing needs of people experiencing homelessness who have serious behavioral health conditions, including a SMI and/or SUD. • **Housing and Homelessness Incentive Program (HHIP),** which allows MCPs to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. • **Enhanced Care Management (ECM),** a statewide Medi-Cal benefit available to select populations of focus, including individuals with SMI or SED, to address clinical and nonclinical needs through intensive coordination of health and health-related services, including providing connections to housing and other resources. • **Community Supports services** to address members health-related social needs, including through housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing and recuperative care. Managed Care Plans (MCPs) are not required to provide Community

Prompts	Summary
	Supports, but every MCP in California has opted to do so. By January 2025, every MCP will have contracts in place in at least one county for each of the housing-related Community Supports, but not every housing-related Community Support will be available in every county in which each MCP operates. A complete summary of CalAIM Community Supports Managed Care Plan Elections is available here. • **Proposition 1**, passed by California voters in March 2024, encompasses Senate Bill (SB) 326 and Assembly Bill (AB) 531. **SB 326** (Chapter 790, Statutes of 2023) requires counties to allocate behavioral health funding for housing interventions for children and families, youth, adults and older adults living with significant behavioral health needs who are experiencing or at risk of homelessness. Counties may use this funding for rental subsidies, operating subsidies, shared housing, project-based housing assistance, other housing supports, and capital development projects, including affordable housing. DHCS is currently developing guidelines for these allowable uses of funding. **AB 531** includes a $6.38 billion bond to build new treatment facilities, community infrastructure and supportive housing for individuals living with significant behavioral health needs, including: ○ The recent release of $3.3 billion in competitive grant funding to expand the behavioral health continuum and provide appropriate care to individuals experiencing mental health conditions and substance use disorder; ○ A second round of up to $1.1 billion in grant funding for additional behavioral health treatment site infrastructure; and ○ Up to $2 billion to build permanent supportive housing for veterans and others that are homeless or at risk of homelessness and have mental health or substance use challenges.
	Future Status As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure all Participating Psychiatric Settings assess members' housing situations and coordinate with housing services providers when needed and available. In addition to maintaining the requirements and policies identified above, the State also intends to further support connections to housing through referrals to members' MCPs for Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, and Housing Deposits (currently covered by all MCPs as Community Supports) and the authority requested under BH-CONNECT for MCP coverage of up to **six months of Transitional Rent** for members who meet eligibility criteria.
	Summary of Actions Needed As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement that Participating Psychiatric Settings assess beneficiaries' housing status and coordinate with housing support providers. (Timeline 3-6 months)

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status.* Milestone partially achieved. While all Psychiatric Settings are subject to discharge planning requirements, and many make a practice of contacting members after discharge and following up with the community-based provider the person was referred to, the relevant requirements for Psychiatric Settings do not fully capture the milestone requirement.
	Future Status As part of a BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure that Participating Psychiatric Settings and/or BHPs contact members and community-based providers through the most effective means possible, including the requirement to ensure that follow-up care is accessed by contacting the member *and* the community provider the member was referred to *within 72 hours* post discharge. (Timeline: 3-6 months)
	Summary of Actions Needed The State will fully and expressly capture the requirement that Participating Psychiatric Settings and/or BHPs contact beneficiaries and community-based providers within 72 hours of discharge as part of the BH-CONNECT BHINs. (Timeline: 3-6 months). BHPs will need to establish their compliance with this requirement in their opt-in implementation plans subject to review and approval by DHCS.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status.* Milestone achieved. The State has implemented and is planning several initiatives to prevent admission and decrease lengths of stay in EDs among members with SMI or SED, including: • **Community-Based Mobile Crisis Intervention Services**, which was authorized as a Medi-Cal benefit under SPA 22-0043, effective Jan. 1, 2023. One of the goals of this benefit is to help resolve mental health, SED and SUD crises in the community, mitigating the need for ED visits. • **CA Bridge Program**, a statewide program which launched at 52 hospitals in 2018 and currently supports 266 hospitals, representing 80% of hospitals in the state. CA Bridge trains hospital staff to screen for opioid use disorder and other SUDs, initiate MAT and mental health care in the emergency department, and facilitate access/referrals to community-based providers for follow-up care. DHCS continues to support the sustainability of the CA Bridge Program with State Opioid Response (SOR) III and SOR IV grant dollars through fall 2027 to:

Prompts	Summary
	○ Provide training and technical assistance (TTA) to BHNs and prescribers, empowering them to facilitate access to MAT and other evidence-based substance use disorder (SUD) therapies and support community health worker (CHW) workforce development to ensure seamless patient transitions and care continuity. ○ Provide sustainability TTA to transition the behavioral health navigation services supported through the CA Bridge program from grant-based funding to Medi-Cal reimbursement through implementation of the Community Health Worker (CHW) benefit in accordance with State Plan Amendment 22-001 and All Plan Letter 24-006. This will include identifying and showcasing various CHW billing pathway models to facilitate the implementation of the CHW benefit in EDs on the CA Bridge website. ○ Support the development of six outpatient Bridge Clinics to expand the network of telemedicine capable low-barrier clinics able to receive referrals and provide a best practices guide statewide. ○ Develop and launch an online patient portal, the CA Bridge Treatment Access Network, which will enable patient access to a network of BHNs, low-barrier clinics, and telehealth. • DHCS' **Comprehensive Quality Strategy (CQS)** includes high priority metrics applicable to all BHPs and MCPs to drive annual improvements in quality outcomes by measuring follow-up after ED visits for a mental health or substance use condition. Measures are calculated using data from EDs and are reported as the percentage of ED visits for which the member received follow-up within 7 days and 30 days of the ED visit. Specialty behavioral health and managed care delivery systems must meet minimum performance levels on these metrics (which are also part of CMS' core set) and will be subject to corrective action, up to and including monetary sanctions, if they fail to meet these targets. • Under the **CalAIM Population Health Management** initiative, Medi-Cal Managed Care health plans (MCPs)[9] are accountable for providing strengthened Transitional Care Services – which includes enforcing Admissions, Discharge, and Transfer (ADT) notifications. As described under Milestone 2a., while BHPs are primarily responsible for coordination of care with the member upon discharge from psychiatric settings, under DHCS' Memoranda of Understanding (MOUs) between MCPs and BHPs, MCPs are required to develop a joint process with BHPs to coordinate TCS for members. Consistent with the policy that the MCP is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the MCP or its contracted care manager is responsible for ensuring transitional care coordination in instances where the MCP is not the primary source of coverage for the triggering service (e.g., an inpatient psychiatric admission covered by a BHP). MCPs are also required to assign or contract with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services. • **The Behavioral Health Quality Improvement Program (BHQIP)** included the following measures as part of its required deliverables for Medi-Cal behavioral health delivery systems ("participating entities"):

[9] MCPs are responsible for covering physical health services, and Non-Specialty Mental Health Services, for their enrolled Medi-Cal members and for ensuring their Network Providers coordinate care for Members as provided in the applicable Medi-Cal Managed Care Contract, and coordinating care from other providers of carve-out programs, services, and benefits, including Specialty Mental Health Services. MHPs are responsible for providing or arranging for the provision of Specialty Mental Health Services.

Prompts	Summary
	○ Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA); ○ Follow-Up After Emergency Department Visit for Mental Illness (FUM); • **Semi-Statewide Electronic Health Record (EHR) System**: The California Mental Health Services Authority (CalMHSA) leveraged its Joint Powers Authority to bring counties together to procure and implement a new semi-statewide EHR. In July 2023, CalMHSA launched the initial phase of the semi-statewide EHR program which covered over 37 percent of the state's Medi-Cal population at the county option, and CalMHSA will expand the program to additional counties in 2024. The EHR captures relevant milestones as members progress through their care in the behavioral health specialty system. EHR data collection begins with the initial request for services by the member, their support persons and/or professional referral. The behavioral health staff use the EHR to document services received during the course of treatment in multiple programs/care settings. Diagnosis and problems (via a problem list) are used to monitor a member's progress in recovery until services can eventually be stepped down and the member transferred to a non-specialty level of care/discharged. CalMHSA continues to build additional methods within the EHR to allow for tracking of referrals to agencies/services outside of behavioral health to ensure that members successfully navigate these treatment transitions. The new EHR System will make it possible for BHPs to more readily identify when one of their members has been admitted to an ED for a behavioral health condition, and to ensure that follow up care is provided. Additional initiatives are outlined in Section 3.c below, including developing a bed tracking tool to provide real-time information to behavioral health providers on the availability of inpatient and crisis stabilization beds, in accordance with state and federal HIT standards and regulations, with implementation planned for 2026.
	Future Status The State will continue to build out the continuum of community-based behavioral health care that helps to prevent and decrease lengths of stay in EDs among members with SMI or SED. Additional initiatives to build out the continuum of care are discussed in Topic 3 below, which details how the State is seeking to cover **additional community-based services** at county option that will help prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission in participating counties, including through Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), and Individual Placement and Support (IPS) model of Supported Employment. In addition to maintaining the policies and programs above, as part of the demonstration DHCS has proposed the **Access, Reform, and Outcomes Incentive Program** which will drive additional investments in BHPs to support strategies to prevent and decrease lengths of stays in EDs.

Prompts	Summary
	Summary of Actions Needed None.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status.* Milestone achieved. The State has implemented several initiatives and requirements to improve care coordination and connections to community-based care. These include: • **Enhanced Care Management (ECM)** is a statewide Medi-Cal benefit available to select populations of focus, one of which is individuals with serious mental health and/or SUD needs. The ECM lead care manager is charged with coordinating care and addressing needs related to physical health, mental health, substance use disorders and health-related social needs. • **Transitional Care Services**, a new set of requirements for MCPs that strengthen standards and MCP accountability for assisting members transferring from one setting or level of care to another, such as from institutional or residential settings to community-based care. Requirements include assignment of a single point of contact upon admission. Discharge risk assessment and planning, and post-discharge services and follow-up. This requirement applies even when the BHP or DMC-ODS is the primary payer for services provided during the inpatient stay. • **CalAIM Justice-Involved Initiative**, under which the State will offer a targeted set of Medicaid services to youth and eligible adults in state prisons, county jails, and youth correctional facilities and help them access key services upon their return to community. • **The Behavioral Health Quality Improvement Program (BHQIP)**, which incentivized county behavioral health delivery systems to improve data exchange capabilities to improve quality and coordination of care. Over the course of the program, participating entities demonstrated direct sharing of data either with Medi-Cal Managed Care Plans (MCPs) and/or onboarding to a Health Information Exchange (HIE). Counties collaborated and established agreements for bi-directional data exchange through signing the California Health and Human Services Data Exchange Framework Data Sharing Agreement with MCPs or the California Data Use and Reciprocal Support Agreement and California Trusted Exchange Network to onboard with an HIE. These established agreements strengthen the ability to provide effective care coordination for Medi-Cal beneficiaries who are transitioning across behavioral health delivery systems. BHQIP also improved the ability of participating entities to exchange data and report on quality measures. Through BHQIP, DHCS reviewed and approved deliverables specific to data exchange achievements, resulting in more than 50% of counties achieving success across reporting periods with implementing and improving data exchange capabilities. Success in meeting data exchange milestones means that counties submitted supporting documentation that includes data-sharing agreements, transaction logs, and written reports outlining how counties are leveraging direct data exchange to improve care coordination.

Prompts	Summary
	• **Peer Support Services**, a Medi-Cal benefit under the SMHS, DMC, and DMC-ODS delivery systems available at county option to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery. • **CalAIM No Wrong Door Policy**, which allows members to receive mental health services regardless of the delivery system where they seek care (specialty behavioral health, MCP or the FFS delivery system). • **CalAIM Screening and Transition Tools** to support BHPs and MCPs in determining the most appropriate Medi-Cal mental health delivery system referral for members who are not currently receiving mental health services, and to ensure that members receive timely and coordinated care when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment. • BHPs and DMC-ODS are **contractually required to conduct care coordination** in accordance with 42 C.F.R. § 438.208. • BHPs are also required to provide **Targeted Case Management** for select populations, including individuals with SMI/SED, which includes coordination of all medically necessary services. • As part of its oversight and monitoring activity, DHCS includes in its auditing process a **review of BHP and DMC-ODS compliance** with this care coordination requirement.
	Future Status In addition to maintaining the requirements and policies identified above, the State also intends to further support connections to community care and coordination across systems as part of the BH-CONNECT demonstration, including: • **Access, Reform, and Outcomes Incentive Program** to build upon the work done as part of BHQIP to support county behavioral health delivery systems in strengthening quality infrastructure and improving performance on quality measures, including those related to care coordination. • Requirement for counties that opt-in to the BH-CONNECT demonstration to cover **Community Health Worker Services** and **Peer Support Services** with a forensic specialization to ensure members living with SMI and SED have access to community-based supports from individuals living in their community and with lived experience.
	Summary of Actions Needed None.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities.	

Prompts	Summary
Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring report	*Current Status.* Milestone achieved. The State has conducted an assessment of the availability of mental health providers offering mental health services across the state, as required. The assessment is included in Appendix 2 of the application.
	Future Status The State intends to conduct and report the required assessments over the course of the demonstration.
	Summary of Actions Needed The State will complete and submit the assessment each year of the demonstration period in the annual demonstration monitoring plan.
3.b Financing plan	*Current Status:* See Topic 5 below.
	Future Status: See Topic 5 below.
	Summary of Actions Needed: See Topic 5 below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status*. Milestone not achieved.
	Future Status, DHCS will contract with a vendor to develop and implement a bed tracking service to provide real-time information on the availability of inpatient and crisis stabilization beds, in accordance with state and federal HIT standards and regulations, with implementation planned by July 2026. Initially, DHCS is developing the bed tracking service to focus on, at a minimum, acute psychiatric hospitals, general acute care hospitals with psychiatric units, psychiatric health facilities, provider sites certified to provide crisis stabilization by DHCS or a BHP, and psychiatric residential treatment facilities in the state. The service may be expanded in the future to include other behavioral health facility types. At minimum, the bed availability data generated by the service will be available to authorized users including BH facilities and specialty behavioral health delivery systems participating in the demonstration.

Prompts	Summary
	Summary of Actions Needed DHCS plans to work intensively with stakeholders to develop the final list of participating facility types and reportable data elements, and to identify those entities that may become authorized users within the bed tracking service. DHCS anticipates executing a contract with a vendor for the bed tracking service no later than January 1, 2025, launching the service by July 1, 2026, or within 18 months of the contract effective date. DHCS may adjust this timeline as needed based on the final contract. (Timeline: 18-24 months)
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status.* Milestone not achieved. For all children and youth who receive SMHS, including but not limited to those involved in child welfare, providers are required to use the Child and Adolescent Needs and Strengths (CANS) tool, a multi-purpose tool that supports decision-making, though a shared vision and uses youth and family information to inform service planning by identifying youth and family actionable needs and useful strengths, as well as to measure youth functioning." Pursuant to AB 403 and the Continuum of Care Reform (CCR), the California Department of Social Services (CDSS) selected the CANS as the functional assessment tool to be used with the Child and Family Team (CFT) process to guide case planning and placement decisions. DHCS also selected the CANS, as well as the Pediatric Symptom Checklist, to measure child and youth functioning.[10] Under BH-CONNECT, DHCS intends to develop and provide guidance on the use of an aligned CANS tool across the child welfare and specialty mental health systems, in order to: • Ensure both child welfare and behavioral health providers are using the same CANS tool with the same modules • Ensure the CANS tool is administered in the same way, whether done by a specialty mental health provider or by a child welfare worker, so that outcomes can be tracked over time; and • Support a cohesive approach to decision making and service planning across systems. DHCS and CDSS are currently working to align the CANS tool being used in county behavioral health and child welfare and expects to release joint-guidance in December 2024. Beginning in 2025, DHCS and CDSS will use an aligned version of the CANS across children and youth involved in both systems. For adults, there is no current requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay. However, the CalAIM initiative “Screening and Transition of Care Tools for Medi-Cal Mental Health Services” establishes a precedent for this milestone by implementing standardized screening requirements to ensure all Medi-Cal Members receive timely, coordinated services across Medi-Cal mental health

[10] All County Letter (ACL) No.18-85.

Prompts	Summary
	delivery systems.[11] These tools consist of: (1) the Adult Screening Tool for Medi-Cal Mental Health Services; (2) the Youth Screening Tool for Medi-Cal Mental Health Services; and (3) the Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth). The Screening Tools determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or BHP seeking mental health services. The Transition of Care Tool ensures that Members who are receiving mental health services from one delivery system receive timely and coordinated care when their existing services need to be transitioned to the other delivery system, or when services need to be added to their existing mental health treatment from the other delivery system. The results from the BHQIP program demonstrated that participating entities were successful with the implementation of standardizing screening and transition of care tools. In accordance with DHCS Behavioral Health Information Notice 21-074, entities were required to implement standardized, statewide Adult and Youth Screening and Transition of Care Tools to guide referrals of Adult and Youth beneficiaries to the appropriate Medi-Cal mental health delivery system and ensure that beneficiaries requiring transition between delivery systems receive timely coordinated care. Participating entities were required to submit policy and procedures, training plans, and screening and transition tool logs. Through BHQIP, DHCS reviewed and approved deliverables related to the implementation of screening and transition of care tools, resulting in more than 70% success with implementing policies and demonstration of tools. DHCS has also developed standardized, domain-based documentation requirements outlined in BHIN 23-068. Assessments for DMC and DMC-ODS members will continue to occur using the American Society of Addiction Medicine criteria. Assessments for SMHS members under the age of 21 must capture specified clinical data elements organized into seven assessment domains.
	Future Status Under BH-CONNECT, the State will require providers to use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay, and require BHPs to enforce these requirements for their network providers. For children and youth, providers will be required to continue using the CANS tool. For adults, the State will determine a set of allowable assessment tools that providers may use, informed by a variety of factors including but not limited to: • Review of national policy guidance, grey literature, and evidence-base including available systemic reviews and meta-analyses • Implementation-related factors such as the landscape of tools adopted across the State and related costs of adoption of proprietary tools

[11] The Screening and Transition of Care Tools for Medi-Cal Mental Health Services can be accessed at: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-MediCal-Mental-Health-Services.aspx.

Prompts	Summary
	• Stakeholder input As part of a BH-CONNECT BHIN, the State will fully and expressly capture the requirement to ensure providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay. The state will synthesize the information gathered to identify an approved set of evidence-based assessment tools for counties to utilize in meeting the BH-CONNECT requirement and, following stakeholder feedback, issue a BHIN to provide counties with the necessary guidance. DHCS will offer webinars and issue Frequently Asked Questions on acceptable tools as needed. BHPs will be required to identify the widely recognized, publicly available patient assessment tool (or tools) for adults that they have selected from the approved list in their Opt-In Implementation Plan and will require providers to use; county implementation plans must also describe how the BHP will oversee and enforce compliance with this and other demonstration requirements among its network providers. (CANS will continue to be used for children and youth under age 21.)
	Summary of Actions Needed The State will identify assessment tools that BHPs may use to determine the appropriate level of care and length of stay for adults (Timeline: 3-6 months). The State will then issue one or more BHINs for BHPs fully and expressly capturing this requirement, including solicitation of stakeholder input (Timeline: 3-6 months). On an ongoing basis, the State will provide technical assistance to BHPs on use of evidence-based assessment tools, including webinars and Frequently Asked Questions as needed (Timeline: Ongoing, as needed).
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* Milestone achieved. The State has been very active in developing initiatives to improve access to a full continuum of behavioral health care, including crisis stabilization. These include: • **988 Suicide and Crisis Lifeline**, to which DHCS is investing over $80 million from 2021-22 through 2025-26 to support California's network of 988 crisis centers to support the launch of the new national 988 hotline for people seeking help during a behavioral health crisis. The Miles Hall Lifeline and Suicide Prevention Act, enacted in 2022, established the California 988 State Suicide and Behavioral Health Crisis Services Fund, consisting of the revenue generated by the 988 surcharge assessed on users under Section 41020 of the Revenue and Taxation Code, providing ongoing support for 988 in California. • **Community-Based Mobile Crisis Intervention Services**, which was authorized as a Medi-Cal benefit under SPA 22-0043, effective Jan. 1, 2023. • **California Youth Behavioral Health Initiative** (CYBHI), which is a multi-faceted $4.4 billion investment to enhance, expand and redesign the systems that support behavioral health for children and youth, including through early intervention/prevention services, across four strategic areas:

Prompts	Summary
	○ Creating a larger, more representative workforce supporting the emotional, mental, and behavioral health of young people; ○ Developing infrastructure to support behavioral health to ensure there is no wrong door for help; ○ Creating coverage pathways to access behavioral health services, including by implementing dyadic care services as a newly covered benefit under Medi-Cal and creating a statewide multi-payer fee schedule for school-linked behavioral health services; and ○ Reducing stigma and raising awareness around emotional, mental, and behavioral health using culturally – and linguistically – appropriate campaigns. • **Behavioral Health Continuum Infrastructure Program** (BHCIP), which awards competitive grants ($2.2 billion in total) to qualified entities to construct, acquire and rehabilitate real estate assets, or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. • **Community Assistance, Recovery and Empowerment (CARE) Act,** which connects individuals struggling with untreated schizophrenia or other psychotic spectrum disorders to county behavioral health treatment services through a civil court process. These individuals can receive an array of services through voluntary engagement, an approved CARE agreement, or a court-ordered CARE plan, which may include clinically prescribed, individualized interventions with medication, a housing plan, and several supportive services, including Supplemental Security Income/State Supplementary Payment (SSI/SSP), Cash Assistance Program for Immigrants (CAPI), CalWORKs (a welfare program that gives cash aid and services to eligible California families in need), California Food Assistance Program, In-Home Supportive Services (a program that provides in-home assistance to eligible older, blind and disabled individuals as an alternative to out-of-home care), and CalFresh (known federally as SNAP). • **CalAIM Behavioral Health Payment Reform**, which will move counties away from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal members. • Expanding SUD services delivered by county **Drug Medi-Cal Organized Delivery System (DMC-ODS)** plans to include access to all levels of care along the continuum defined in The American Society of Addiction Medicine (ASAM) criteria. • **Recovery Incentives – California's Contingency Management Program**, which is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. • **Medication-Assisted Treatment (MAT) Expansion Program**, which increases access to MAT, reduces unmet treatment need, and reduces opioid overdose-related deaths through the provision of prevention, harm reduction, treatment, and recovery activities. The California MAT Expansion Project supports more than 30 projects across the state and has expanded access to MAT to 282 hospitals/emergency departments, 37 (out of 58) county jail systems, 12 Indian Health Programs, 650 MAT Access Points; and has distributed over 3 million units of naloxone resulting in more than 200,000 reported overdose reversals.

Prompts	Summary
	• Proposal of a $6.38 billion bond as part of **Assembly Bill 531** (Chapter 789, Statutes of 2023) to build new treatment beds and housing units for Californians living with the most acute behavioral health issues. In addition, BHPs are currently required to cover a **wide array of community-based mental health services**. These services include: • Mental health services • Day treatment intensive services • Day rehabilitation services • Medication support services • Crisis intervention services • Crisis stabilization services • Intensive care coordination (i.e., targeted case management for those under 21) • Intensive home-based services • Therapeutic behavioral services • Therapeutic foster care • Targeted case management including for individuals at risk of institutionalization or in jeopardy of negative health or psycho-social outcomes
	Future Status As part of the BH-CONNECT demonstration and through other complementary initiatives, the State is planning to further strengthen this continuum through the addition of new services and programs. These include: • **New community-based behavioral health services** for which the State will seek State Plan authority, including ACT, FACT, CSC for FEP, the IPS model of Supported Employment, Community Health Worker (CHW) services, and Clubhouse Services. • A **Workforce Initiative** as part of the demonstration that would include investments to support recruitment and retention of staff for community-based Medi-Cal behavioral health services providers, thereby expanding access to community-based behavioral health services. • Reforms proposed as part of **Assembly Bill 531** (Chapter 789, Statues of 2023) and **Senate Bill 326** (Chapter 790, Statutes of 2023) to provide additional resources to care for and house Californians living with the most severe mental health needs and SUDs, including through a bond to fund new treatment beds and supportive housing settings and updates to the Mental Health Services Act (MHSA) to expand resources for housing and workforce and increase accountability for community-based services for prevention and early intervention services.

Prompts	Summary
	Summary of Actions Needed None.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported education programs	*Current Status:* Milestone achieved. The State has implemented several statewide initiatives to identify and engage beneficiaries with or at risk of SMI or SED in treatment sooner. These include: • **CalAIM No Wrong Door Policy**, which allows members to receive mental health services regardless of the delivery system where they seek care (specialty behavioral health, MCP or the FFS delivery system). NWD policy includes clarification that reimbursement is available for assessments and covered, medically necessary outpatient treatment services before formal diagnosis. The No Wrong Door (NWD) policy applies in all counties throughout the state of California and applies to any Medi-Cal member who requires mental health services, and, as such, potentially offer better access to early intervention and treatment. • Updates to the **Specialty Mental Health Services and DMC/DMC-ODS Criteria** to access behavioral health services to improve members' access to services and reduce provider administrative burdens. As highlighted in CMS guidance, California covers non-specialty mental health services (NSMHS) such as evaluations and individual, group, and family psychotherapy to individuals with potential mental health disorders not yet diagnosed. NSMHS are provided through Medi-Cal Managed Care Plans and the fee-for-service delivery system. California also covers a range of specialty mental health services (SMHS), including but not limited to targeted case management, crisis services, residential services, and a variety of specialty outpatient mental health services. SMHS are provided through BHPs. For children and youth, medically necessary SMHS are available to beneficiaries with a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. In addition, for children and youth, medically necessary SMHS are available to beneficiaries who have a need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide, and a suspected mental health disorder that has not yet been diagnosed .

Prompts	Summary

	• **Complex Care Capacity Building**, which is a $43.3 million investment (authorized under Assembly Bill 153) in both county welfare agencies and probation departments to support counties with establishing a high-quality continuum of care designed to support foster children and nonminor dependents (NMDs) in the least restrictive setting, consistent with the child/NMD's permanency plan. Funding uses related to capacity building can include intensive child-specific recruitment, family finding and engagement, and support programs for children with complex needs. This may include, but is not limited to:
	  ○ Specialized permanency support services and activities associated with the Active Supportive Intervention Services for Transition programs.
	  ○ Specialized models of integrated care and support for family-based settings and community-based treatment models that create alternatives to out-of-home or residential placement.
	• **California Youth Behavioral Health Initiative (CYBHI)**, which is a multi-faceted $4 billion state investment to enhance, expand and redesign the systems that support behavioral health for children and youth, including through early intervention/prevention services. The CYBHI is comprised of over twenty (20) different strategies. Under CYHBI's Public Awareness strategic initiative, the "Never a Bother" Youth Suicide Prevention Media and Outreach Campaign offers a data-driven, multicultural, and multilingual approach to intervention. CYBHI includes behavioral health virtual services platforms for access to web- and app-based platforms aimed at parents and caregivers, young children, teens, and young adults. Media efforts are combined with five rounds of grants funding to youth-serving community-based organizations (CBOs) and tribal entities fostering evidence-based and community-focused suicide-prevention strategies. CYBHI's all-payer fee schedule for school-based services creates a more approachable billing model and reduces uncertainty around students' coverage, helping to ensure that youth who need behavioral health support can receive those services, including screening and assessment, in schools. Within the Multi-Tiered System Support (MTSS), students will have access to Certified Wellness Coaches, and educators will gain resources to learn about Adverse Childhood Experiences (ACEs) and leverage a toolkit to support healing. In partnership with the Office of the California Surgeon General, the ACEs Aware initiative has provided 2.3 million screenings across 56 counties, and 17,100 providers eligible for Medi-Cal payment have been trained to identify, screen and respond to ACEs. The dyadic services benefit addresses developmental and behavioral health conditions of children in a dyad with their caregiver.
	• **Student Behavioral Health Incentive Program (SBHIP)**, which supports partnerships between MCPs and schools to increase access to preventative services. SBHIP designated $389 million over three years for meeting predefined goals related to increasing prevention, early intervention, and behavioral health services by school-affiliated providers. This program aims to break down siloes and improve coordination as well as address health equity gaps. As of September 2024, all 58 counties are participating in partnership with 22 MCPs, 57 County Offices of Education (COEs). and approximately 3,789 Local Education Agencies (LEAs). There have been 147 targeted interventions implemented and 1.4 million school aged youth impacted. 48% of those interventions represent new behavioral health services not previously provided by counties.

Prompts	Summary

	• **Enhanced Care Management (ECM),** a statewide Medi-Cal benefit available to select populations of focus addresses clinical and nonclinical needs of the highest-need enrollees through intensive coordination of health and health-related services.
	  ○ Since its launch on January 1, 2022, 183,700 Medi-Cal MCP members received ECM as of December 31, 2023. In the last twelve months of the reporting period, 62,395 members with SMI/SED and/or living with SUD received ECM.
	• **Community Assistance, Recovery and Empowerment (CARE) Act,** which connects individuals struggling with untreated mental illness with a CARE agreement or a court-ordered CARE plan for up to 24 months, which can include clinically prescribed, individualized interventions with several supportive services, medication, and a housing plan. To be eligible, individuals must be in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others.
	  ○ The CARE Act is being implemented in two phases. The counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne, and the City and County of San Francisco (Cohort I) implemented the CARE Act on October 1, 2023. Los Angeles implemented on December 1, 2023, and all other counties (Cohort II) are required to implement the CARE Act by December 1, 2024.
	• **CalAIM Justice-Involved Initiative,** which will allow the state to offer a targeted set of Medicaid services to youth and eligible adults in state prisons, county jails, and youth correctional facilities and help them access key services upon their return to community. Correctional facilities will begin to go-live with pre-release services on October 1, 2024. Specialty behavioral health delivery systems and MCPs must coordinate with correctional facilities to support reentry for members as they transition from incarceration into the community and managed care. This will help to ensure continuity of health care coverage after incarceration, enabling access to programs and services like Enhanced Care Management (ECM) and Community Supports, warm linkages to medical and mental health services, and prescription medications in hand upon release.
	  ○ The State is implementing a phased approach for the state prison system and county correctional facilities to go live in several readiness-based cohorts on a quarterly basis over a two-year phase-in period. All county behavioral health agencies will be required to go-live with behavioral health links by October 1, 2024
	  ○ An estimated 400,000 individuals are released from correctional facilities in the state each year. Of these, an estimated 80-90 percent are eligible for Medi-Cal. An estimated 37% of individuals in prisons are living with SMI/SED and 58% with SUD.[12]
	• **Peer Support Services**, a Medi-Cal benefit available at county option to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery. Research speaks to the efficacy of peers in engaging

[12] SAMSA (2017)

Prompts	Summary
	beneficiaries in treatment sooner, with one study finding an average reduction of over 43% in inpatient services and a 30% increase in outpatient treatment visits for those who received peer-support services.[13] ○ As of June 2024, 51 counties (covering 99% of Medi-Cal members) include Medi-Cal Peer Support Services as a benefit in one or both of their delivery systems. • **Dyadic Services**, a preventive Medi-Cal benefit to serve both parent(s) or caregiver(s) and child together, targeting family well-being as a mechanism to support healthy child development and mental health. • **Community Health Worker (CHW) Services**, a preventive Medi-Cal benefit to address the control and prevention of chronic conditions or infectious diseases; mental health conditions and substance use disorders; need for preventive services; perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and violence prevention. A growing body of evidence demonstrates the effectiveness of CHWs as part of care teams and their importance to the continuum of behavioral health services, including suicide prevention.[14] ○ The State has invested in a multipronged effort to develop and train CHWs, with the goal of adding 25,000 new CHWs to the care economy workforce by 2025. ○ The Medi-Cal CHW benefit launched in FFS and managed care delivery systems in July 2022, and as part of BH-CONNECT, Enhanced CHW services will be made available under the SMHS and DMC/DMC-ODS delivery systems at county option (see Future State). • **Full Service Partnership** programs, which provide wraparound or "whatever it takes" services to members who are unserved or underserved and who may be homeless or at risk of homelessness. These programs are funded with state dollars and available in all counties throughout California. ○ Over 60,000 individuals are enrolled in an FSP program across the state.
	Future Status As part of the demonstration, the State is seeking to cover **additional community-based services** at county option that will help identify and engage beneficiaries at risk of SMI or SED in treatment sooner in participating counties, including: • **ACT**, which leverages an assertive, team-based outreach approach to engage members with significant behavioral health needs in treatment and coordinate care. • **FACT**, which builds upon the ACT model to address criminogenic risk and needs as part of the treatment plan, including the use of evidence based cognitive behavioral therapies shown to reduce recidivism. • **CSC for FEP**, which is designed to engage members in treatment as soon as they experience an initial psychotic episode and support ongoing recovery.

[13] NAMI, "The Case For Expanding Peer Support" (April 2023).
[14] Commonwealth Fund, "Medicare Reforms Support Behavioral Health by Expanding Access to Peer Support Specialists and Community Health Workers" (February 2024).

Prompts	Summary
	○ More than half of counties in the State currently offer CSC for FEP programs funded in part through SAMHSA block grants and with training and technical assistance offered through UC Davis. The SPA will cover CSC for FEP as a new bundled Medi-Cal service at county option. • **Enhanced CHW Services**, which utilize a preventative approach that can includes control and prevention of chronic conditions, mental health conditions and substance use disorders through health education and navigation, screening and assessment, and individual support or advocacy. CHW services are available through both FFS and managed care delivery but will be expanded at county option within the SMHS and DMC/DMC-ODS delivery systems to offer CHW services tailored for individuals with behavioral health conditions. • **Clubhouse Services**, which offer ongoing social supports to enhance mental and physical health by reducing disconnectedness, reducing risk of social isolation and need for inpatient care. • **Supported Employment,** an evidence-based Individual Placement and Support (IPS) model of supported employment for Medicaid members living with significant behavioral health needs.
	Summary of Actions Needed Pending CMS approval of the BH-CONNECT demonstration and associated State Plan Amendments(s), services described above will be available at county option effective January 1, 2025. Counties that opt to receive IMD funding will be required to implement a full suite of BH-CONNECT community-based services (with the exception of Clubhouse Services) during the demonstration period on a rolling basis as follows: • Upon IMD Opt-In County go-live: Begin providing Enhanced CHW Services; • Within One Year of Demonstration go-live: Fully Implementing ACT; • Within Two Years of Demonstration go-live: Begin providing FACT and CSC for FEP; and • Within Three Years of Demonstration go-live: Begin providing IPS Supported Employment.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* Milestone achieved. Specialty mental health services can be provided in an array of community-based, non-specialty settings, including the home, when appropriate. The State has also implemented several initiatives to increase integration of behavioral health care in non-specialty care settings to improve early identification of SMI/SED and linkages to treatment, many connected to the **Children and Youth Behavioral Health Initiative (CYBHI)**. Key CYBHI initiatives include: • **Student Behavioral Health Incentive Program (SBHIP)**, which supports partnerships between Medi-Cal managed care plans and schools to increase access to preventative behavioral health services. • **Behavioral Health Integration Incentives (BHI) Program**, which aims to incentivize improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in an MCP network.

Prompts	Summary
	• A statewide **e-consult platform** launched in 2024 to offer provider access to remote and real-time consultation support with behavioral health professionals. • **The Behavioral Health Virtual Services Platform**, a new technology-enabled services solution for all children, youth, and families in California, supports the delivery of equitable, appropriate, and timely behavioral health services from prevention to treatment to recovery, provides support and resources, such as interactive digital education, self-monitoring tools, application-based games, and mindfulness exercises, and offers access to free, on-demand one-on-one coaching and counseling supports. The State's Mental Health Services Oversight & Accountability Commission released a draft statewide strategic plan on Early Psychosis Intervention (EPI) emphasizing measurable and specific goals that include elements such as increasing access to timely, affordable, high-quality EPI care and reduced time to treatment. DHCS has also implemented **Dyadic Services**, a preventive Medi-Cal benefit to serve both parent(s) or caregiver(s) and child together, targeting family well-being as a mechanism to support healthy child development and mental health.
	Future Status The State will continue to implement the initiatives described above. As part of the BH-CONNECT demonstration, the State is also seeking expenditure authority for a **Workforce Initiative** that would drive investments in peer training and supports aimed at children and youth; strengthen the pipeline of behavioral health professionals; and establish loan repayment programs for behavioral health professionals.
	Summary of Actions Needed Pending CMS approval, the state intends to implement the Workforce Initiative mid-2025.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status.* Milestone achieved. California has several specialized settings and services, include crisis stabilization, for young people living with SMI/SED. These include intensive treatment settings including Short-Term Residential Treatment Programs, Children's Crisis Residential Programs, and Community Treatment Facilities. The State has also implemented several initiatives to ensure specialized settings and services, including crisis stabilization, are available to children and youth. These include: • **Community-Based Mobile Crisis Intervention Services**, authorized as a Medi-Cal benefit under SPA 22-0043, effective Jan. 1, 2023, which is available to children and youth. As part of required training for mobile crisis teams,

Prompts	Summary
	mobile crisis teams must participate in training on strategies to work effectively with children, youth and young adults experiencing behavioral health crises. Training may include, but is not limited to, delivering culturally responsive care, particularly when working with children, youth and young adults who are LGBTQ+, Black, Indigenous, and People of Color, involved in the child welfare system, or living with I/DD. Required training must also include an overview of existing minor consent obligations and appropriate protocols for communicating with parents, guardians and other responsible adults who may or may not be present at the time of the crisis. • School-linked partnership and capacity grants available through the **Children and Youth Behavioral Health Initiative (CYBHI).** The program provides resources to county offices of education, local education agencies and institutions for higher education to support institutional readiness and promote utilization of the statewide multi-payer school-linked fee schedule. The activities include expanding provider capacity, developing critical partnerships and building necessary infrastructure. DHCS intends to award $550 million in one-time grants under this program, with approximately $400 million allocated to public K-12 schools and the remaining dollars leveraged by institutions of higher education. • **Family Urgent Response System (FURS)**, a coordinated statewide, regional, and county-level system designed to provide collaborative and timely response during situations of instability for current and former foster youth and their caregivers. • **Behavioral Health Continuum Infrastructure Program** (BHCIP), which awards competitive grants ($2.2 billion in total) to qualified entities to construct, acquire and rehabilitate real estate assets, or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources.
	Future Status DHCS will continue to fund and oversee the specialized settings and initiatives described above. It is on track to submit a State Plan Amendment to **cover CSC for FEP** in the 4th quarter of 2024. The State is also establishing **psychiatric residential treatment facilities (PRTFs)** as a new category of residential health facilities licensed by the State to treat individuals under 21. DHCS will utilize interim PRTF licensing regulations adopted by the state in February of 2024 to establish final regulations, which are expected to be published no later than December 2027.
	Summary of Actions Needed Pending CMS approval of the BH-CONNECT demonstration and associated State Plan Amendments(s), services will be available at county option effective January 1, 2025. Counties that opt to receive IMD funding will be required to implement CSC within two years of demonstration go-live. Utilizing its existing interim regulations, DHCS will issue final regulations for PRTFs no later than December 2027.

Prompts	Summary
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status.* Milestone achieved. See initiatives described in 4a. and 4b. above, and in particular those included in: • **Student Behavioral Health Incentive Program (SBHIP)**, which supports partnerships between Medi-Cal managed care plans and schools to increase access to preventative services. • Various initiatives included in the **Children's Youth Behavioral Health Initiative (CYBHI),** including efforts to expand awareness of Adverse Childhood Experiences (ACEs) and toxic stress; increase screening of and outreach to youth with mental health needs; a youth suicide reporting and crisis response pilot; a youth peer-to-peer support program; mindfulness and well-being grants; and a virtual services platform to provide resources to children and youth and support the delivery of equitable, appropriate and timely behavioral health services. • Requirement for each county to develop and implement a Memorandum of Understanding outlining the roles and responsibilities of local entities that serve children and youth in foster care to establish a more comprehensive **Children and Youth System of Care.** • **Access to Specialty Mental Health Services** for beneficiaries under 21 who meet certain eligibility requirements, without a requirement of a diagnosed mental health disorder. The SMHS access criteria for children and youth are different than for adults. DHCS strives to identify children with significant issues before they turn into a formal diagnosed condition. For example, Medi-Cal members under age 21 qualify for SMHS assessments and services if they are at high risk for a mental health disorder due to the experience of trauma (including being child-welfare involved, juvenile-justice involved, or experiencing homelessness), or if they have a need for specialty mental health services, prior to a formal diagnosis being established. The July 2024 release of ACL 24-35 requires that child welfare and juvenile probation submit referrals for connection to SMHS within three business days of opening a case. • **Coordinated Specialty Care for First Episode Psychosis,** based on an evidence-based early intervention service model for individuals experiencing a first episode of psychosis (FEP) that can improve their quality of life and social and clinical outcomes. More than half of counties in the State offer CSC for FEP programs funded in part through SAMHSA block grants, with training and technical assistance offered through UC Davis. ○ The State also plans to submit a State Plan Amendment to cover CSC for FEP as a bundled Medi-Cal service at county option.
	Future Status Continue to implement the initiatives described above. In addition, the State plans to implement a **joint initial child welfare and specialty mental health assessment** at the entry point into child welfare.
	Summary of Actions Needed

Prompts	Summary
	Effectuation of the joint initial child welfare and specialty mental health assessment (for which DHCS is not requesting any waiver or expenditure authority) is under evaluation by DHCS with a target of 2025. DHCS will utilize BHINs to put forth the requirements, offering webinars to ensure clarity of guidance and compiling frequently asked questions as needed.
SMI/SED. Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non- hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status.* Milestone achieved. The State has expanded access to non-hospital, non-residential crisis stabilization services using a coordinated community response including through: • **BHCIP Round 1**: (Crisis Care Mobile Units) awarded more than $205 million to 47 grantees, including 403 mobile crisis teams and 159 vehicles purchased in order to produce or improve mobile crisis response teams in the state of California. As of July 15, 2024, 25,142 total CCMU dispatches with CCMU services were provided. Other services include clinical assessments by mental health professionals, triage/screening on-site, crisis and safety planning, de-escalation, conflict resolution, referral to outpatient behavioral health services, welfare checks, support for family and friends, peer support services, referral to medical services, and transportation. • **BHCIP Round 5**: Crisis and Behavioral Health Continuum, $430 million awarded to 33 grantees. These grants will support behavioral health facilities to expand capacity to serve a projected 73,848 individuals served on an annual basis in new or expanded outpatient settings. Round 5 focused on the construction and expansion of crisis and behavioral health facilities across the state, including the addition of seven Behavioral Health/Mental Health Urgent Care walk-in centers with voluntary stabilization-oriented services specific to individuals experiencing behavioral health and/or mental health crisis for less than 24 hours. • Medi-Cal coverage of **Community-Based Mobile Crisis Intervention Services**, a community-based intervention to provide de-escalation and relief to individuals experiencing a mental health or substance use-related crisis that must be provided statewide by all specialty behavioral health delivery systems. As of September 2024, all counties have submitted implementation plan to begin delivering mobile crisis services under Medi-Cal. 45 counties have received final approval and are actively delivering services compliant with DHCS guidance; these counties cover more than 97% of the state's Medi-Cal population., ○ BHIN 23-025 includes detailed requirements for county behavioral health delivery systems to ensure that mobile crisis services available under Medi-Cal are aligned with federal guidance and national best practices. County behavioral health delivery systems are required to coordinate with the 988 Suicide and Crisis Lifeline,

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	local law enforcement and 911 systems, the Family Urgent Response System (FURS), and community partners to ensure beneficiaries have information about mobile crisis services. County behavioral health delivery systems must also coordinate with law enforcement to determine how mobile crisis teams and law enforcement can best work together to safely resolve and de-escalate behavioral health crises, minimizing the role of law enforcement except when necessary and appropriate for safety reasons. • **FURS** is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth. • The **Community Paramedicine or Triage to Alternate Destination Act**, which offers an opportunity for counties to further develop alternative transportation options that would allow an individual in crisis to be transported from the community to a variety of health facilities using the least restrictive methods possible. Currently approved Triage to Alternate Destination Programs are located in Fresno County, Los Angeles County, San Francisco County, and Stanislaus County. AB 767 extended the Community Paramedicine or Triage to Alternate Destination Act until January 1, 2031, and expanded the allowable community paramedicine services program specialties to include provision of short-term, post-discharge follow-up, including collaboration with, and by providing referral to, home health services when eligible. • The **988 Suicide and Crisis Lifeline**, in which DHCS has invested over $130 million of combined federal grant and state funding from State Fiscal Years 2021-22 through 2025-26, supports California's network of 988 crisis centers to support the launch of the national 988 hotline for people seeking help during a behavioral health crisis. The Miles Hall Lifeline and Suicide Prevention Act, enacted in 2022, established the California 988 State Suicide and Behavioral Health Crisis Services Fund, consisting of the revenue generated by the 988 surcharge assessed on users under Section 41020 of the Revenue and Taxation Code, providing ongoing support for 988 in California. Commercial health plans are also required to cover behavioral health crisis services that are provided to member by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in-network or out-of-network provider or facility.
	Future Status • As described above, the State is working closely with county behavioral health delivery systems to implement **Community-Based Mobile Crisis Intervention Services as a required Medi-Cal service**. The State is facilitating comprehensive training and technical assistance to mobile crisis services providers and county behavioral health delivery systems to train and support new mobile crisis teams to ensure services are available 24/7/365 across the state. The BHCIP Round 1 2024 Launch Ready Request for Application is open until December 13, 2024. This round of grant funding makes $3.3 billion available for eligible applicant types including Behavioral Health Urgent Care/Mental Health Urgent Care, Community Wellness/Prevention Center and Crisis Stabilization Unit. The

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	remaining thirteen counties are working towards approval of their implementation plans. These counties remain subject to DHCS corrective action, including corrective action plans and sanctions, until they implement the Medi-Cal benefit in a compliant manner. They are also required to deliver mobile crisis services to the extent possible while they work to come into full compliance; all are able to deliver mobile crisis response in at least some regions of the county and/or during some time periods (though they may not yet be able to provide 24/7 mobile response countywide). Over the course of the BH-CONNECT demonstration, the State will continue to expand access to existing crisis services that may be delivered in non-hospital, non-residential settings, including mental health crisis stabilization and intervention and SUD crisis intervention. As part of the **Access, Reform and Outcomes Incentive Program**, county behavioral health delivery systems will be eligible to earn incentive payments for increasing their capacity to deliver crisis services. In addition, the State plans to submit a State Plan Amendment to cover **ACT** and **CSC for FEP** as bundled Medi-Cal services; both evidence-based practices include crisis support for members with SMI/SED as part of the comprehensive treatment model. More than half of counties in the State offer CSC for FEP programs funded in part through SAMHSA block grants training and technical assistance offered through University of California, Davis.
	Summary of Actions Needed DHCS will partner with counties to approve outstanding mobile crisis implementation plans and determine community-responsive methods for bolstering crisis response. Depending on the size and population density of counties the interventions will vary. DHCS expects counties to continue to build mobile crisis capacity over time. BHCIP Rounds 1, 2, and 5, support continued expansion of facility-based services, including but not limited to crisis services. For BHCIP funded projects awarded in Rounds 3 through 5, communities can anticipate an expansion of new behavioral health facilities by 2027. By the end of 2024, 21 projects are anticipated to complete construction and more BHCIP funded projects will be underway to leverage gaps in the behavioral health care continuum. Through the BHCIP program and Behavioral Health Transformation Bond funding (see milestone 2b), the State is continuing to invest in behavioral health facility infrastructure expansion to an unprecedented degree. DHCS will implement over $4 billion in grant funding to expand behavioral health facility capacity, including the implementation of the Bond BHCIP Round 1: Launch Ready RFA which commits $3.3 billion to expand community-based behavioral health treatment infrastructure based on local needs, including Behavioral Health Urgent Care, Mental Health Urgent Care, Crisis Stabilization Units, and Community Wellness/Prevention Centers (for Tribal entities).

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	The state will continue to expand its 988 program to ensure more robust coordination with local mobile crisis dispatch to support connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner, by promoting collaboration and coordination of state, county and regional behavioral health and cross sector partners to connect individuals in behavioral health crises to immediate and ongoing care, and developing a process and/or structure to support connection and coordination with mobile crisis services. The Access, Reform and Outcomes Incentive Program will launch in 2025. ACT and CSC for FEP will be available for county option in January 2025 per guidance to be released in the BH-CONNECT BHIN and subsequent implementation guidance.
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status.* Milestone achieved. **BHCIP Rounds 2-5** awarded competitive grants to qualified entities to expand the continuum of behavioral health treatment resources including by increasing capacity for community and outpatient behavioral health services, and other clinically enriched longer-term treatment and rehabilitation opportunities for individuals with behavioral health disorders, in the least restrictive and least costly setting. • **Round 2** (County and Tribal Planning Grants) awarded $16 million to 18 tribal entities and 30 county behavioral health agencies. • **Round 3** (Launch Ready) awarded $518.5 million to 45 grantees. These grants will support behavioral health facilities to expand capacity to serve a projected 130,321 individuals on an annual basis in new or expanded outpatient settings. Round 3 was determined, in part, through a statewide needs assessment that identified significant gaps in available crisis services. • **Round 4** (Children and Youth) awarded $480.5 million awarded to 52 grantees. These grants will support behavioral health facilities to expand capacity to serve a projected 76,977 individuals on an annual basis in new or expanded outpatient settings. See also Section 4.a. for a description of the State's efforts to increase the availability of community-based services and services in integrated settings.
	Future Status As described in milestone 4a, the State intends to submit a State Plan Amendment to cover an enhanced set of community-defined services and evidence-based practices under Medi-Cal. Beginning in 2025, opt in counties will begin implementing ACT, CSC, etc., with the intent of serving all members eligible for the service, including **ACT, FACT, CSC for FEP, CHW Services, and Clubhouse Services**. To ensure these services are widely available for Medi-Cal members for whom they

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	are medically appropriate, the State is developing bundled payment rates for new services that cover the full cost of delivering the team-based models. In addition, as part of the BH-CONNECT demonstration the State has proposed to establish the **Access, Reform, and Outcomes Incentive Program** to incentivize BHPs and DMC-ODS counties to improve performance on timely access to outpatient services and increased utilization of community-based evidence-based practices with a focus on members living with SMI/SED and/or SUD who are otherwise at risk of hospitalization or other significant adverse health outcomes. In addition, the State intends to clarify that Intensive Outpatient or Partial Hospitalization programs that meet the Medi-Cal requirements for the current State Plan service Day Treatment Intensive, may be Medi-Cal certified to provide Medi-Cal reimbursable Day Treatment Intensive Services (and existing State Plan benefit) for Medi-Cal members. This will allow a provider to offer a single program that simultaneously meets the requirements of Intensive Outpatient or Partial Hospitalization for the purposes of commercial insurance and Day Treatment Intensive for the purposes of Medi-Cal. This clarification is designed to increase access to these service types for Medi-Cal members. Bond BHCIP grant funding, totaling $4.4 billion, will be released in state fiscal years 2024-25 (round 1) and 2025-26 (round 2). Bond BHCIP Round 1 (Launch Ready) Request for Applications was released on July 17, 2024 with applications due December 13, 2024. Anticipated award announcements in May 2025 awarding up to $3.3 billion statewide. Bond BHCIP Round 2: Unmet Needs RFA is expected to be released in mid-May 2025 for up to $1.1 billion in funding. Bond BHCIP is estimated to fund 26,700 outpatient treatment slots for behavioral health and will build on other major behavioral health initiatives in California. **Under Proposition 1, AB 531** includes a $6.38 billion bond to build new treatment facilities, community infrastructure and supportive housing for individuals living with significant behavioral health needs, including: • The recent release of $3.3 billion in competitive grant funding to expand the behavioral health continuum and provide appropriate care to individuals experiencing mental health conditions and substance use disorder; • A second round of up to $1.1 billion in grant funding for additional behavioral health treatment site infrastructure; and • Up to $2 billion to build permanent supportive housing for veterans and others that are homeless or at risk of homelessness and have mental health or substance use challenge
	Summary of Actions Needed Pending CMS approval of the BH-CONNECT demonstration and associated State Plan Amendments(s), services described above will be available at county option effective January 1, 2025. Counties that opt to receive IMD funding will be required to implement a full suite of BH-CONNECT community-based services (with the exception of Clubhouse Services) during the demonstration period.

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SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[15] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.	*Current Status.* Partially achieved. California has sufficient health IT and data exchange governance, policy, technical, and operational infrastructure at every level to support the goals of the BH-CONNECT demonstration. Examples of this statewide infrastructure are below: • **California Data Exchange Framework (DxF)**: At the state level, California's data exchange efforts are guided by the California Data Exchange Framework (DxF). In accordance with California Health and Safety Code § 130290, the California Health and Human Services Agency (CalHHS) launched the DxF initiative with a vision that "every Californian, and the health and human service providers and organizations that care for them, will have timely and secure access to usable electronic information that is needed to address their health and social needs and enable the effective and equitable delivery of services to improve their lives and wellbeing." On July 5, 2022, CalHHS released the DxF, a Data Sharing Agreement (DSA), and an initial set of DxF Policies and Procedures. California Health and Safety Code § 130290 requires that on or before January 31, 2023, the DxF DSA shall be executed by providers and hospitals that include "physician organizations and medical groups" and "acute psychiatric hospitals." Beginning January 31, 2024, DSA signatories must exchange health information or provide health information to and from other signatories. California Health and Safety Code § 130290 stipulates that physician practices with fewer than 25 physicians, acute psychiatric hospitals, and state-run acute psychiatric hospitals are not required to exchange data in conformance with the DxF until January 31, 2026. As of November 1, 2023, more than 2,000 organizations had signed the DxF DSA. • **Health Information Exchanges (HIEs)**: With respect to California's data exchange technical infrastructure, nine health information exchanges (HIEs) and two community information exchanges (CIEs) were operational as of June

[15] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

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	2023. Based on a 2019 survey, the nine HIEs included data exchange with behavioral health providers, and two of the HIEs were identified as providing functions specific to priority domains and are described below.[16] A range of incentives and funding opportunities have been made available to support behavioral health providers' access to HIEs. In 2023, one HIE launched analytic dashboards to support California's behavioral health providers in meeting the requirements of the state's Behavioral Health Quality Improvement Program (BHQIP). The dashboards allow provider organizations to view, analyze, and enhance the management of patient populations. DHCS's Incentive Payment Program (IPP) provides incentives for Managed Care Plans (MCPs) to support HIE across their entire network, including with behavioral health providers. DHCS's Providing Access and Transforming Health (PATH) program has health IT-related grant funding for community and county-based providers, including behavioral health providers. CalHHS's Center for Data Insights and Innovation (CDII) has a grant program that supports onboarding to qualified Health Information Organizations (HIOs) and is open to behavioral health providers and counties. **EHR Adoption:** At the county level, electronic health records (EHRs) have become an integral part of ensuring the highest quality of care for members receiving behavioral healthcare. Most BHPs implemented newer EHRs with California's Mental Health Service Act technology funds that became available between 2008 and 2013. Statewide, 24 out of 56 BHPs (43 percent) maintain member health records fully electronically, one BHP had not yet implemented an EHR system as of July 2021, and the rest maintain a combination of both electronic and paper records.[17] However, many EHR systems fall short of being fully interoperable and supporting behavioral health business needs. As such, the California Mental Health Services Authority (CalMHSA) leveraged its Joint Powers Authority to bring counties together to procure and implement a new semi-statewide EHR system specifically tailored to the needs of behavioral health entities and providers. • CalMHSA released a request for proposals on September 20, 2021, and selected Streamline Healthcare Solutions' SmartCare EHR. In July 2023, CalMHSA launched the initial phase of the semi-statewide EHR program which covered over 37 percent of the state's Medi-Cal population, and CalMHSA will expand the program to additional counties in 2024.[18] • CalMHSA has customized the EHR to meet the needs of the public behavioral health system in several ways. In California, the BHPs function as both a managed care plan, and, depending on the county, can also operate as a provider of services, and the EHR supports both roles. The EHR supports plan-level functions related to provider network management (service rates, claims adjudication, etc.) and to benefit management (service authorizations, utilization management, etc.) as well as supporting reporting of population level indicators and outcomes. CalMHSA has customized the EHR to allow for, with appropriate client consent, the integration of substance use and mental health treatment information, which empowers providers to provide integrated comprehensive care. The converse is

[16] Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator's national survey of HIOs included in DHCS's California State Medi-Cal Health Information Technology Plan. Published online March 2022. [17] Behavioral Health Concepts, Inc. FY 2021-2022 Statewide Technical Report: Medi-Cal Specialty Mental Health. Published online April 26, 2023.
[18] CalMHSA Semi-Statewide EHR website. Accessed August 9, 2023.

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	also true, with data from mental health and substance use treatment providers being segmented from each other if client consent to share information is not given. Additionally, this data segmentation ensures that the EHR data is configured for data exchange opportunities. The CalMHSA continues to customize the EHR to support the unique workflows, provider types and settings in which behavioral health practitioners operate, including inpatient, residential, and psychiatric inpatient settings. • The participants in CalMHSA's semi-statewide EHR program currently leverage CalMHSA Connex to achieve robust interoperability standards. CalMHSA Connex is a specialized Health Information Exchange (HIE) which enables comprehensive regulatory interoperability compliance to multiple current requirements, including the California Data Exchange Framework (DxF) and the Centers for Medicare & Medicaid Services (CMS) Interoperability mandates. The behavioral health-focused HIE meets DxF requirements through its integration with the Care Quality framework, ensuring seamless data exchange across various healthcare systems and a variety of EHR systems. At the organizational level, hospitals and ambulatory care providers have varying rates of EHR adoption and HIE integration. ○ Hospital adoption of EHRs in California is high. As of 2019, 83.2 percent of hospitals had adopted either a basic or a comprehensive EHR. The most common EHR vendors used by California hospitals are Cerner, Epic and Meditech.[19] Specific hospital IT functionalities related to Section 1115 demonstration capabilities are described below. Adoption of EHRs in the behavioral health ambulatory care market has been dominated by three legacy vendors (Cerner, NetSmart, and Echo). The recent increase in EHR implementation is marked by the entry of several new vendors that offer updated products that promise to enhance BHP capabilities to meet recently released DHCS requirements and more seamlessly care for Medi-Cal members. In addition to the examples of statewide infrastructure listed above, DHCS has several ongoing initiatives that support BH-CONNECT's goals. The BH-CONNECT demonstration is integral to California's broader efforts to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. Building upon Center for Medicare and Medicaid Services' (CMS') approval of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration in December 2021, the BH-CONNECT demonstration will directly address the need to continue expanding and strengthening the continuum of care for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED) through targeted incentive programs and contractual requirements. • **DHCS' Contractual Requirements for BHPs**: DHCS' Memoranda of Understanding (MOU) between MCPs and BHPs require all parties to share information necessary to facilitate referrals across sectors and coordinate care. They must have policies and procedures for: timely exchange of member information, including behavioral health and

[19] Adler-Milstein J. California Health IT Landscape Assessment (2022).

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	physical health data; maintaining the confidentiality of exchanged information and data; supporting bidirectional monitoring of data exchange processes; and obtaining member consent. The data elements to be shared must be agreed upon jointly by the parties, reviewed annually, and set forth in the MOU. They must share, at a minimum, member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the member's health and/or welfare. Starting in January 2024, MCPs are required to enter into MOUs with various programs and services, including BHPs to facilitate care coordination and information exchange. The state intends to leverage the standards under the CMS Interoperability Rules to ensure that health information can be exchanged seamlessly. These standards are required for Medi-Cal contracted plans and are being adopted by the California Data Exchange Framework. • **Behavioral Health Related Incentives**: The BHQIP is a statewide incentive program that supports BHPs and Drug Medi-Cal State Plans (DMC) as they prepare for and implement changes under CalAIM and other administration priorities. These entities can earn incentive payments by completing deliverables tied to milestones. The incentive funds may be used to assist counties in pursuing CalAIM requirements, which may include staffing, technology, infrastructure, or training costs. Relevant to health IT, the BHQIP is currently incentivizing bi-directional data exchange between BHPs, DMCs, and MCPs with the goal of enhancing care coordination efforts. To receive incentive payments, entities must either demonstrate direct sharing of data with MCPs or demonstrate onboarding to a HIE. BHQIP has three domains, one of which focuses on data-sharing agreements among MCPs and BHPs. Additionally, the BHQIP incentivizes the implementation of standardized screening tools, assessment tools, and documentation. The movement towards standardized tools and documentation standards throughout California will allow for greater interoperability of behavioral health data. While BHQIP is set to conclude in March 2024,[20] BH-CONNECT will continue to build on the BHQIP and incentivize BHPs' infrastructure for quality measurement and reporting. • **Children and Youth Behavioral Health Initiative**: As part of California's Children and Youth Behavioral Health Initiative (CYBHI), in January 2024 DHCS will launch a statewide e-Consult solution that will enable primary care physicians (PCPs), pediatricians and other health care providers to consult with licensed behavioral health professionals (including child and adolescent psychiatrists) via a technology-enabled service platform. This statewide platform will better equip PCPs with the knowledge, skills, and abilities to appropriately provide treatment to members living with behavioral health needs. Also in January 2024, DHCS launched two virtual services platforms to provide members with one-on-one coaching, educational resources, peer communities and more. One platform will serve children ages 0-12 and their parents/caregivers. The other platform will provide services to youth and young adults

[20] State of California Department of Health Care Services. CalAIM Behavioral Health Quality Improvement Program. Published online September 21, 2022. https://www.dhcs.ca.gov/bhqip

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	ages 13-25. The CYBHI is a payer agnostic and not specific to the Medi-Cal program; however, Medi-Cal members will have access to and be able to benefit from these programs.
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	*Current Status.* Partially achieved. California's Substance Use Disorder (SUD) Health IT Plan is aligned with California's broader State Medicaid Health Information Technology Plan (SMHP). In March 2022, DHCS released the final SMHP which required DHCS to assess the impacts of the Medicaid Promoting Interoperability Program (titled the Medi-Cal Promoting Interoperability Program in California). DHCS formulated six future goals based on its HIT landscape assessment. Those goals were to: **1. Establish the CalHHS DxF, which creates:** • Standards for statewide data exchange. • A functional HIE network throughout the state. **2. Meet key business needs supported by the CalHHS DxF that:** • Meet the needs for whole person care and CalAIM. • Improve access to bidirectional exchange with public health registries. • Increase utilization of HIEs by emergency services. • Establish a statewide registry for advanced directives. **3. Implement the CMS Interoperability and Patient Access Rule to increase member access to health care data through payer, formulary, and patient access application programming interfaces (APIs).** **4. Identify funding for existing gaps in the HIT/HIE landscape as recommended by the CalHHS DxF Advisory Group, including:** • Financial stability for the state's HIEs. • Increased EHR adoption by professionals who have been ineligible for the Medi-Cal Promoting Interoperability Program with associated technical assistance on EHR and HIE use to address gaps. • Increased EHR adoption by hospitals and other facilities that have been ineligible for the Medi-Cal Promoting Interoperability Program with associated technical assistance on EHR and HIE use to address gaps. **5. Establish universal broadband access throughout California as supported by the California Broadband Council under the Broadband for All Action Plan, which in turn supports:** • Continued increased use of telehealth throughout California after the end of the COVID-19 public health emergency.

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	6. Improve availability to equipment and technical assistance for low-income Californians to bridge the digital divide, access their health information, and benefit from the Interoperability and Patient Access Final Rule. On May 22, 2023, CMS approved California's SUD Monitoring Protocol, which included "Attachment E: SUD Health IT Plan."
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	*Current Status.* Partially achieved. DHCS intends to assess and consider the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B and implement them as appropriate. • **DHCS Initiatives**: As per Behavioral Health Information Notice 22-068, BHPs must comply with the CMS Interoperability and Patient Access Final Rule, including implementing and maintaining standards-based Application Programming Interfaces (APIs) and a publicly accessible Provider Directory API. BHPs are to comply with 42 CFR 438.242, 45 CFR 170.215, and the provider directory information requirements specified in 42 CFR 438.10. DHCS requires BHPs to implement and maintain a Patient Access API that can connect to provider EHRs and practice management systems, in accordance with requirements specified at 42 CFR section 431.60. The Patient Access API must permit third-party applications to retrieve, with the approval and at the direction of a member or member's authorized representative, data specified in this BHIN through the use of common technologies and without special effort from the member. BHPs must also implement and maintain a publicly accessible standards-based Provider Directory API as described in 42 CFR section 431.70 and meet the same technical standards of the Patient Access API, excluding the security protocols related to user authentication and authorization. **California DxF**: In addition, all signatories to the California DxF DSA must exchange data in conformance with the DxF's Technical Requirements for Exchange Policy and Procedure which stipulates that signatories abide by standards approved by the DxF Governance Entity, which will review and consider new and maturing "national and federally adopted standards" (i.e., standards specifically included by the U.S. Department of Health and Human Services in a published version of the Standards Version Advancement Process) for potential inclusion in the DxF.
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact.	

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Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e- referrals from physician/mental health provider to physician/mental health provider	*Current Status.* Milestone partially achieved. Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider can be accomplished directly through EHR capabilities or facilitated through HIEs. • **External Landscape (Counties and HIEs)**: At the county level, 50 percent of California's BHPs reported that their contracted providers were using operational EHRs that included referral management capabilities as of 2022.[21] With respect to regional data exchange, four HIEs in California made referral data available to connected providers as of 2019.[22] As of 2022, two California HIEs offer, or are in the process of implementing, e-referrals and closed loop referral capabilities. At this time, the HIE-facilitated referrals are not fully closed loop – the referral form is completed and delivered electronically, and then loop closure is determined upon receipt of the progress note (i.e., there is no tracking of referral status). One of California's operational CIEs also supports e-referrals. • **California DxF**: In addition, all signatories to the California DxF DSA must exchange data in conformance with the DxF's Technical Requirements for Exchange Policy and Procedure which stipulates that signatories that create "Health and Social Services Information regarding a specific Individual in conjunction with an Order or Referral must send that Health and Social Services Information to the ordering Participant electronically via Information Delivery if the ordering Participant is technically capable of electronic receipt."
	Future Status At the county level, CalMHSA's semi-statewide behavioral health EHR system was launched in July 2023 and now covers over 37 percent of the state's Medi-Cal population.[23] CalMHSA will expand the EHR to additional counties in 2024.[24] The semi-statewide behavioral health EHR system will include closed loop referral capabilities.[25]

[21] Behavioral Health Concepts, Inc. FY 2021-2022 Statewide Technical Report: Medi-Cal Specialty Mental Health. Published online April 26, 2023.
[22] Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator's national survey of HIOs.
[23] As of November 1, 2023, according to CalMHSA's website, twenty-three California counties were participating in the semi-statewide behavioral health EHR system: Colusa, Contra Costa, Fresno, Glenn, Humboldt, Imperial, Kern, Kings, Lake, Marin, Mono, Nevada, Placer, Sacramento, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Siskiyou, Sonoma, Stanislaus, Tulare, Ventura.
[24] CalMHSA Semi-Statewide EHR website. Accessed August 9, 2023.
[25] Miller A. Interview with the California Mental Health Services Authority (July 25, 2022).

Prompts	Summary
	California's requirements for statewide data exchange via the DxF and DHCS' contractual requirements and incentive programs with MCPs will accelerate behavioral health providers' connectivity to and exchange of information via HIEs which, in turn, will create opportunities for behavioral health providers to access and utilize closed loop referrals. DHCS requires that MCPs' MOUs with BHPs must require BHPs to support closed loop referral services. By January 1, 2025, BHPs must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, Enhanced Care Management (ECM) benefits, and/or community-based resources.[26] The Parties must work collaboratively to develop and implement a process to ensure that MCPs and BHPs comply with the applicable provisions of closed loop referrals guidance within 90 days of issuance. The parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar forthcoming guidance.
	Summary of Actions Needed • Continue expansion of CalMHSA's semi-statewide behavioral health EHR system • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs • Assess opportunities to expand DxF requirements to include requirements for closed loop referrals • Provide additional guidance and technical assistance to BHPs to support the expanded use of closed loop referral systems • Provide funding for the adoption and deployment of closed loop referral systems
1.2 Closed loop referrals and e- referrals from institution/hospital/clinic to physician/mental health provider	*Current Status*: Please see response to section 1.1.
	Future Status: Please see response to section 1.1.
	Summary of Actions Needed: Please see response to section 1.1.
1.3 Closed loop referrals and e- referrals from physician/mental health provider to community based supports	*Current Status.* Milestone partially achieved. CalAIM offers a wide array of Community Supports and facilitates coordination between physician and mental health providers to community-based organizations (CBOs). Currently, closed loop referrals and e-referrals from physician/mental health provider to CBOs are being supported through HIEs, CIEs, and social drivers of health (SDOH)-focused closed loop referral systems.

[26] As referenced in the CalAIM Population Health Management (PHM) Policy Guide, APL 22-024, and the 2024 Managed Care Contract, as amended from time to time, and as set forth by DHCS through APL, or other, similar guidance.

Prompts	Summary
	As of September 2023, two of California's HIEs offer e-referral capabilities to a range of their data exchange participants. • One HIE is developing e-referrals to CBOs for multiple referral types. • One HIE currently uses the Unite Us community resource referral platform to provide closed loop CBO referrals. California's two operational CIEs provide information on the availability of community-based support services.
	Future Status California's requirements for statewide data exchange (i.e., the DxF) and DHCS' contractual requirements and incentive programs with MCPs will accelerate behavioral health providers' connectivity to and exchange of information via HIEs which, in turn, will create opportunities for behavioral health providers to access and utilize closed loop referrals for community-based supports. • **DHCS Initiatives**: DHCS requires MCPs to have MOUs with BHPs, and all parties must enact policies and procedures that include a process for the BHP to send regular, real-time or batch referrals to ECM providers and Community Supports referrals to MCPs. MCPs' MOUs with BHPs will require all plans to support closed loop referral services. By January 1, 2025, BHPs must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Policy Guide, APL 22-024, and the 2024 Managed Care Contract, and as set forth by DHCS through APLs, or other, similar guidance. The parties must work collaboratively to develop and implement a process to ensure that BHPs comply with the applicable provisions of closed loop referrals guidance within 90 days of issuance. The parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.
	Summary of Actions Needed • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs, CIEs, and SDOH closed-loop referral systems • Assess opportunities to expand DxF requirements to include requirements for closed loop referrals • Provide additional guidance and technical assistance to support expansion of closed loop referral systems among MCPs, BHPs, and other entities • Provide funding for the deployment of closed loop referral systems
Electronic Care Plans and Medical Records (Section 2)	
	Current Status. Milestone partially achieved.

Prompts	Summary
2.1 The state and its providers can create and use an electronic care plan	The ability for stakeholders to create electronic care plans has been and remains a priority for DHCS. • **DHCS Initiatives**: The DHCS Population Health Management program requires that entities providing Complex Care Management (CCM) or ECM must include a comprehensive assessment of each member's condition, available benefits, and resources (including Community Supports), as well as develop and implement a care management plan with goals, monitoring, and follow-up.[27] Under the CalAIM Documentation Redesign Initiative, DHCS shifted from away from requiring the documentation of standalone treatment plans toward allowing treatment planning activities to be recorded more flexibly within an EHR (i.e., within a problem list and/or progress notes) as long as the treatment plan can be easily extracted and shared. These flexibilities are allowed except for in cases where federal requirements mandate a standalone treatment plan. On November 20, 2023, DHCS implemented BHIN 23-068 which replaced BHPs' client plan documentation requirements with a problem list and progress notes documentation. This shift was intended to help behavioral health providers align terminology and data elements with the physical health care system, allowing for easier data sharing and care coordination. Providers responsible for a member's care are responsible for creating and maintaining a problem list, as well as updating the problem list on a regular basis to reflect the member's current condition. Through BHQIP, BHPs are incentivized via payments to meet specific milestones, one of which is implementing DHCS' revised documentation standards, including problem lists and progress notes. Earned incentive funds may be used to assist counties in pursuing CalAIM requirements, which may include staffing, technology, infrastructure, or training. • **External Landscape**: At a regional level, five of California's HIEs make care plan field data, including goals and instructions, available.[28] All signatories to the California DxF DSA must exchange data in conformance with the DxF's Data Elements to Be Exchanged Policy and Procedure which stipulates that signatories must exchange data elements in the United States Core Data for Interoperability (USCDI) Version 2, including data elements for care plans.
	Future Status As per DHCS' requirement that MCPs have MOUs with BHPs, all parties must share information necessary to facilitate referrals and coordinate care. They must have policies and procedures for exchanging member information and data, including behavioral health and physical health data, in a timely manner; maintaining the confidentiality of exchanged

[27] CalAIM: Population Health Management (PHM) Policy Guide: Updated May 2023.
[28] Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator's national survey of HIOs.

Prompts	Summary
	information and data; bidirectional monitoring of data exchange processes; and obtaining member consent. The data elements to be shared must be jointly agreed upon by the parties, reviewed annually, and set forth in the MOU. The data elements must include, at a minimum, member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the member's health and/or welfare. BHPs and MCPs must also develop joint processes for reviewing and updating a member's problem list, as clinically indicated. The joint processes must also describe circumstances for updating care plans and coordinating with outpatient SUD providers.
	Summary of Actions Needed • Assess opportunities to expand DxF requirements to include requirements for electronic care plan creation and transmission • Provide additional guidance to support expansion of electronic care plan creation and transmission • Provide funding for electronic care plan creation and transmission
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current Status.* Milestone partially achieved. An additional milestone of the BHQIP involves behavioral health entities demonstrating improved data exchange capabilities. To receive incentive payments, entities must: • Demonstrate direct sharing of data with MCPs or demonstrate onboarding to a HIE • Demonstrate an active Fast Healthcare Interoperability Resources API that will allow the BHP to be compliant with CMS-mandated interoperability rules • Demonstrate that the BHP has mapped data elements to the USCDI Version 2 standard set While not specific to electronic care plans, improved data exchange capabilities supported through BHQIP may facilitate the interoperability and accessibility of electronic care plans among BHPs. As of 2022, two of California's HIEs had capabilities to share electronic care plans. One HIE currently shares electronic care plan information, though electronic care plans cannot be modified after sharing on the HIE. Additionally, another HIE currently shares electronic care plans via Activate Care, a health IT product featuring social needs screening and care coordination/referral capabilities to address patients' social needs, which was implemented in February 2021.
	Future Status

Prompts	Summary
	As per DHCS' requirement that MCPs and BHPs enter into MOUs, all parties must share information necessary to facilitate referrals and coordinate care. They must have policies and procedures for exchanging member information and data, including behavioral health and physical health data, in a timely manner; maintaining the confidentiality of exchanged information and data; bidirectional monitoring of data exchange processes; and obtaining member consent. The data elements to be shared must be jointly agreed upon by the parties, reviewed annually, and set forth in the MOU. The data elements must include, at a minimum, member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the member's health and/or welfare. BHPs and MCPs must also develop joint processes for reviewing and updating a member's problem list, as clinically indicated. The joint processes must also describe circumstances for updating care plans and coordinating with outpatient SUD providers.
	Summary of Actions Needed • Assess opportunities to expand DxF requirements to include requirements for electronic care plan creation and transmission • Provide additional guidance in the State Health Information Guidance (SHIG) to support expansion of electronic care plan creation and transmission • Provide funding for electronic care plan creation and transmission
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current Status.* Milestone partially achieved. To avoid duplication of care and to facilitate transitions between healthcare systems, DHCS developed and implemented the Transition of Care Tool for Medi-Cal Mental Health Services for Youth and Adults to leverage existing clinical information to document a member's mental health needs and facilitate a referral to the member's MCP or BHP, as needed. The Transition of Care Tool is used when a member who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system (i.e., MCP or BHP) or 2) services need to be added to their existing mental health treatment from the other delivery system. These tools are part of CalAIM and are available on DHCS' Screening and Transition of Care Tools for Medi-Cal Mental Health Services website and are further detailed in BHIN 22-065. According to CalMHSA, every BHP operates an integrated record with a client ID that is age agnostic. This allows for medical records and care plans/problem lists to flow as members transition from youth to adult care.[29] In addition, a number of California's HIEs provide capabilities to support the transition of youth to adult behavioral health systems. For example,

[29] Miller A. Interview with the California Mental Health Services Authority (July 25, 2022).

Prompts	Summary
	one HIE does not automatically share records or care plans when a youth transitions to adult services, but adult services organizations can query and access medical records and care plans from youth care.
	Future Status • Improved usage of child and adult transition of care tools
	Summary of Actions Needed • Monitor and assess the implementation and usage of child and adult transition of care tools • Support increased usage through technical assistance or funding (e.g., incentives), as appropriate
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current Status.* Milestone partially achieved. See section 2.3 for a discussion of transitions from youth to adult behavioral health care. As the state moves away from requiring the documentation of standalone care plans and toward allowing increased flexibility for providers to document care planning activities anywhere within the clinical record (e.g., problem lists and progress notes) as long as the information can be easily extracted and shared as needed, this information is expected to become more interoperable between providers. Under CalAIM, DHCS developed policies to support the innovative use of EHR capabilities and facilitate the meaningful use of EHRs, care coordination, and quality assurance through the flexible use of EHR capabilities. In addition, DHCS removed burdensome and duplicative treatment planning documentation requirements (BHIN 23-068) except for instances where a standalone treatment plan is mandated by federal requirements. DHCS implemented standardized "Screening and Transition of Care Tools for Medi-Cal Mental Health Services" (BHIN 22-065). The purpose of standard "Screening and Transition of Care Tools for Medical Health Services" is to ensure coordination between delivery systems, including when service needs change for members over age 21 or under age 21. Under CalAIM, documentation is standardized between providers and delivery systems. See section 2.1 for more discussion on Problems List and progress notes and 2.3 for more discussion of transitions between youth to adult behavioral health care.
	Future Status

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td></td><td>Improved usage of child and adult transition of care tools. For example, beginning January 31, 2024 for most DSA signatories, health information exchange must be conducted in conformance with the DxF's Data Elements to Be Exchanged Policy and Procedure which stipulates that signatories must exchange data elements in the USCDI Version 2, which includes data elements for intake, assessment and screening tools.</td></tr>
<tr><td></td><td>Summary of Actions Needed

• Monitor and assess implementation and usage of child and adult transition of care tools
• Conduct a comparative analysis and feasibility assessment of aligning the tools with industry standards, specifications, and formats where applicable, to support streamlined integration and exchange of information across providers systems
• Support increased usage through technical assistance or funding (e.g., incentives), as appropriate</td></tr>
<tr><td>2.5 Transitions of care and other community supports are accessed and supported through electronic communications</td><td>Current Status. Milestone partially achieved.

As described above, support for transitions of care through electronic communications are part of CalAIM and are available on DHCS' Screening and Transition of Care Tools for Medi-Cal Mental Health Services website.

In the 2020 American Hospital Association (AHA) IT Supplement survey, seven California psychiatric hospitals reported on their ability to send and receive a summary of care record when a patient transitions to another care setting outside the organization, using various electronic modalities.[30] See table below.

<table>
<tr><th>Ability to send and receive a summary of care record when a patient transitions to another care setting outside the organization, using the following electronic modalities:</th><th>Send</th><th>Receive</th></tr>
<tr><td>eFax using her</td><td>4</td><td>3</td></tr>
<tr><td>Provider portals that allow outside organizations to view records in your EHR system</td><td>2</td><td>2</td></tr>
<tr><td>Interface connection between EHR systems (e.g., Health Level 7 (HL7) interface)</td><td>0</td><td>1</td></tr>
<tr><td>Login credentials that allow access to your her</td><td>1</td><td>0</td></tr>
<tr><td>Health Information Service Providers that enable messaging via the DIRECT protocol</td><td>3</td><td>1</td></tr>
<tr><td>Regional, state, or local (HIE/HIO); not a local proprietary, enterprise network</td><td>3</td><td>1</td></tr>
<tr><td>EHR vendor-based network that enables exchanges with the vendor's other users (e.g., Epic's Care Everywhere)</td><td>1</td><td>1</td></tr>
</table>
</td></tr>
</table>

[30] AHA Healthcare IT Database.

Prompts	Summary
	National networks that enable exchanges across different EHR vendors (e.g., CommonWell, e-Health Exchange, Carequality) | 1 | 1 Additionally, one HIO currently uses Activate Care to offer this capability. Improving provider-patient attribution and care team identification is on its roadmap to improve in the coming years.
	Future Status • Improved usage of transition of care tools • Infrastructure in conformance with and in support of the DxF
	Summary of Actions Needed • Monitor and assess the implementation and usage of transition of care tools • Support increased usage– through technical assistance or funding (e.g., incentives), as appropriate
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current Status.* Milestone partially achieved. Efforts are occurring statewide and at HIEs to support and operationalize electronic consent. • **DHCS Initiatives**: As per DHCS' requirements, MCPs and BHPs must adopt joint policies and procedures to ensure data is exchanged timely and maintained securely and confidentially and in compliance with applicable rules and regulations. They must share protected health information for the purposes of medical and behavioral health care coordination pursuant to CAL. CODE REGS. tit. 9, § 1810.370(a)(3) and in compliance with the Health Insurance Portability and Accountability Act and its implementing regulations, as amended (HIPAA), 42 CFR Part 2, as well as other state and federal privacy laws. With respect to statewide guidance, CalHHS published the SHIG on Sharing Behavioral Health Information in June 2017. The SHIG clarifies the circumstances under which mental health and SUD information can be exchanged. This is accomplished through the use of scenarios developed through comprehensive research and stakeholder input. The guidance contained in the SHIG is considered to be authoritative but non-binding and is continuously updated to reflect new rules, regulations, and policies. SHIG version 1.2, which focuses on the sharing of behavioral health information in California, was released in April 2023.

Prompts	Summary
	DHCS also released CalAIM Data Sharing Authorization Guidance in March 2022 that included exemptions to California rules that implicate sharing of mental health information. In October 2023, DHCS released an updated version of the guidance, CalAIM Data Sharing Authorization Guidance Version 2. On October 7, 2023, Governor Newsom signed Assembly Bill 1697, the Uniform Electronic Transactions Act, which amended the California Medical Information Act and allows electronic signatures to be accepted to authorize sharing of information related to sensitive services effective January 1, 2024. • **External Landscape**: Among California's HIEs, three offered consent management to their participants as of 2019.[31]
	Future Status As described above, beginning January 31, 2024, for most DSA signatories, health information exchange must be conducted in conformance with the DxF's Privacy and Security Policy and Procedure which stipulates that signatories abide by applicable laws with respect to disclosure decisions. DHCS is developing detailed data sharing toolkits that will be published in 2024. Stakeholders requested behavioral health specific guidance and on-the-ground technical assistance to clearly define specific data sharing requirements for BHPs. DHCS will provide the guidance through a BHIN and focused technical assistance for stakeholders. DHCS is developing plans for a consent management approach that includes standardized processes, tools, and services to obtain and manage a Medi-Cal member's consent for sharing sensitive health information. Consent management services could be used for multiple purposes contemplated by DHCS, including: 1. Facilitating the protection of sensitive personal information (e.g., Part 2 data) that requires informed consent to be shared. 2. Supporting and respecting member preferences regarding sharing of admission, discharge, and transfer (ADT) notifications with other CalAIM partners (health plans, providers, etc.). 3. Supporting DHCS' Interoperability and Patient Access Final Rule requirements to provide Medi-Cal members with access to their Electronic Health Information. In 2023, DHCS piloted the Authorization to Share Confidential Medi-Cal Information (ASCMI) Form and consent management service (collectively referred to as the "ASCMI Pilot"). The ASCMI Form is a standard release of information that is intended to inform Medi-Cal members of their rights and expressed preferences to share sensitive physical, social, and behavioral health information. ASCMI forms are securely stored and managed by contracted HIE and CIE organizations

[31] Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator's national survey of HIOs.

Prompts	Summary
	and can be accessed by members and their providers, health plans, county agencies, and others. In the summer of 2023, DHCS launched an evaluation of the ASCMI Pilot to identify best practices, issues, and operational complexities of implementing the ASCMI Form and consent management service to inform a broader rollout in the future. The ASCMI pilot demonstrated the infrastructure that is necessary for the exchange of data to implement programs such as ECM and Community Supports, which requires obtaining members' consent for sharing sensitive data, as mandated by state and federal law. At the local level, CalMHSA plans to implement this standardized consent form in its behavioral health EHR system.[32] In addition, two HIEs are planning to develop comprehensive universal consent management systems within the next few years.
	Summary of Actions Needed • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs • Address infrastructure necessary to support consent management • Develop more detailed CalAIM Data Sharing Authorization Guidance toolkits, release an updated BHIN, and support the provision of technical assistance to behavioral health stakeholders
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current Status.* Milestone partially achieved. Current efforts to improve the collection and exchange of intake, assessment, and screening information as structured data include the following DHCS initiatives and external activities. • **DHCS Initiatives**: As part of CalAIM, DHCS developed and implemented standardized screening and transition of care tools. These tools are outlined in BHIN 22-065 available on DHCS's Screening and Transition of Care Tools for Medi-Cal Mental Health Services website. The standardized screening tools, one for youth and one for adults, help identify the appropriate delivery system to meet the member's needs. DHCS has also developed standardized, domain-based documentation requirements outlined in BHIN 23-068. Assessments for DMC and DMC-ODS members will continue to occur using the American Society of Addiction Medicine criteria. Assessments for SMHS members under the age of 21 capture seven assessment domains.

[32] Miller A. Interview with the California Mental Health Services Authority (July 25, 2022).

Prompts	Summary
	• **External Landscape**: As of 2019, six California HIEs provided assessment and plan of treatment data.[33] For example, one HIE receives and sends screening forms, though only as PDF files. Similarly, another HIE shares assessments as PDF files which can be converted to CSV files or exported as HL7 messages.
	Future Status As described above, beginning January 31, 2024 for most DSA signatories, health information exchange must be conducted in conformance with the DxF's Data Elements to Be Exchanged Policy and Procedure which stipulates that signatories must exchange data elements in the USCDI Version 2, which includes data elements for intake, assessment and screening tools. DHCS is working alongside the California Department of Social Services to align on a single Child and Adolescent Needs and Strengths assessment tool for BHPs to use that will help inform the various assessment domains. The movement toward standardized screening and assessment tools throughout California will allow for greater interoperability of behavioral health assessment and screening data. CalMHSA plans to pilot the implementation of these screening and assessment tools as part of its semi-statewide behavioral health EHR implementation.
	Summary of Actions Needed • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs • Assess opportunities to expand DxF requirements to include requirements for assessment data
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current Status.* Milestone partially achieved. California defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site."[34] A brief history and overview of DHCS' telehealth policies and initiatives to encourage uptake is below. • **Early Policy**: DHCS' telehealth coverage began in 1996 with the passage of the California Telemedicine Advancement Act (SB 1665), which established telemedicine payment and provision of care requirements, and additional legislation continued to expand access to services through the 2000s. The passage of the Telehealth

[33] Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator's national survey of HIOs.
[34] Business and Professions Code section 2290.5(a)(6)

Prompts	Summary
	Advancement Act (AB 415) in 2011 laid the foundation for Medi-Cal to drastically expand coverage of telehealth in Medi-Cal, eliminating the ban on email and telephone-delivered services, permitting patients to verbally consent to telehealth, and enabling all California-licensed and Medi-Cal enrolled providers to practice via telehealth. • **Policy Updates in 2019**: In August 2019, DHCS clarified telehealth policies for MCPs in APL 19-009. While selected psychiatric diagnostic and therapeutic services are existing benefits, the APL allows DHCS to further utilize telehealth services for behavioral health needs. More information was included in BHIN 20-009 which provided behavioral health programs with flexibilities granted by CMS and through Governor Newsom's executive orders to ensure ongoing access to care. The notice emphasized telehealth as an allowable mechanism to provider clinical services. • **COVID-19 Pandemic**: In response to the COVID-19 pandemic, DHCS implemented telehealth flexibilities via waivers and Disaster Relief state plan amendments. Behavioral health needs across the state intensified due to the COVID-19 pandemic. The pandemic also created new barriers for members living with SMI/SED and SUD, as well as increased the prevalence of these conditions. DHCS implemented the Behavioral Health Response and Rescue Project (BHRRP) to increase access to behavioral health care for all Californians. Funds for the BHRRP have been used to support and expand the full continuum of behavioral health care needs, including further expansion of the telehealth infrastructure by March 2023. • **Policy Updates in 2021**: In 2021, DHCS released a Request for Application for behavioral health providers to request additional support to develop, enhance, and/or expand the telehealth infrastructure due to the COVID-19 pandemic. DHCS utilized available federal grant funding provided by the Substance Abuse and Mental Health Services Administration to support activities to improve the existing behavioral health telehealth infrastructure. The goal of the project was to address the needs of providers who provide treatment and recovery services to members living with SUD and/or mental health disorders, including youth and adults with SEDs. • **Policy Updates in 2023**: In April 2023, DHCS updated the Telehealth Services Policy in APL 23-007 for MCPs, which superseded APL 19-009 and established that "effective no sooner than January 1, 2024, all Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. Also effective no sooner than January 1, 2024, to preserve a Member's right to access Covered Services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following: (1) offer those same services via in-person, face-to-face contact or (2) arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care."

Prompts	Summary
	DHCS updated its guidance for BHPs and DMC programs, releasing Behavioral Health Information Notice 23-018 in April 2023, which superseded prior policy guidance, and ensured Medi-Cal covered services delivered via telehealth (synchronous audio-only and synchronous video interactions) are reimbursable. • **The Substance Abuse and Mental Health Services Administration's** 2020 National Mental Health Services Survey reported on uptake of telehealth among California's mental health providers. It found of the 868 California-based mental health treatment facilities surveyed, 634 (73 percent) offered telemedicine-based therapy.[35] During the COVID-19 pandemic, California actively worked to remove policy and regulatory barriers to telehealth utilization and reimbursement. One study of California community health centers found that the total number of behavioral health visits remained stable during the pandemic largely because telehealth visits were able to replace in-person visits. DHCS also implemented new grants and programming during the pandemic, allowing behavioral health entities to purchase telehealth equipment and Medi-Cal members to receive a broadband benefit covering up to $50 per month for Internet costs.[36] Survey data from 53 county behavioral health agencies in California captures the proportion of different types of professionals offering SUD services via telehealth before and during the COVID-19 pandemic. Agencies were asked "in your agency, which types of professionals provided SUD services to clients via telehealth? Please check all that apply." Prior to the pandemic the range across types of professionals was 2 percent to 21 percent. The most common telehealth user roles included: physicians (21 percent), certified SUD counselors (19 percent), and licensed marriage and family therapists (13 percent); the least common telehealth user roles included: psychiatric technicians (2 percent), licensed clinical psychologists (4 percent), and licensed clinical social workers (4 percent). Higher proportions of professionals reported offering telehealth SUD treatment during the pandemic, with a range of 15 percent to 89 percent. The most common telehealth user roles included: certified SUD counselors (89 percent), registered SUD counselors (75 percent), licensed marriage and family therapists (70 percent); the least common telehealth user roles included: nurse practitioners and physician assistants (4 percent), psychiatric technicians (15 percent), and community health workers (21 percent), The survey was conducted by UCSF in collaboration with the California Behavioral Health Directors Association (CBHDA) to inform the development of a long-term strategy to inform the public behavioral health system's workforce needs.[37]
	Future Status

[35] Data from the National Mental Health Services Survey (N-MHSS). Published online 2021. https://www.samhsa.gov/data/data-we-collect/n-mhss-national-mental-health-services-survey
[36] State of California Department of Health Care Services: Assessing the Continuum of Care for Behavioral Health Services in California - Data, Stakeholder Perspectives, and Implications. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf
[37] Coffman J. Data from the 2021 UCSF and CBHDA Behavioral Health Workforce Survey.

Prompts	Summary
	DHCS continues to support the use of telehealth through policy and technical infrastructure and advance efforts that will improve the ability to track and monitor telehealth usage in behavioral health settings. In specialty behavioral health settings, modifiers for telehealth and audio-only visits were implemented effective November 1, 2021 (with extensions given to January 1, 2022, if needed due to the public health emergency). Through use of the modifier, DHCS can monitor variations in telehealth data reporting across providers to assess for data quality and compliance, which could include reporting back to data submitters.[38] Using this data, DHCS will publish a bi-annual Telehealth Utilization Report and a telehealth dashboard that will include behavioral health utilization.
	Summary of Actions Needed • Continue to advance DxF and broadband capabilities to support telehealth • Continue to support mental health providers' uptake of telehealth
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment)	*Current Status.* Milestone partially achieved. According to CalMHSA, many BHPs have implemented alerting capabilities in their systems for patients at risk of discontinuing care or who have stopped engaging in care.[39] There are also more general alerting capabilities that could be expanded to support this use case. For example, two of five psychiatric hospitals (as reported in the 2020 AHA IT survey) with emergency departments routinely provide electronic notification to a PCP after an emergency department visit. Additionally, as of 2022, all of California's operational HIEs offered some form of alerting services (e.g., gaps in care) and/or event notification (e.g., ADT) for HIE participants.
	Future Status California's DxF requirements, DHCS Population Health Management program's guidelines and requirements, and DHCS' contractual requirements and incentive programs will accelerate behavioral health providers' connectivity to and exchange of information via HIEs which, in turn, will create opportunities for behavioral health providers to access and use notifications and alerts. As per DHCS' requirements, BHPs must enact policies and procedures to implement the following with regard to information sharing:

[38] DHCS Telehealth: Research and Evaluation Plan (December 19, 2022).
[39] Miller A. Interview with the California Mental Health Services Authority (July 25, 2022).

Prompts	Summary
	• A process for BHPs to send regular real-time or batch referrals. • A process for BHPs to send ADT data to MCPs when members are admitted to, discharged from, or transferred from facilities contracted by BHPs (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities), and for MCPs to receive this data. • A process to implement mechanisms to alert MCPs of behavioral health crises (e.g., BHPs alert MCPs of uses of mobile health, psychiatric inpatient care, and crisis stabilization; MCPs alert BHPs of a member's visits to emergency departments and hospitals). • A process for MCPs to send ADT data to BHPs when members are admitted to, discharged from, or transferred from facilities contracted by MCPs (e.g., emergency departments, inpatient hospitals, nursing facilities), and for BHPs to receive this data. For inpatient residential SUD treatment provided by a DMC-ODS facility or for inpatient hospital admissions or emergency department visits known to MCPs, the process must include the specific method to notify each party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services. DHCS is also developing contractual requirements for health plans that will be in place in 2024 and will require all hospitals and skilled nursing facilities with Certified EHRs to send ADT notifications to MCPs and all necessary care team members (including behavioral health providers).
	Summary of Actions Needed • Continue to advance DxF's and CMS' Interoperability Rule requirements to support care coordination
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current Status.* Milestone partially achieved. As of 2021, 41 BHPs (71 percent) in California offer dedicated programs serving members experiencing their first episode of psychosis (FEP). These programs include psychotherapy, medication management, case management, family education and support, and intensive care coordination services.[40] However, as of 2022, half of California BHPs' EHRs lacked care coordination functionalities, and they continued to rely on communication from providers and other manual processes to assist in the coordination of services as members transition between locations of care.[41] UC Davis, a nationally recognized leader in providing outpatient, team-based coordinated specialty care for early psychosis, developed and leads the EPI-CAL Network. This network provides statewide training, technical assistance, and outcome

[40] State of California Department of Health Care Services: Assessing the Continuum of Care for Behavioral Health Services in California - Data, Stakeholder Perspectives, and Implications.
[41] Behavioral Health Concepts, Inc. FY 2021-2022 Statewide Technical Report: Medi-Cal Specialty Mental Health. Published online April 26, 2023.

Prompts	Summary
	evaluation for California's FEP programs. All participating FEP programs collect the same data over the same time periods. EPI-CAL then leverages a FEP-focused technology system so programs can learn from their own data and from others in the network. FEP program managers get access to survey data from their clinics on this technology platform so they can evaluate performance, compare their outcome data to the network, and identify areas of strength or for improvement. The technology platform also collects and visualizes client data across recovery-oriented measures, allowing providers, clients, and their families to use this data in care decisions and appointments.[42]
	Future Status • The DxF will create the technical, legal, and operational infrastructure to support data exchange for care coordination. DxF has established technical requirements for all DxF Participants (organizations that has signed the DxF Data Sharing Agreement), including policies and procedures for data exchange. These standards are aligned with federal interoperability standards, and specifically indicate that: "Participant[s] [are] encouraged to support delivery using HL7 Fast Healthcare Interoperability Resources (FHIR) Release 4 conforming to the US Core Implementation Guide for Information Delivery." HL7 FHIR includes specifications for an Application Programming Interface, or APIs that have been adopted to ONC. • Other federal standards that have been adopted by the DxF include the Applicability Statement for Secure Health Transport (i.e., Direct Secure Messaging); the IHE Cross-Enterprise Document Reliable Interchange (XDR) and the IHE Cross-Community Document Reliable Interchange (XCDR) exchange profiles – the latter of which have been adopted with the TEFCA national networks (which are federally qualified health information networks).
	Summary of Actions Needed • Continue to advance DxF's and CMS' Interoperability Rule requirements to support care coordination
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current Status.* Milestone partially achieved. California administers the Medi-Cal program through multiple delivery systems, including MCPs, fee-for-service, and BHPs. Additionally, the data exchange landscape in California includes multiple HIOs that facilitate data exchange between providers and associated EHRs. Given this environment, DHCS does not have visibility into the specific medical record functionality asked about in this item. Based on feedback from HIOs, full medical record linkage is uncommon due to privacy

[42] EPI-CAL. California Collaborative Statewide Early Psychosis Program Evaluation.

Prompts	Summary
	and 42 CFR issues, especially as a child ages. In regard to HIOs, if name and contact information about a child's next of kin and/or support person is available, the HIO may share this information as part of the normal HIE and CIE workflows.
	Future Status • Improved ability for stakeholders to link a child's health information with their respective parent/caretaker's records
	Summary of Actions Needed • Monitor and assess stakeholders' ability to link a child's health information with their respective parent's/caretaker's records
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current Status.* Milestone partially achieved. California administers the Medi-Cal program through multiple delivery systems, including MCPs, fee-for-service, and BHPs. Additionally, the data exchange landscape in California includes multiple HIOs that facilitate data exchange between providers and associated EHRs. Given this environment, DHCS does not have visibility into the specific medical record functionality asked about in this item.
	Future Status In response to California Health and Safety Code § 130290, CalHHS published a Strategy for Digital Identities in July 2022. As described above, beginning January 31, 2024 for most DSA signatories, health information exchange must be conducted in conformance with the DxF's Technical Requirements for Exchange Policy and Procedure which stipulates that signatories must exchange specific identifiers related to health if maintained by the DxF Participant and only as permitted by applicable law when specifying a person to match or a matched Individual in a request for information or identifying an individual in information delivery or notifications of ADT events if supported by the technical exchange standard in use, including but not limited to state or federal identifiers related to health (e.g., Medi-Cal or Medicare ID) and local identifiers related to health (e.g., medical record number or plan member identification number). Participants may also retain and use specific identifiers related to health and exchange them as an aid in person matching. CalHHS seeks to develop and implement a new cross-agency digital person identity matching capability that will provide query and linkage functionalities to different records that exist in different data sources managed by different agency departments. The new technology capability will provide an intermediary service that makes linking cross-agency records

Prompts	Summary
	possible to better enable a whole-person view of a person's records without disruption of the data source(s). DHCS and DxF participants are expected to align their digital identity matching capabilities in accordance with the CalHHS digital identity matching technology standards and specifications. Per the CalHHS Data Exchange Framework policy and procedures documentation, it is CalHHS' intent to align with National and Federally Adopted Standards, whenever possible.
	Summary of Actions Needed • Continue to advance the DxF Strategy for Digital Identities • Continue to implement policies, requirements, and systems to support compliance with the patient access provisions of the CMS Interoperability Rule and HIPAA

ATTACHMENT E

Reserved for Monitoring Protocol

ATTACHMENT F

Reserved for Evaluation Design

ATTACHMENT G

Reserved for HRSN Services Protocol

ATTACHMENT H

HRSN Services Matrix

Target Populations	**Housing Services**
Transition Populations who meet the clinical and social risk factors. Transitions defined as:	Rent/temporary housing for up to 6 months
Are transitioning out of an institutional care or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use disorder treatment facility, an inpatient or residential mental health treatment facility, or nursing facility.	X
Are transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities	X
Are transitioning out of foster care	X
Are transitioning out of short-term recuperative care or short-term post-transition housing	X
Are transitioning out of transitional housing or rapid re-housing	X
Are transitioning out of a homeless shelter/interim housing, including domestic violence shelters or domestic violence housing	X
Meet the criteria of unsheltered homelessness as described at 24 CFR part 91.5	X
Meet eligibility criteria for a Full Service Partnership (FSP) program	X

Social Risk Factor
Beneficiaries must meet the US Department of Housing and Urban Development's (HUD's) current definition of homeless or the definition of individuals who are at risk of homelessness as codified at 24 CFR part 91.5, with two modifications: 1) If exiting an institution individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; **and** 2) The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days The state only seeks to use 91.5 (1)(ii) and (1)(iii), (2), and (3) of the at-risk of homeless definition and will omit 91.5 (1)(i) from their definition.

Clinical Condition	Clinical Criteria Detail
Clinical Condition 1	Pregnant individuals
Clinical Condition 2	Up through 12 months postpartum
Clinical Condition 4	One or more serious chronic physical health condition
Clinical Condition 5	Physical, intellectual, or developmental disabilities
Clinical Condition 6	Meets the access criteria for Drug Medi-Cal (DMC)
Clinical Condition 7	Meets the access criteria for Drug Medi-Cal Organized Delivery System (DMC-ODS)
Clinical Condition 8	Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS) stipulated in this matrix

Access Criteria	State Criteria
Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Adults	Medi-Cal members age 21 or older meet access criteria for DMC-ODS or DMC services if they meet **at least one** of the following criteria: (1) Have at least one diagnosis from the most current version of the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders **OR** (2) Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Children	Members under 21 are eligible for DMC-ODS or DMC if they meet the medical necessity standard for one or more SUD services provided through these delivery systems, as recommended by a licensed behavioral health practitioners.
Medi-Cal Specialty Mental Health Services Children	Medi-Cal members under age 21 qualify for SMHS if they meet both of the following requirements: a. The beneficiary has at least one of the following: i. a significant impairment ii. A reasonable probability of significant deterioration in an important area of life functioning iii. A reasonable probability of not progressing developmentally as appropriate. iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. b. The beneficiary's conditions as described in (2) above is due to one of the following: i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the International Statistical Classification of Disease and Related Health Problems. ii. A suspected mental health disorder that has not yet been diagnosed. iii. Individuals with health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect.
Medi-Cal Specialty Mental Health Services Adults	Medi-Cal members age 21 or older qualify for SMHS if they meet **both** of the following criteria: (1) the beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability or dysfunction in social, occupational, or other important activities. b. A reasonable probability of significant deterioration in an important area of life functioning. **AND** (2) the beneficiary's condition is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems. b. A suspected mental disorder that has not yet been diagnosed.

ATTACHMENT I

Reserved for HRSN Implementation Plan

ATTACHMENT J

DSHP List

Attachment J
Approved List of Designated State Health Programs (DSHPs)

The DSHP-eligible expenditures in this list exclude prohibited costs, in accordance with STC 11.2.

Program	Description	DSHP-Eligible Expenditures
Department of Developmental Services (DDS or Lanterman)	The Lanterman Act provides for the coordination and provision of services and supports to enable people with intellectual and developmental disability to lead more independent, productive, and integrated lives.	$2,438,721,971
Total Allowable DSHP-Eligible Expenditures		$2,438,721,971
Total Allowable DSHP-Eligible Expenditures with Adjustment		$2,316,785,872
Total DSHP Cap. The state must not claim more than the capped amount of DSHP.		$1,615,000,000

ATTACHMENT K

Reserved for **Provider Rate Increase**

Attestation Table