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The California Behavioral Health Community-Based Continuum Demonstration

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The California Behavioral Health Community-Based Continuum Demonstration

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Introduction

As highlighted in the California Department of Health Care Services' (DHCS) comprehensive 2022 assessment of California's behavioral health landscape *Assessing the Continuum of Care for Behavioral Health Services in California* (2022 Assessment), California faces a growing crisis exacerbated by the COVID-19 pandemic.[1] Prior to the pandemic, the rate of serious mental illness (SMI) in California increased by 50 percent from 2008 to 2019.[2] As of 2019, nearly one in 20 (4.5 percent) adults in California was living with SMI, a rate expected to grow as more mid-to-post-pandemic data becomes available.[3] At the same time, one in 13 children in California was living with a serious emotional disturbance (SED), with rates of depression and suicide higher among youth who are low-income, Black, American Indian and Alaska Native, Latino, and LGBTQ.[4,5,6] Of particular concern is the approximately 25 percent of California residents with SMI who are experiencing homelessness and, therefore, at higher risk of justice involvement. Among incarcerated individuals, data suggest that close to one in three are living with an SMI.[7]

In the face of COVID-19, even more people are living with serious mental health or substance use disorders (SUDs) related to social isolation, economic hardship, loss of family members and other disruptions.[8] For children and youth, in particular, the pandemic has exacerbated mental health and SUD issues, prompting the American

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[1] CDC, Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24-30, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm; CDC, National and State Trends in Anxiety and Depression Severity Scores Among Adults During the COVID-19 Pandemic — United States, 2020-2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7040e3.htm; CDC Drug Overdose Deaths in the U.S. Top 100,000 Annually, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[2] SAMHSA, California Behavioral Health Barometer Volume 6. https://www.samhsa.gov/data/sites/default/files/reports/rpt32821/California-BH-Barometer_Volume6.pdf.

[3] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

[4] Holzer C and Nguyen H, "Estimation of Need for Mental Health Services." Accessed October 2021. Available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Joint%20Health%2002_26_19%20Teare%20to%20Ctte.pdf.

[5] "Native American Youth Depression and Suicide," Child Welfare Information Gateway, Department of Health & Human Services. Available at https://www.childwelfare.gov/topics/systemwide/diverse-populations/americanindian/wellbeing/depression/.

[6] Chapin Hall, Missed Opportunities: LGBTQ Youth Homelessness in America, https://voicesofyouthcount.org/wp-content/uploads/2018/05/VoYC-LGBTQ-Brief-Chapin-Hall-2018.pdf, April 2018.

[7] "Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding," Californian Budget and Policy Center, March 2020. Available at https://calbudgetcenter.org/wpcontent/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[8] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. Available at https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

Academy of Pediatrics and other leading national associations to declare a public health emergency. Nationally, suicide rates among youth between the ages of 10 and 18 have increased, as has the rate for Black and Hispanic youth between the ages of 10 and 24.[9] In California, hospitals have reported a significant increase in the number of adolescents seeking psychiatric treatment in emergency departments (EDs) since the beginning of the pandemic.[10]

In response, the DHCS has made strengthening California's behavioral health system a top priority, particularly for individuals with the greatest needs. DHCS is making unprecedented investments in expanding behavioral health services, housing and social supports for individuals living with mental illness and/or an SUD. For Medi-Cal beneficiaries, these initiatives include a robust Medi-Cal initiative, California Advancing and Innovating Medi-Cal (CalAIM), which includes:

- the renewal of California's Section 1115 demonstration to provide a comprehensive continuum of care for SUD treatment through the Drug Medi-Cal Organized Delivery System (DMC-ODS);
- behavioral health payment reform;
- revamping the access criteria and process used to connect Medi-Cal beneficiaries to specialty mental health services (SMHS);
- adding new services for the most vulnerable beneficiaries, including Enhanced Care Management (ECM) and Community Supports; and
- other policies designed to improve access and increase quality of care.

In addition, DHCS will launch a new mobile crisis benefit and a new treatment for stimulant use disorder (contingency management) under Medi-Cal in 2023. However, significant gaps remain in the current continuum of care available to Medi-Cal members living with SMI/SED, particularly among children and youth (including those involved in child welfare), individuals who are experiencing or at risk of homelessness, and those who are justice-involved.

To help address these significant gaps, DHCS intends to apply for a new Medicaid Section 1115 demonstration to expand access to and strengthen the continuum of mental health services for Medi-Cal beneficiaries living with SMI and SED.

The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration aims to amplify the state's ongoing investments in behavioral health and further strengthen the continuum of care for Medi-Cal beneficiaries. It will take advantage of 2018 guidance from the Centers for Medicare & Medicaid Services (CMS)

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[9] CDPH, "Suicide in California – Data Trends in 2020, COVID Impact, and Prevention Strategies," July 2021. Available at https://www.psnyouth.org/wp-content/uploads/2021/08/Suicide-in-California-Data-Trends-in-2020-COVID-Impact-and-Prevention-Strategies-Slide-Deck.pdf.

[10] Wiener, Jocelyn. "Stranded in the ER: Can California change its treatment of kids in crisis?" Cal Matters, September 27, 2021. Available at https://calmatters.org/health/2021/09/children-suicide-residential-treatment-crisis-california/.

that allows states to secure federal financial participation (FFP) for care provided during short-term stays in Institutions for Mental Disease (IMDs), designated psychiatric facilities with more than 16 beds, as long as they meet certain standards.[11] Consistent with California's priorities, these standards require that states build out their continuum of community-based care and ensure that the care provided in institutional settings is high-quality and time-limited. California's proposed goal for the CalBH-CBC Demonstration, based in large part on the findings from data and stakeholder perspectives described in the 2022 Assessment (Box 1),[12] is to strengthen the state's continuum of community-based behavioral health care services and to better meet the needs of Medi-Cal beneficiaries living with SMI and SED across the state.

Box 1: Key Issues and Opportunities Identified in California's 2022 Report *Assessing the Continuum of Care for Behavioral Health Services in California*[13]

- **Community-based treatment, including crisis care.** It is critical to have a comprehensive approach to behavioral health treatment that includes a robust continuum of crisis services (e.g., 988 Crisis Line, Mobile Crisis and CalHOPE) and emphasizes community-based treatment and supports (e.g., Supported Employment and linkages to Community Supports, affordable housing and permanent supportive housing), and prevention (e.g., Children and Youth Behavioral Health Initiative).
- **Children and youth.** More treatment options (e.g., multisystemic therapy) are vital for children and youth living with significant mental illness and SUDs, including those involved in child welfare (e.g., activity stipends).
- **Evidence-based practices.** More can be done to ensure that evidence-based and community-defined practices (e.g., Assertive Community Treatment) are used consistently and with fidelity.
- **Justice-involved populations.** Building a system to effectively address the behavioral health needs – and related housing, economic and physical health issues – of the most vulnerable, including individuals who are justice-involved (e.g., Forensic Assertive Community Treatment), at risk of or experiencing homelessness (e.g., rent), and severely impaired (e.g., Community Assistance, Recovery and Empowerment (CARE) Court) is critical.

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[11] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[12] DHCS, "Assessing the Continuum of Care for Behavioral Health Services in California; Data, Stakeholder Perspectives, and Implications," January 10, 2022. Available at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

[13] DHCS, "Assessing the Continuum of Care for Behavioral Health Services in California; Data, Stakeholder Perspectives, and Implications," January 10, 2022. Available at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

The proposed demonstration approach also includes elements designed particularly for children and adolescents, adults who are experiencing or at risk of homelessness, and those who are justice-involved. Specifically, the demonstration aims to expand community-based services to transition-age youth and adults; provide family-based services and supports to high-risk children and youth; connect people living with mental illness and SUDs to employment, housing, and social services and supports; and reduce the risk of individuals entering the criminal justice system due to untreated mental illness. In addition, the proposed demonstration will provide counties with the option to receive FFP for short-term stays in IMDs if counties meet specified conditions to ensure they provide a robust continuum of community-based services and provide high-quality care in institutional settings when it is medically appropriate.

Box 2: Faces of the CalBH-CBC Demonstration

Sasha was diagnosed with schizophrenia as a young adult. She struggled with loneliness, depression and erratic behavior at home and at school. After her parent's divorce, she left home and began living on the street. Over the past five years, Sasha has frequently presented in the ED, has been arrested and detained in jails, and has received intensive psychiatric care, including inpatient hospitalization, residential treatment and 5150 stays. Often, she remains stable and on medication for a short period after leaving a facility, but without robust supports in the community, she sometimes stops taking her medication, and her condition destabilizes.

Through the CalBH-CBC Demonstration, Sasha will meet with a care coordinator before discharging from a short-term inpatient treatment stay. Her care coordinator can connect Sasha with an Assertive Community Treatment team who will be dedicated to supporting Sasha in managing her condition and living independently in the community. Together, they will be able to work on her continued treatment and goals. Sasha will be able to access supported housing, better manage her medication and begin job coaching offered as a Supported Employment service.

Through CalAIM, DHCS is building a Medi-Cal system that is standardized, simplified and focused on helping individuals live healthier lives. The CalBH-CBC Demonstration will complement the state's efforts to strengthen California's behavioral health continuum of care and improve access to mental health services.

This concept paper describes DHCS' proposed approach to the CalBH-CBC Demonstration, provides information about the 2018 CMS guidance that establishes the demonstration opportunity and describes key features of the proposed demonstration. **Stakeholders are encouraged to review the concept paper and provide comments via email to CalBHCBC@dhcs.ca.gov no later than January 13, 2023, to inform the development of the demonstration application.** Stakeholders also will have the opportunity to respond to and comment on a complete draft of the demonstration application before it is submitted to CMS.

Federal Demonstration Opportunity and Requirements

The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration takes advantage of the Medicaid opportunity described in a November 2018 State Medicaid Director Letter (SMDL) detailing options to adopt innovative delivery system reforms for adults living with SMI and children living with serious emotional disturbance SED.[14] The SMDL describes how states can use existing authorities to improve care for these populations and outlines a new opportunity for Section 1115 demonstrations to support individuals living with SMI/SED.

The Section 1115 demonstration opportunity is focused on building out a full continuum of mental health services while also permitting states to secure FFP for services provided during short-term stays, defined as stays up to 60 days, in psychiatric hospitals or residential treatment settings that are considered IMDs.[15] In addition to excluding FFP for any part of any stay that exceeds 60 days, the Section 1115 demonstration opportunity also requires states to meet a statewide average length of stay of 30 days for all stays included in the demonstration.

CMS has recently allowed states to seek expenditure authority for services provided to children and youth involved in the foster care system in qualified residential treatment programs that are IMDs. These programs are referred to as short-term residential therapeutic programs (STRTPs) in California. There is an exemption on the length-of-stay limitations allowing residential treatment for up to two years. To obtain an exemption, states must provide CMS with a plan for transitioning children and youth out of STRTPs that are IMDs over a two-year period.[16]

CMS' goals for the demonstration opportunity include reduced utilization and lengths of stay in EDs among beneficiaries living with SMI/SED, reduced preventable readmissions to residential treatment settings, improved availability of crisis stabilization services, and improved care coordination and access to community-based services. In addition to the length-of-stay limitations referenced above, demonstration approval is contingent on states' provision of robust, evidence-based treatment options for community-based care and improved quality of care in various institutional settings, including a maintenance-of-effort requirement for community-based outpatient treatment, a strong crisis system, and appropriate oversight and monitoring of IMDs.

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[14] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[15] Ibid.

[16] CMS, "Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements," October 19, 2021. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf.

States must also describe plans to meet additional milestones outlined by CMS in a formal implementation plan, described in more detail in the “Demonstration Implementation and Phasing” section below and included in Appendix 2.

Proposed CalBH-CBC Demonstration Approach

Through the CalBH-CBC Demonstration, California intends to strengthen the provision, coordination and integration of mental health and SUD services across the continuum by building on the federal requirements set forth in CMS’ 2018 guidance. The demonstration approach reflects the state’s ongoing commitment to ensuring that services are provided in the least restrictive setting appropriate for a beneficiary’s needs. DHCS recognizes that a comprehensive continuum of community-based care for Medi-Cal beneficiaries living with SMI/SED, inclusive of housing supports and other community supports, ensures that residential care and inpatient care are available when medically necessary and clinically needed to stabilize and transition adults, children and youth to community-based care.

The proposed CalBH-CBC Demonstration includes five key components designed to strengthen the continuum of care available to Medi-Cal beneficiaries across the state with significant behavioral health needs. The five components – summarized below in Figure 3 and outlined in more detail in succeeding sections – are:

1. **Strengthening the statewide continuum of community-based services** and evidence-based practices available through Medi-Cal for individuals living with SMI or SED, leveraging concurrent funding initiatives, including clarifying coverage requirements for evidence-based practices for children and youth.
2. **Supporting statewide practice transformations** and improvements in the county-administered behavioral health system to better enable counties and providers to strengthen the continuum of community-based services and evidence-based practices; to improve the quality of care delivered in residential and inpatient settings; and to strengthen transitions from these settings to the community, including:
    - developing Centers of Excellence (COEs), as defined below;
    - offering incentives to counties for expanding quality improvement; infrastructure and improving performance on quality measures;
    - providing statewide tools to connect beneficiaries living with SMI/SED to appropriate care;
    - promoting and standardizing the quality of care in residential and inpatient settings; and
    - increasing coordination with wraparound supports and services, including housing supports.

3. **Improving statewide county accountability** for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance and oversight.
4. **Establishing a county option to enhance community-based services** through coverage of specific evidence-based practices that can reduce the need for institutional care and improve outcomes, particularly for individuals who are justice-involved or who are experiencing or at risk of homelessness. These services, which counties can cover on a voluntary, opt-in basis as indicated, include:
    - Assertive Community Treatment (ACT);
    - Forensic Assertive Community Treatment (FACT);
    - Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP);
    - Supported Employment;
    - Community Health Worker Services; and
    - Rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system.
5. **Establishing a county option to receive FFP for services provided during short-term stays in IMDs**, contingent on counties meeting robust accountability requirements. These requirements include ensuring that care is provided in an institutional setting only when medically necessary and in a clinically appropriate manner; that the county offers a full array of enhanced community-based services; and that the county reinvests any net new Medi-Cal funding into community-based care.

Specific features of the demonstration were designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI/SED (Figure 1). In identifying the key elements of the demonstration, DHCS also dedicated particular attention to the needs of populations that experience a disproportionate impact of behavioral health conditions, including children and youth, individuals who are experiencing or at risk of homelessness, and individuals who are justice-involved (Figure 2).[17] The proposed initiatives in the demonstration are also designed to benefit beneficiaries with the most severe impairments due to SMI and/or SUD, including those receiving services in Community Assistance, Recovery and Empowerment (CARE) Court. Through the CalBH-CBC Demonstration, DHCS intends to examine and address disparities in access and outcomes among American

[17] The CalCBC Demonstration will not directly address individuals who are currently deemed Incompetent to Stand Trial (IST). Per CMS guidance, "FFP will not be available through these demonstrations for services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the facility by operation of criminal law." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Indian/Alaska Native individuals, Black individuals and other populations experiencing worse health outcomes and inequities related to race, ethnicity, gender identity, sexual orientation, age or other demographic features consistent with DHCS' Comprehensive Quality Strategy.[18] DHCS, for example, intends to incorporate strategies to address these disparities into performance measurement and incentive programs under the CalBH-CBC Demonstration.

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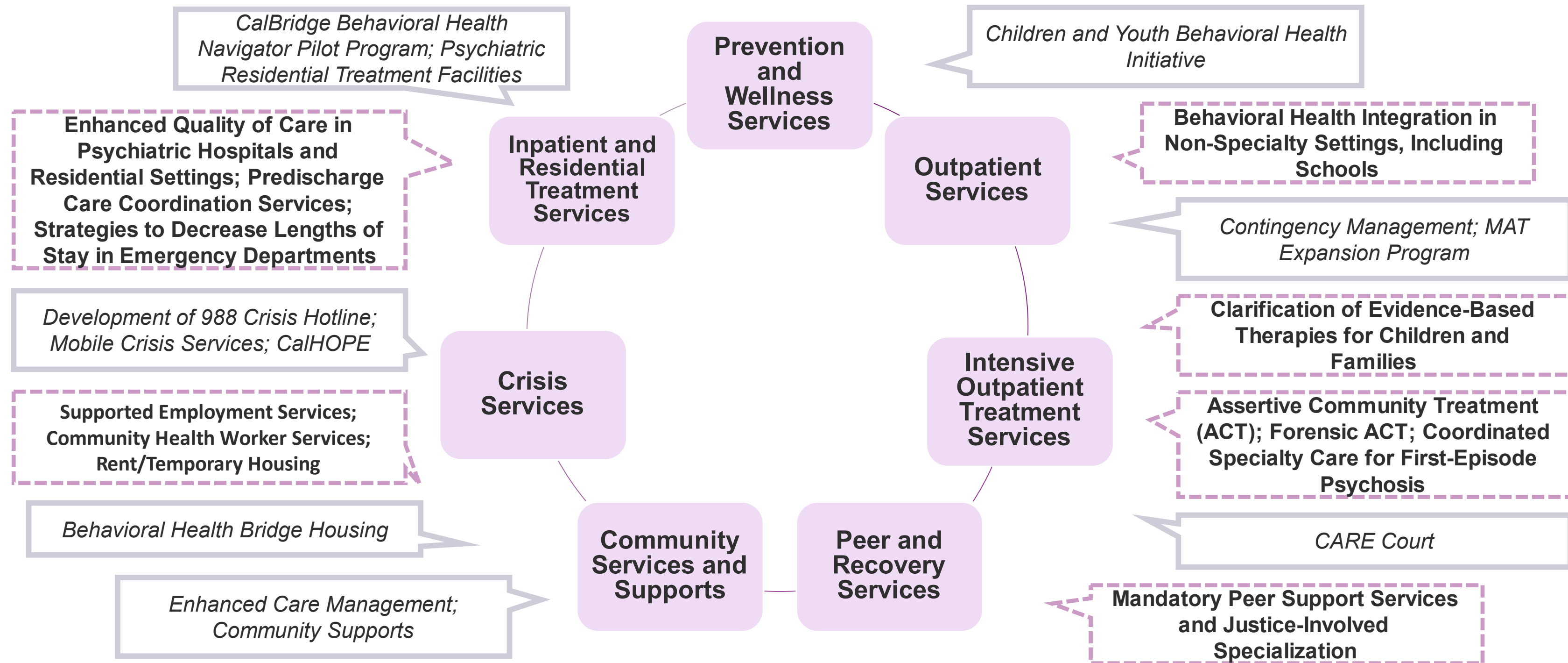
[18] DHCS, "Comprehensive Quality Strategy," 2022. Available at https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf.

Figure 1: Building Out the Continuum of Care for Individuals Living with SMI/SED

Key: Proposed CalBH-CBC Demonstration initiatives are in **bold with purple outline.** *Existing initiatives are italicized.*



Note: This depiction does not identify all ongoing initiatives; additional details about California's other initiatives and investments in behavioral health are detailed in Appendix 1. Some of the proposed CalBH-CBC Demonstration features are specific to counties that opt in to receive FFP for care provided during short-term stays in IMDs.

Figure 2: Populations of Focus

Children and Youth	Individuals Experiencing or at Risk of Homelessness	Individuals Who Are Justice-Involved
• Clarify statewide service coverage requirements and issue guidance for specific evidence-based family and in-home therapies. • Strengthen statewide, cross-agency coordination for children and youth in child welfare through a joint Child Welfare/Specialty Mental Health behavioral health assessment and a cross-sector incentive pool. • Provide activity stipends for children and youth in child welfare to promote social and emotional well-being and counteract the harmful effects of trauma.	• Establish new benefits to help beneficiaries find and keep employment and housing, including Community Health Worker Services and up to six months of rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system. • Incentivize counties to reduce homelessness among beneficiaries living with SMI/SED. • Coordinate with Medicaid managed care plans (MCPs) to connect beneficiaries to Community Supports, ECM and other related initiatives. • Strengthen behavioral health services for people with severe impairments, including those served by CARE Court.	• Offer new services specifically for individuals who are justice-involved, including Forensic Assertive Community Treatment; Supported Employment; Peer Support Services, including services with forensic (e.g., justice-involved) specialization; and up to six months of rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness and leaving correctional settings. • Provide technical assistance to increase collaboration with law enforcement and collaborative courts, including CARE Court.[19] • Coordinate with other statewide initiatives to support individuals who are justice-involved, including Community Supports, Enhanced Care Management, CalAIM Justice-Involved initiatives, and mobile crisis services.

[19] Community Assistance, Recovery and Empowerment (CARE Court); more information available at https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf.

Figure 3: Key Components of the CalBH-CBC Demonstration Proposal

Key Demonstration Components				
Statewide			**County Options**	
Strengthen Continuum of Community-Based Services	**Support Practice Transformations**	**Improve Statewide County Accountability for Medi-Cal Services**	**Option to Enhance Community-Based Services**[20]	**Option to Receive FFP for Short-Term Stays in IMDs**
• Clarification of Coverage Requirements for Evidence-Based Practices for Children and Youth: ○ Multisystemic Therapy ○ Functional Family Therapy ○ Parent-Child Interaction Therapy ○ Potentially Additional Therapeutic Modalities • Cross-Sector Incentive Pool for Foster Youth	• Statewide COEs • Statewide Incentive Program • Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care • Promotion and Standardization of Quality of Care in Residential and Inpatient Settings	• Transparent Monitoring Approach • Establishment of Key Performance Expectations and Accountability Standards in County Mental Health Plan Contract • Streamlined Performance Review Process	• ACT • FACT • Supported Employment • CSC for FEP • Community Health Worker Services[21] • Rent/Temporary Housing for Up to Six Months for Beneficiaries Who Meet the Access Criteria SMHS, DMC and/or DMC-ODS Services and Who are Homeless or at Risk of Homelessness, Including Individuals Transitioning from Institutional Care,	• FFP for Short-Term Stays in IMDs • Requirement to Provide All Enhanced Community-Based Services for Beneficiaries Living with SMI/SED • Incentive Program for Opt-In Counties • Other CMS Requirements Related to Accreditation and ED Strategy

[20] For individuals under 21, counties already must provide all medically necessary services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. In addition, elements of many of these services are covered as part of existing Medi-Cal benefits even if they are not currently billed as a bundled service. The Cal BH-CBC Demonstration will not remove or reduce any existing requirements for covered benefits.

[21] To support county behavioral health outreach and engagement.

Key Demonstration Components				
Statewide			County Options	
Strengthen Continuum of Community-Based Services	Support Practice Transformations	Improve Statewide County Accountability for Medi-Cal Services	Option to Enhance Community-Based Services[20]	Option to Receive FFP for Short-Term Stays in IMDs
• Activity Stipends for Youth in Child Welfare • Initial Child Welfare/Specialty Mental Health Behavioral Health Assessment at Entry Point into Child Welfare			Leaving Incarceration, and Youth Transitioning Out of the Child Welfare System	

Strengthening the Statewide Continuum of Community-Based Services

The CalBH-CBC Demonstration aims to expand and strengthen the continuum of community-based care, especially for children, youth and their families. While a comprehensive set of community-based services for children and youth is currently coverable under Medi-Cal pursuant to the EPSDT mandate, DHCS intends to establish clear guidance to support implementation of specific evidence-based practices statewide. DHCS proposes clarifying statewide coverage requirements and ensuring access to at least three specific evidence-based services that can be delivered at home or in the community under current Medi-Cal coverage authority: multisystemic therapy, functional family therapy and parent-child interaction therapy. These services are known to help reduce the institutionalization of high-risk children and youth, including those who are involved in the juvenile justice system and those who have been removed from their homes, experienced homelessness, or confronted other major disruptions. DHCS' guidance will include specific service definitions, provider qualifications, implementation requirements and dedicated billing codes to incentivize provider delivery and monitor utilization and performance.[22] With the COEs, resources will be available to support county and provider implementation of these and other services with fidelity to service models, and reflecting cultural factors and the diversity of California children and youth.

1. **Multisystemic Therapy** (MST). MST is an evidence-based intensive family- and community-based intervention for children and young people aged 11-17 who are at risk of out-of-home placement in either care or custody due to a history of arrest or behavioral health issues. DHCS intends to issue guidance to counties that clarifies and streamlines Medi-Cal coverage of and reimbursement for MST as a bundled service for qualifying children and youth.[23]

2. **Functional Family Therapy** (FFT). FFT is a family-based prevention and intervention program for high-risk youth between the ages of 11 and 18 that addresses complex and multidimensional problems with a flexibly structured and culturally responsive practice.[24] DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for FFT.

3. **Parent-Child Interaction Therapy** (PCIT). PCIT is an evidence-based, short-term treatment designed to teach parents strategies that will promote positive behaviors in children and youth who exhibit disruptive or externalizing behavioral

[22] While these three services could be clarified as covered through other mechanisms, DHCS proposes to include coverage requirements as part of the CalBH-CBC Demonstration as part of meeting CMS expectations that SMI/SED demonstrations build out community-based care options.

[23] Currently, MST is billable under discrete components through SMHS covered in the Medi-Cal State Plan.

[24] FFT is coverable under the SMHS therapy benefit in the Medi-Cal State Plan.

problems.[25] DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for PCIT.

In addition, the CalBH-CBC Demonstration may request authority from the federal government to make targeted improvements statewide for children and youth who are involved in the child welfare system. A substantial share of such children and youth have or are at risk of developing significant behavioral health conditions, both due to being removed from their homes and due to the circumstances that led to the removal.[26] With the goal of identifying improvements in the system of care for children and youth in child welfare, the California Department of Social Services (CDSS) and DHCS hosted a Foster Care Model of Care Workgroup between June 2020 and April 2021. While the CalBH-CBC Demonstration is not intended to serve as a vehicle for implementing a comprehensive approach to responding to these recommendations, it does propose to carry out a number of recommendations delivered by the workgroup.[27] DHCS intends to work with stakeholders to further consider how to best address the needs of children and youth in the child welfare system.

- **Cross-Sector Incentive Pool.** Given the complex and overlapping systems that serve children and youth in the child welfare system, DHCS proposes to establish a cross-sector incentive pool to collectively reward MCPs and county behavioral health and child welfare agencies for meeting specified outcome measures for children and youth in the child welfare system.[28] This cross-sector pool will incentivize the three systems to work together to address the needs of foster children and youth in their communities and address concerns about cross-sector accountability. Based on the initial implementation experience with children and youth in the child welfare system, DHCS may seek to expand this pool to promote improved outcomes and accountability for children and youth involved with juvenile justice and the Department of Developmental Disabilities. To facilitate shared accountability among the three systems, DHCS and CDSS may require contract changes and a Memorandum of Understanding to ensure MCPs and county behavioral health and child welfare agencies share data and work together to improve outcomes. As part of these contract changes, MCPs would be required to have a dedicated Foster Youth Liaison on staff to enable

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[25] PCIT is coverable under the SMHS therapy benefit in the Medi-Cal State Plan.

[26] Polihronakis, Tina, "Information Packet: Mental Health Care Issues of Children and Youth in Foster Care," April 2008. Available at http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/Mental_Health.pdf.

[27] DHCS, "Foster Care Model of Care Workgroup." Available at https://www.dhcs.ca.gov/provgovpart/Pages/Foster-Care-Model-Workgroup.aspx.

[28] To align with CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria, DHCS proposes to include children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the past 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

effective oversight and delivery of Enhanced Care Management (ECM). The Foster Care Liaison would have expertise in child welfare services, county behavioral health services, and other sectors; ensure appropriate ECM staff attend child and family team meetings; and ensure managed care services are closely coordinated with other services. The Foster Care Liaison would be a management-level position at the MCP with responsibility to oversee the ECM providers with foster care children and youth in their caseload, provide technical assistance to MCP staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with county and community partners.

- **Activity Stipends.** Many children and youth in child welfare do not have access to the activities that support physical health, mental wellness, healthy attachment and social connections – all protective factors that promote resilience and prevent mental illness and substance use. In response, DHCS intends to develop a new benefit for children aged 3 and older in the child welfare system to be used for activities to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful effects of trauma.[29] These payments would support activities not otherwise reimbursable in Medi-Cal, such as mindfulness-based stress reduction, movement activities, sports, leadership, nature activities, music and art programs, and other activities to support healthy relationships with peers and supportive adults. DHCS intends to request federal expenditure authority to support the activity stipends in the CalBH-CBC Demonstration application, which will be administered by the CDSS and county child welfare agencies.
- **Initial Child Welfare/Specialty Mental Health Assessment at Entry Point into Child Welfare.** As part of the Foster Care Model of Care Workgroup, the County Behavioral Health Directors Association and the County Welfare Directors Association proposed a joint home visit with the child welfare worker and a specialty mental health provider for every child or youth entering the child welfare system. DHCS proposes that a specialty mental health provider accompany the child welfare worker during the home visit, approximately 30 days following a hotline call, after a hearing substantiating an allegation of abuse or neglect, and upon the child's entry into the child welfare system. The specialty mental health provider would do a comprehensive behavioral health assessment to identify mental health and/or substance use conditions related to the child and/or the family, identify necessary social supports, and then connect the child and family

[29] To align with CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria, DHCS proposes to include children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the past 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

(both the biological family and the resource family, as appropriate) to any needed clinical or community services. As part of the CalBH-CBC Demonstration, DHCS proposes to develop standards and requirements for the behavioral health assessment and cross-agency collaboration.

Supporting Statewide Practice Transformations

DHCS recognizes that successful implementation of the proposed CalBH-CBC Demonstration will require significant new investments in workforce capacity, service infrastructure, information technology and data exchange at the county behavioral health plan and provider levels. Moreover, it is important to offer tools that help Medi-Cal beneficiaries living with SMI/SED find and use the appropriate treatment options. The CalBH-CBC Demonstration proposes to seek federal expenditure authority to fund statewide COEs, a statewide county behavioral health incentive program and tools to help ensure that beneficiaries are connected to the appropriate level of care. A separate incentive program available only to counties that opt to receive FFP for short-term stays in IMDs is discussed in the "County Option to Receive FFP for Short-Term Stays in IMDs" section below.

- **Statewide COEs.** DHCS proposes to establish and fund COEs to provide training and technical assistance to providers and counties on demonstration implementation. COEs can provide orientation, training, coaching, mentoring, fidelity monitoring and other supports needed to build and sustain capacity in delivering evidence-based practices through a culturally sensitive lens. For example, DHCS anticipates that COEs may provide support to counties and providers in delivering evidence-based practices for children and youth,[30] ACT/FACT services, Supported Employment, crisis services and other evidence-based practices (e.g., motivational interviewing, motivational enhancement therapy, suicide prevention). DHCS will engage stakeholders on opportunities to incorporate community-defined practices and cultural adaptations of evidence-based practices to ensure culturally and linguistically centered services, given the rich diversity in California's communities. One or more COEs might be established to support implementation of CARE Court in the context of the CalBH-CBC Demonstration, focused on ensuring CARE Court participants receive robust, evidence-based behavioral health services. Establishment of COEs will be aligned with other efforts to deliver training and supports to enhance delivery of evidence-based practices and community-defined practices, such as grant funding through the Children and Youth Behavioral Health Initiative.

[30] Evidence-based practices for children and youth may include services for which coverage and billing will be clarified, such as MST, FFT, and PCIT, as well as services for which coverage and billing is already clarified, such as Intensive Care Coordination.

- **Statewide Incentive Program.** DHCS recognizes the need for investments in county behavioral health plans to improve equity, quality and access to care for beneficiaries with behavioral health needs. As part of the CalBH-CBC Demonstration, DHCS intends to incentivize MHPs and DMC-ODS counties to build a robust quality improvement program, to improve performance on quality measures, and to reduce disparities in access and outcomes.

  All counties will be eligible to receive financial incentives based on their work to establish a robust quality infrastructure (e.g., integrating processes that allow it to assess and adjust provider availability and services to address the cultural, ethnic, racial, and linguistic needs and preferences of its members). In addition, after an initial period of quality infrastructure incentive opportunities, counties will later be able to receive financial incentives for demonstrating specific performance improvements. County performance improvement measurements will be based on various behavioral health-related quality measures included in the DHCS Comprehensive Quality Strategy (CQS)[31] Section 1915(b) Special Terms and Conditions[32] and Section 1115 SMI/SED Monitoring Protocol (DHCS' SMI/SED Monitoring Protocol, which must be developed by DHCS and approved by CMS in advance of demonstration implementation).[33,34] Performance improvement measurements will also include rates specific to populations experiencing disparities in behavioral health care access and outcomes, specifically children and youth; individuals who are justice-involved; individuals experiencing or at risk of homelessness; the LGBTQ+ population; and American Indian individuals, Black individuals and other populations experiencing disparities as identified in DHCS' Health Equity Roadmap.[35]

  Design features of this new statewide incentive program will be aligned with other DHCS incentive programs, such as the MCP baseline quality rate adjustment scoring methodology.

- **Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care.** Along with building out the continuum of care, it also is important to help identify the appropriate level of care for Medi-Cal beneficiaries and to connect them to treatment. As highlighted in the 2022 Assessment, it is

[31] DHCS, "DHCS Comprehensive Quality Strategy." Available at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx.

[32] "California Advancing & Innovating Medi-Cal (CalAIM) Waiver Special Terms and Conditions." Available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-stc.pdf.

[33] "1115 Demonstration State Monitoring & Evaluation Resources," Medicaid.gov. Available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html.

[34] "Monitoring Metrics for Section 1115 Demonstrations with SMI/SED Policies," Medicaid.gov. Available at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-monitoring-metrics.pdf.

[35] DHCS, "DHCS Comprehensive Quality Strategy." Available at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx.

unacceptable for anyone living with SMI or SED to wait days or weeks for treatment for urgent matters. As required by the 2018 CMS guidance and the CMS Implementation Plan, DHCS intends to use the CalBH-CBC Demonstration to review the required use of standardized, evidence-based level-of-care tools and develop resources to help individuals who require inpatient treatment find an appropriate facility.

- **Patient Assessment Tool.** DHCS proposes to build on the current SMHS requirement for using the Child and Adolescent Needs and Strengths (CANS) tools for children and youth aged 6-20 for performance data reporting purposes to help guide level-of-care determination and inform treatment planning for select intensive SMHS, including a stakeholder input process. For adults, aligned with requirements in Medi-Cal managed care, DHCS anticipates allowing county MHPs to choose from among available evidence-based assessment tools to guide level-of-care and length-of-stay determinations for mental health inpatient and residential treatment services (e.g., Level of Care Utilization System (LOCUS), InterQual or Milliman Clinical Guidelines (MCG)). CMS has instructed states to require providers and plans to use an evidence-based, publicly available patient assessment tool to help determine appropriate level of care and length of stay.[36]
- **Treatment Bed Availability Platform.** To meet the CMS requirement to improve its capacity to track the availability of inpatient and crisis stabilization units, DHCS is exploring options to track the availability of inpatient and crisis stabilization beds on a statewide basis, making it easier to help people who require higher levels of care to find appropriate treatment options more quickly.[37]

- **Promotion and Standardization of Quality of Care in Residential and Inpatient Settings.** DHCS proposes to build on CMS Implementation Plan requirements and use the CalBH-CBC Demonstration as an opportunity to ensure that all residential and inpatient facilities, including IMDs, provide care consistent with clinical and quality standards for utilization, integrated care, and care transitions. Clinical standards of care stipulate that residential and inpatient treatment providers identify and ensure that their patients' comorbid physical and/or SUD needs are treated. They also require that residential and inpatient care are used when clinically indicated, for only as long as needed to prepare individuals to transition to community-based care. To achieve these goals, DHCS intends to require all mental health inpatient and residential facilities to screen

[36] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

[37] Ibid.

and address beneficiaries' comorbid physical conditions and SUDs either directly or through the facilitation of referrals.

DHCS is committed to ensuring that individuals who are ready for discharge from inpatient and residential treatment are supported during the transition and connected to community-based services and supports, including housing. DHCS proposes to require all mental health and residential facilities and counties to meet CMS requirements related to employing a utilization review process to ensure access to appropriate levels of care and appropriate inpatient/residential admissions and length of stay, conducting intensive predischarge care coordination, incorporating housing needs during discharge planning and making referrals to community services before discharge, and following up with beneficiaries within 72 hours of discharge. In addition, as part of the demonstration, DHCS proposes adding a new county option to provide up to six months of rent/temporary housing for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness after receiving treatment in an institutional setting, further supporting counties' efforts to assist individuals in finding housing.

Improving Statewide County Accountability

DHCS plans to work with counties to strengthen the community-based care continuum, supporting behavioral health delivery system transformation through incentives, robust technical assistance and oversight. In partnership with counties and other stakeholders, DHCS proposes to design a transparent monitoring approach to ensure that an array of community-based care options are available and accessible to beneficiaries. The approach is expected to include clear expectations for providers, counties and DHCS, and to allocate resources in a way that reflects these expectations. The goal is to pair incentives and support with clear expectations and accountability to improve performance and better serve Medi-Cal beneficiaries.

Specifically, DHCS anticipates amending the county MHP contract to (1) establish key performance expectations and accountability standards, (2) build on goals and standards included in the state's Medi-Cal Comprehensive Quality Strategy and other quality and evaluation initiatives, and (3) outline incentive payment opportunities. For example, DHCS may amend the contract to include demonstration-related coordination requirements with the MCPs and other entities; new reporting requirements; and network adequacy requirements beyond those already in place, with associated penalties for noncompliance, consistent with DHCS sanction policies. Using measure reporting and on-site reviews, DHCS also envisions streamlining and enhancing its performance review process. DHCS is working toward a multiyear plan to transition from triennial SMHS to biennial to annual reviews over a five-year timeline. For example, counties may be required to report on new measures across key domains that align with the state's demonstration goals, including:

- increasing use of community-based behavioral health care, particularly for children and youth in child welfare and justice-involved individuals;
- diverting individuals experiencing crisis from EDs (as clinically appropriate), juvenile halls and jails;
- effective collaboration and support for Medi-Cal beneficiaries who become CARE Court respondents;
- improving coordination with MCPs for children involved in child welfare;
- addressing the behavioral health needs of individuals experiencing homelessness;
- improving beneficiary experiences;
- decreasing use of longer-term residential and acute inpatient treatment;
- making improvements in supporting individuals in the least restrictive, most independent and community-based setting that appropriately meets their needs; and
- strengthening provider networks.

As detailed above, DHCS also proposes to provide significant support to counties and providers through investments in training and technical assistance through the development of COEs and incentive programs. Finally, after other oversight approaches have been exhausted, DHCS may also utilize corrective action plans (CAPs) and sanctions for persistent gaps in performance, consistent with existing policies.

County Option to Provide Enhanced Community-Based Services

Under the proposed CalBH-CBC Demonstration, all counties will have the option to provide one or more important, evidence-based, community-based services to the extent not already covered or required to be covered under EPSDT. (As noted below, if a county opts in to receiving FFP for short-term stays in IMDs, it will need to provide all of these services.) The new services, including ACT, FACT, Supported Employment, CSC for FEP, Community Health Worker Services and rent/temporary housing,[38] offer important support to individuals with behavioral health needs and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system. These are established, evidence-based practices that can reduce the need for institutional care and improve outcomes, including for individuals who are justice-involved or who are experiencing or at risk of homelessness.[39]

[38] Rent/temporary housing services will be available for beneficiaries who meet the access criteria for SMHS, DMC and/or DMC-ODS services and who are homeless or at risk of homelessness, including individuals transitioning from institutional care, leaving incarceration, and youth transitioning out of the child welfare system.

[39] "Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration," Judge David L. Bazelon Center for Mental Health Law, September 2019. Available at http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf.

While components of ACT, FACT and CSC for FEP are currently coverable under Medi-Cal, DHCS proposes to cover each treatment as a bundled service to ensure they are fully reimbursable under Medi-Cal, to ensure access to these services as a Medi-Cal benefit, and to improve performance monitoring and visibility into service utilization. In parallel with the CalBH-CBC Demonstration, DHCS intends to submit a State Plan Amendment (SPA) authorizing county MHPs to deliver ACT, FACT, and CSC for FEP and Community Health Worker Services.[40] Similar to current Medi-Cal coverage of Peer Support Services, these benefits will be available as a county option. DHCS proposes to cover Supported Employment and rent/temporary housing through Section 1115 Demonstration authority. Consistent with current guidance, DHCS will clarify that beneficiaries under age 21 are entitled to receive all medically necessary services that are coverable under the State Plan, regardless of whether the beneficiary under the age of 21 resides in a county that chooses to cover these services on a voluntary basis.

- **ACT.** ACT provides a person-centered, comprehensive approach to care for individuals living with SMI, using a multidisciplinary team that typically consists of a psychiatrist, a nurse, case managers, peers and other professionals. ACT is widely considered to be one of the most robust community-based and cost-effective treatment options that can reduce institutional care and support individuals living with SMI who are at risk for involvement in the criminal justice system and for homelessness.[41] As of 2018, 33 states cover ACT as a Medicaid benefit.[42] In California, counties operate a similar model through Full Service Partnership (FSP) teams funded by the Mental Health Services Act (MHSA). While FSP teams provide a multidisciplinary approach to mental health care, they may not always operate with full fidelity to the evidence-based ACT model (e.g., not operating with clinical caseload, interdisciplinary team composition, frequency of team meetings and/or service availability consistent with the service model). Robust support and monitoring are essential for verifying that teams are delivering services in accordance with fidelity standards and facilitating intended outcomes for ACT services. By including ACT as a required benefit for opt-in counties, DHCS can optimize FFP for ACT services and help ensure that the

[40] To support county behavioral health outreach and engagement..

[41] SAMHSA. ACT EBP Kit. Available at https://store.samhsa.gov/sites/default/files/d7/priv/theevidence_1.pdf.

[42] Kaiser Family Foundation. "Medicaid Behavioral Health Services: Assertive Community Treatment." Available at https://www.kff.org/medicaid/state-indicator/medicaid-behavioral-health-services-assertive-community-treatment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

model is offered with fidelity.[43] ACT, along with FACT, also will be an important part of the services to which participants in CARE Court are likely to be referred.

- **FACT.** FACT builds on the evidence-based ACT model by making adaptations based on criminal justice issues – in particular, addressing criminogenic risks and needs.[44] FACT has been shown to improve the functioning of individuals who are enrolled in the treatment, as well as to reduce hospitalizations, homelessness, incarceration, and violations of probation and parole. In opt-in counties, FACT can complement parallel initiatives designed to better meet the health care needs of the justice-involved population, such as the CalAIM Justice-Involved Initiatives, the California Health and Human Services Agency (CalHHS) Incompetent to Stand Trial Workgroup, and Assembly Bill 1976.[45]

- **CSC for FEP.** CSC for individuals experiencing FEP is an evidence-based practice that has demonstrated improved outcomes for youth and young adults following an initial psychotic episode. Young adults participating in CSC programs experience significantly greater symptom reductions, fewer hospitalization episodes, and better school and work participation compared with those in usual treatment for early psychosis.[46] Most CSC programs currently operated in California counties are underwritten using Substance Abuse and Mental Health Services Administration (SAMHSA) funds, or MHSA or other state and local funds, and philanthropic contributions to supplement what is reimbursable by Medi-Cal. By including CSC for FEP in opt-in counties, California can dramatically improve the lives of individuals who often feel terrified and hopeless when confronting an initial psychotic episode.[47] This initiative would be coordinated with the Children and Youth Behavioral Health Initiative to ensure that work in this area is synergistic and not duplicative, particularly if CSC for FEP is chosen by the expert task force as one of the prioritized, evidence-based treatments.

- **Supported Employment.** Supported Employment is an evidence-based practice that helps individuals living with SMI obtain and maintain paid competitive jobs through vocational assessment, job-finding assistance and job skills training. It has been shown to reduce health care costs and to help keep individuals stably

[43] Many components of ACT are coverable under the Medi-Cal State Plan via existing benefits such as therapy or medication support services. Section 1115 authority would allow DHCS to cover ACT as a bundled service and include vocational services.

[44] SAMHSA, "Forensic Assertive Community Treatment." Available at https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf.

[45] Assembly Bill No. 1976, September 29, 2020. Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1976.

[46] Srihari VH et al., "First-Episode Services for Psychotic Disorders in the U.S. Public Sector: A Pragmatic Randomized Controlled Trial," Psychiatric Services, February 2, 2015. doi:0.1176/appi.ps.201400236. 66(7), 705-712.

[47] Many components of CSC are coverable under the Medi-Cal State Plan using existing benefits like targeted case management and medication support services. Section 1115 authority would allow DHCS to cover CSC as a bundled service and include vocational services.

housed by ensuring they have access to regular income.[48] Currently, some counties directly fund Supported Employment for some individuals living with SMI/SED and/or SUD, but it is not a Medi-Cal reimbursable service, and therefore counties are not able to leverage federal funding to expand access.[49] In addition, DHCS intends to seek authority to provide stipends to individuals who have experience with the criminal justice system and are reentering the community to encourage their ongoing participation in and completion of Supported Employment services, and promote community integration and improved outcomes.

- **Rent/Temporary Housing.** Housing supports, including services that help individuals find, move into and retain housing, are critical to the treatment and recovery of individuals living with serious behavioral health conditions. As part of the CalBH-CBC Demonstration, DHCS proposes to allow counties to cover rent/temporary housing for up to six months for certain high-need beneficiaries. Beneficiaries must meet the access criteria for SMHS, DMC and/or DMC-ODS services and be homeless or at risk of homelessness. This can include individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, inpatient and residential treatment facilities, and acute care hospitals from stays attributable to a mental health condition or substance use disorder; transitioning out of a correctional facility; or transitioning out of the child welfare system. Coverage of rent/temporary housing through the CalBH-CBC Demonstration will build upon other housing supports available through MCPs as Community Supports services, including housing transition navigation services, housing deposits to assist with one-time expenses, and housing tenancy and sustaining services. Rent/temporary housing services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria.
- **Community Health Worker Services.** Through the CalBH-CBC Demonstration, DHCS proposes to cover Community Health Worker Services as an optional service that counties can opt in to cover. The optional Community Health Worker Services benefit will support county behavioral health providers to perform outreach and support engagement of beneficiaries in behavioral health prevention and treatment services.

County Option to Receive Federal Financial Participation for Short-Term Stays in IMDs

As part of the CalBH-CBC Demonstration, counties that agree to certain conditions ("opt-in counties") can opt to receive FFP for services provided during short-term stays

[48] Bon, Gary and Robert Drake. "Making the case for IPS supported employment," Adm Policy Ment Health. 2014 Jan;41(1):69-73. doi: 10.1007/s10488-012-0444-6. PMID: 23161326.

[49] Other states, including Illinois, Washington and Maryland, have similarly used the SMI/SED demonstration opportunity to add Supported Employment as a covered benefit.

in IMDs consistent with applicable requirements described in federal guidance. To participate, a county must agree to cover the enhanced set of community-based services described above, reinvest dollars generated by the demonstration into community-based care (described in more detail in the "Demonstration Financing and Reinvestment" section below), and meet robust accountability requirements to ensure that IMDs are used when medically necessary and provide high-quality care. DHCS also intends to request authority in the CalBH-CBC Demonstration to establish an incentive program for opt-in counties that can be used to help counties and providers prepare for and sustain the implementation of demonstration features. In addition, as part of the implementation planning process (described in more detail in the "Demonstration Implementation and Phasing" section below), opt-in counties must demonstrate that beneficiaries have sufficient access to current SMHS benefits. A key condition for participation will be the proven availability of community-based services covered as SMHS so that the expansion of Medi-Cal coverage for inpatient and residential treatment provided in IMDs under this waiver facilitates access to such care only when medically necessary and clinically appropriate, and does not result in overutilization or inappropriate use of institutional care as a result of lack of access to community-based services.

- **FFP for Short-Term Stays in IMDs.** Opt-in counties may be able to secure FFP for the cost of Medi-Cal services provided to beneficiaries in IMDs during short-term stays.[50] To date, CMS has determined that a short-term stay covered under the demonstration can be no more than 60 days and that the statewide average length of stay must be no more than 30 days in participating IMDs. (There can be temporary exceptions for children and youth in STRTPs; these facilities would not be included in the calculation of the statewide average for a two-year period). Even under a demonstration, CMS will not cover the cost of room and board associated with the stay unless the setting qualifies as an inpatient facility under section 1905(a) of the Social Security Act. In addition, CMS guidance clarifies that FFP is not available for services provided in nursing homes that qualify as IMDs, nor for services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the IMD facility by operation of criminal law.[51]
- **Requirement to Provide All Community-Based Services for Beneficiaries Living with SMI/SED.** DHCS proposes requiring opt-in counties to cover all of

[50] Only beneficiaries whose County of Responsibility is an opt-in county will be able to access these services when medically necessary and clinically appropriate. FFP will not be available for services provided to beneficiaries in IMDs whose County of Responsibility does not opt in to this opportunity. For example, a county that does not opt in will not be able to receive FFP for services provided in an IMD to their residents, regardless of whether the IMD is located within another county that opts in. This is how the DMC-ODS program works today.

[51] DHCS continues to seek federal approval to cover a targeted set of Medi-Cal services during a 90-day period prior to release from prisons, jails and youth correctional facilities and improve care management through reentry as part of the CalAIM Justice-Involved Initiative. The CalAIM Justice-Involved Initiative does not propose to cover services provided in IMDs.

the enhanced community-based services described above, specifically ACT, FACT, CSC for FEP, Supported Employment, Community Health Worker Services, and rent/temporary housing. In addition, DHCS proposes requiring all opt-in counties to cover Peer Support Services, including for individuals who are justice-involved, through the Peer Support Specialist Certification Program with a forensic (i.e., justice-involved) area of specialization.[52]

- **Incentive Program for Opt-In Counties.** Opt-in counties may need to make significant investments to meet the requirements for receiving FFP for IMDs, including building networks for required benefits, conducting oversight of participating IMDs, and meeting other state and federal requirements. As part of the CalBH-CBC Demonstration, DHCS proposes implementing an incentive program for opt-in counties to support county MHPs and providers participating in the demonstration to prepare for and implement all of the enhanced community-based services that are required for counties seeking to opt in to the IMD opportunity. Counties that do not participate in the option to receive FFP for short-term stays in IMDs but that choose to implement all of the community-based services described above may also participate in the opt-in county incentive program. Counties that do not participate in the option to receive FFP for short-term stays in IMDs but that choose to implement none or some of the community-based services described above may not participate in the opt-in county incentive program but can still participate in the statewide county incentive program described above.

  Opt-in county MHPs may receive incentive payments for:

  - supporting startup and capacity development (e.g., receiving approval of implementation plan and implementing standardized universal patient release of information forms);
  - meeting process metrics (e.g., submitting first year of reporting on baseline for performance and participating in fidelity review on implementation of new benefits); and
  - demonstrating improved outcomes on new benefits.

  In each year of the program, DHCS anticipates requiring a portion of incentive payments earned to be passed through to provider organizations to support investments in workforce, data, information technology and other areas.

- **Meeting Other CMS Requirements.** In accordance with CMS Implementation Plan requirements, DHCS proposes requiring all mental health inpatient and residential facilities in opt-in counties to have accreditation from a nationally recognized entity, except for psychiatric hospitals that are certified by the California Department of Public Health (CDPH) as meeting the Medicare

[52] DHCS, "Behavioral Health Information Notice No: 21-041," July 2021. Available at https://www.dhcs.ca.gov/Documents/CSD_BL/BHIN-21-041.pdf.

Conditions of Participation.[53] In addition, MHPs in opt-in counties may need to describe strategies to prevent or decrease the lengths of stay in EDs among beneficiaries living with SMI/SED. These strategies may include strengthening crisis response and stabilization options, and successfully transitioning clients who seek care from a hospital ED to placements in their county behavioral health continuum. These strategies to prevent or decrease the lengths of stay in EDs will be included in the county implementation plans, described in more detail in the "Demonstration Implementation and Phasing" section below.

Demonstration Financing and Reinvestment

Demonstration Financing

The proposed CalBH-CBC Demonstration represents a significant expansion in the continuum of behavioral health care for Medi-Cal beneficiaries across the state. In particular, the demonstration is committed to expanding community-based benefits for people living with SMI and SED, including children and youth, and individuals who are experiencing or at risk for homelessness and incarceration; promoting practice transformation; incentivizing counties and providers to implement changes; and establishing tools to ensure that individuals are connected to the right type and level of care.

Continuing Investments in Behavioral Health

Currently, counties pay for the cost of care provided to many individuals in IMDs as well as other services not currently covered under Medi-Cal (e.g., ACT/FACT) using county funds such as MHSA and Realignment funds, as well as federal funds such as the SAMHSA Mental Health Block Grant for early SMI/FEP. If the CalBH-CBC Demonstration is approved, counties will begin receiving FFP for the cost of these services, allowing counties to maximize the use of their limited county resources for community-based care.

- **Leverage MHSA Funding.** In particular, county participation in the proposed CalBH-CBC Demonstration will allow counties to maximize limited MHSA funding to support community mental health services for individuals living with SMI and SED. Counties currently use MHSA funds within the Medi-Cal program. Counties also use MHSA to fund prevention and early interventions, as well as community services and supports for individuals with mental health needs and services for low-income individuals who remain uninsured.

  As detailed above, FSP programs commonly include services that are similar to ACT and FACT for individuals with SMI. While many components of ACT and FACT, including therapy and medication supports, are coverable under the Medi-Cal State Plan as discrete services, vocational supports and housing expenses

[53] "Psychiatric Hospitals," CMS.gov, December 2021. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PsychHospitals

are not covered. DHCS also does not currently cover ACT or FACT as a bundled service under the Medi-Cal program. Many counties are currently using limited MHSA funds to pay for ACT- and FACT-like services for Medi-Cal beneficiaries; while many of these dollars can be matched under Medi-Cal, a percentage cannot be without a new SPA clarifying State Plan coverage for ACT. Similarly, some counties currently provide Supported Employment and CSC for FEP to qualifying individuals, including Medi-Cal beneficiaries using MHSA funds. If the demonstration is approved, counties will be able to use MHSA funding for the nonfederal state share of these newly covered Medi-Cal services and will be able to draw down FFP.

- **Requirement to Reinvest in Behavioral Health.** DHCS proposes to extend this requirement to counties that take up the option to cover short-term inpatient and residential mental health care services in IMDs, as well to all counties that participate in statewide and county incentive programs to support quality improvement and practice transformation. DHCS is committed to ensuring the infusion of new Medi-Cal funding available through this Demonstration on a statewide and opt-in basis, including new FFP to support the delivery of services currently funded through MHSA and Realignment, or through and for statewide and county incentive programs are reinvested in the behavioral health delivery system. DHCS is committed to ensuring the new Medi-Cal funding available as a result of the CalBH-CBC Demonstration is reinvested in expanding the provision of behavioral health services and capacity in community-based settings.

  Accordingly, DHCS proposes that counties participating in the demonstration, including those receiving county incentive funding in the statewide and/or opt-in programs and providing certain services covered under the demonstration, will expend new funding from the demonstration on Medi-Cal behavioral health service provision, quality improvement or capacity expansion. DHCS intends to effectuate this requirement through a financing plan and amendments to state-county behavioral health contracts. DHCS proposes to require opt-in counties to submit an implementation plan (described in more detail in the “Demonstration Implementation and Phasing” section below) that will include a “financing plan” section to prompt the county to describe its proposed plan for reinvesting the equivalent amount of new Medi-Cal funding associated with its participation in the CalBH-CBC Demonstration into the provision or capacity expansion of behavioral health services. This will help position each county to use the new funding to address the unique behavioral health needs of its residents. The financing and implementation plan will be subject to DHCS approval. In addition, to ensure the new Medi-Cal funds available to all counties under the proposed county incentive program are reinvested in behavioral health service provision or capacity expansion, DHCS proposes to amend county MHP contracts and state-county DMC-ODS contracts.

The implementation plan requirements will provide examples of allowable reinvestment modalities that are not duplicative of concurrent funding initiatives (e.g., the Behavioral Health Continuum Infrastructure Program (BHCIP) or the Behavioral Health Quality Improvement Program (BH-QIP)). These allowable reinvestment modalities may include, but are not limited to:

- covering the nonfederal share of Medi-Cal behavioral health services;
- investing in housing and homelessness strategies and partnerships with community-based organizations and other relevant entities;
- supporting connections with other justice initiatives;
- providing wraparound services and supports not reimbursable by Medi-Cal;
- hiring additional behavioral health clinicians, providers and staff;
- enhancing provider payment rates (e.g., to build capacity and expand workforce); and
- investing in quality improvement infrastructure.

In addition, DHCS proposes to require counties to commit to maintaining aggregate behavioral health expenditure levels consistent with Realignment and MHSA statutory and regulatory requirements to ensure that funds deposited into behavioral health-related county accounts are not diverted, reduced or redirected from these accounts or expended for purposes other than allowable behavioral health service provision or administration provided for by these authorities.

Counties opting in to the Demonstration will be required to attest to this requirement in their implementation plan. DHCS intends to review each county's reinvestment proposal using structured and standardized evaluation criteria. DHCS may require counties to attest to their adherence to the approved financing plan and will develop a monitoring approach such that participating counties demonstrate compliance with the financing plan via administratively efficient methods. The approved implementation plan will be incorporated into the state-county MHP contract and state-county DMC-ODS contract by reference. DHCS proposes to amend all county behavioral health plan contracts to ensure that general funds and federal funds associated with the statewide county incentive programs are reinvested in behavioral health service provision or capacity expansion and that Realignment and MHSA funding is not diverted, reduced or redirected from allowable behavioral health provisions.

Demonstration Implementation and Phasing

DHCS intends for most proposed features of the CalBH-CBC Demonstration to "go live" at implementation but recognizes that some elements of the demonstration will take longer to stand up. In parallel with the demonstration application, DHCS intends to develop an implementation plan that describes how the state will meet a series of CMS milestones. DHCS, in turn, may require opt-in counties to demonstrate readiness to

participate in CalBH-CBC Demonstration activities by submitting a county-specific implementation plan.

CMS Implementation Plan

CMS has outlined a series of milestones that states and participating facilities must meet to receive IMD expenditure authority as part of the SMI/SED Section 1115 demonstration opportunity (Appendix 2).[54] In parallel with the CalBH-CBC Demonstration application, DHCS will submit a formal implementation plan to CMS that explains how California will meet all CMS requirements. This implementation plan must be approved by CMS before FFP will be available for any IMD expenditures. DHCS envisions applying many CMS requirements to opt-in counties and qualifying facilities and may require a select number of changes statewide. DHCS' approach to meeting the implementation plan milestones that are detailed in Appendix 2 include:

- **Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Promotion and Standardization of Quality of Care in Residential and Inpatient Settings" subsection above.
- **Improving Care Coordination and Transitions to Community-Based Care.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Promotion and Standardization of Quality of Care in Residential and Inpatient Settings" subsection above.
- **Increasing Access to Continuum of Care, Including Crisis Stabilization Services.** DHCS intends to build on ongoing investments to meet the requirements of this milestone statewide, including:
- **Increasing Availability of Community-Based Crisis Services.** In tandem with this Demonstration, DHCS and CalHHS are strengthening the crisis system using BHCIP and other investments focusing on 988 Lifeline Efforts, creation of a Mobile Crisis Medi-Cal benefit, and improved access to Crisis Stabilization Units.
    - **Treatment Bed Availability Platform.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Supporting Statewide Practice Transformations" section above.
    - **Patient Assessment Tool.** DHCS' approach to meeting CMS Implementation Plan requirements is expanded on in the "Supporting Statewide Practice Transformations" section above.
- **Earlier Identification and Engagement in Treatment, Including Through Increased Integration.** DHCS proposes to leverage key features of the CalBH-

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[54] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

CBC Demonstration to meet the requirements of this milestone to engage children and adolescents in treatment early, including through the provision of Supported Employment and CSC for FEP. The CalBH-CBC Demonstration will be synergistic, not duplicative, of efforts in the Children and Youth Behavioral Health Initiative and the Student Behavioral Health Incentive Program. CalHHS' Children and Youth Behavioral Health Initiative focuses on prevention and early intervention, including in schools and primary care settings, to help reduce children and youth's risk of developing serious mental, emotional and developmental challenges. DHCS' Student Behavioral Health Incentive Program aims to improve access to preventive, early intervention and behavioral health services by school-affiliated providers for Medi-Cal enrolled children and adolescents in grades TK-12 in public schools. As noted in the "County Implementation Plans" subsection immediately below, counties will be required to describe their strategy for meeting these requirements at a local level.

County Implementation Plans

Before implementing demonstration activities, opt-in counties may be required to submit and secure DHCS approval of an implementation plan that outlines how each county will meet the requirements for securing IMD funding. County implementation plans are expected to address the following:

- **Access and Network Adequacy for CalBH-CBC Demonstration Services and Existing Services.** A description of the county's approach to ensuring that beneficiaries will have sufficient access to new and current SMHS benefits, informed by a review of community-based SMHS service utilization. As noted above, a key condition for participation will be the proven availability of community-based services covered as SMHS so that the expansion of Medi-Cal coverage for inpatient and residential treatment provided in IMDs under this waiver facilitates access to such care only when medically necessary and clinically appropriate and does not result in overutilization or inappropriate use of institutional care as a result of lack of access to community-based services.
- **New Benefits Schedule.** A proposed schedule for offering new Medi-Cal benefits required as part of the CalBH-CBC Demonstration for opt-in counties. The schedule must be consistent with DHCS-determined time frames. (See an initial description in Figure 4 below.)
- **CMS Requirements.** A description of how the county will meet certain CMS-specified requirements included in DHCS' implementation plan submitted to CMS, including the requirements described above regarding accreditation and ED strategy.
- **Community Engagement Strategies.** A county's proposed strategy for working with community stakeholders during the implementation of CalBH-CBC Demonstration activities, including, at a minimum, beneficiaries living with mental

health conditions, advocacy groups, behavioral health providers, MCPs, law enforcement, CARE Court, other counties and Tribal partners.

- **Outreach to Populations of Focus.** Equity-centered strategies for expanding services and supports for populations disproportionately affected by SMI/SED or for whom gaps in care are particularly notable, including children and youth, especially those involved in the child welfare system; individuals who are justice-involved; and individuals who are experiencing or at risk of homelessness (including individuals involved in CARE Court).
- **Housing and Homelessness Strategies.** Strategies for engaging with MCPs and continuums of care (CoC),[55] working collaboratively with ongoing initiatives to link beneficiaries to housing services, and ensuring that inpatient and residential treatment facilities address each beneficiary's housing needs at discharge.
- **Integration.** Strategies for working toward whole-person care through greater integration and collaboration with MCPs, DMC-ODS and other stakeholders.
- **Reporting.** Plans to meet reporting requirements on key measures related to CalBH-CBC Demonstration activities and goals (e.g., referrals to ECM and Community Supports, readmission rate following IMD stay, number of ACT teams, and beneficiaries receiving ACT services).
- **Financing Plan.** Strategies to reinvest the new resources associated with services and expenditure authority covered under the CalBH-CBC Demonstration, and an attestation that a county will maintain behavioral health funding efforts.

Demonstration Phasing

DHCS intends to phase in implementation of proposed CalBH-CBC Demonstration activities. While it is anticipated most statewide demonstration activities will launch in year one of implementation, select initiatives that require a longer lead-up period will be phased into the demonstration during year two of implementation (see Figure 4).

In addition, opt-in counties may join the CalBH-CBC Demonstration at any time during the demonstration period to allow them time to meet the enhanced expectations associated with using Medi-Cal funding for short-term stays in IMDs. Most demonstration activities specific to opt-in counties will be implemented upon a county's launch date, with others phased in within the first two years of county participation (see Figure 4).

DHCS will conduct stakeholder engagement throughout the demonstration design process.

[55] A CoC is a regional or local planning body that coordinates housing and services funding for homeless families and individuals on behalf of the U.S. Department of Housing and Urban Development.

Figure 4: CalBH-CBC Demonstration Timeline

<table>
<tr><th colspan="2">Demonstration Timeline</th></tr>
<tr><td colspan="2">Launch Statewide Activities</td></tr>
<tr><td>Year One of Implementation</td><td>

Clarification of existing Children- and Family-Focused Benefits
MST
FFT
PCIT
Potentially Additional Therapeutic Modalities
Performance Supports
Statewide COEs
Statewide County Incentive Program
Meet County Accountability Requirements
</td></tr>
<tr><td>Year Two of Implementation</td><td>

Performance Supports
Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care
Promotion and Standardization of Quality of Care in Residential and Inpatient Settings
Supports for Youth in Child Welfare
Cross-Sector Incentive Pool
Activity Stipends
Initial Child Welfare-Specialty Mental Health Assessment at Entry Point into Child Welfare
</td></tr>
<tr><td colspan="2">Launch County Option Benefits</td></tr>
<tr><td>Rolling Basis</td><td>

County Option to Provide Enhanced Community-Based Services:
ACT
FACT
CSC for FEP
Supported Employment
Community Health Worker Services
Rent/Temporary Housing
</td></tr>
<tr><td>Upon IMD Opt-In County Go-Live
(anticipated rolling basis)</td><td>

County Option to Receive FFP for Short-Term Stays in IMDs
Meet Requirement to Provide Community-Based Services for Beneficiaries Living with SMI/SED:
ACT
Peer Support Services, Including Justice-Involved Specialization
Opt-In County Incentive Program (startup and capacity development milestones)
Meet County Accountability Requirements
Meet CMS Accreditation and ED Strategy Requirements
</td></tr>
</table>

Demonstration Timeline	
Within Two Years of IMD Opt-In County Go-Live	• Meet Requirement to Provide Community-Based Services for Beneficiaries Living with SMI/SED: o FACT o Supported Employment o Community Health Worker Services o Rent/Temporary Housing • Opt-In County Incentive Program (process metrics (e.g., participating in COE training and meeting performance benchmarks for new Medi-Cal benefits))

Appendix 1: California's Major Behavioral Health Initiatives

The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration was designed to complement and build on California's other major behavioral health initiatives. These initiatives include, but are not limited to, children- and youth-focused initiatives, enhanced supports for populations of focus, other initiatives to strengthen the continuum of care, and behavioral health delivery system reforms.

Children- and Youth-Focused Initiatives

- **Children and Youth Behavioral Health Initiative (CYBHI).**[56] CYBHI is a $4.4 billion investment to enhance, expand and redesign the systems that support behavioral health for children and youth. The goal of CYBHI is to reimagine mental health and emotional well-being for all children, youth and families in California by delivering equitable, appropriate, timely and accessible behavioral health services and supports.
- **Student Behavioral Health Incentive Program (SBHIP).**[57] SBHIP includes a designated $389 million over a three-year period from January 1, 2022, to December 31, 2024, to increase the number of Medi-Cal enrolled children and adolescents receiving behavioral health services through schools and improve coordination of child and adolescent behavioral health services through increased coordination with schools, MCPs, counties and mental health providers. The programs will distribute incentives to MCPs that meet goals and metrics associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools.
- **Complex Care Capacity Building.**[58] Assembly Bill 153 provided $43.3 million in funding to 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 in the least restrictive setting, consistent with the child's permanency plan.

[56] CalHHS, "Children and Youth Behavioral Health Initiative," May Revision 2021-22. Available at https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.

[57] DHCS, "Student Behavioral Health Incentive Program (SBHIP) Application, Assessment, Milestones, Metrics." Available at https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SBHIP-Overview-and-Requirements-2-1LR.pdf.

[58] CDSS, All County Letter No. 21-143, November 2021. Available at https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2021/21-143.pdf?ver=2021-11-17-115026-727.

Enhanced Supports for Populations of Focus

- **CalAIM Justice-Involved Initiatives.**[59] CalAIM Justice-Involved Initiatives support justice-involved individuals by enrolling individuals in prisons, jails and youth correctional facilities in Medi-Cal coverage, providing key services pre-release, and connecting them with behavioral health, Enhanced Care Management, social services and other providers that can support their reentry.
- **Behavioral Health Bridge Housing.**[60] The 2022-23 California State Budget includes $1.5 billion in general fund spending over two years to provide short-term housing and treatment supports intended to transition individuals living with significant behavioral health needs out of unsheltered homelessness into a stable living environment in advance of further placement into permanent housing.
- **Felony Incompetent to Stand Trial (IST) Waitlist Solutions.**[61] The 2022-23 California State Budget includes $535.5 million in general fund spending in 2022-23, increasing to $638 million per year in 2025-26 and ongoing at the Department of State Hospitals for solutions focusing on Early Stabilization and Community Care Coordination and Expanding Diversion and Community-Based Restoration Capacity for the IST population.
- **Housing and Homelessness Incentive Program.**[62] As a means of addressing social determinants of health and health disparities, the Housing and Homelessness Incentive Program allows MCPs to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. MCPs and the local homeless continuum of care, in partnership with local public health jurisdictions, county behavioral health, public hospitals, county social services and local housing departments, must submit a homelessness plan to the Department of Health Care Services (DHCS).
- **Community Assistance, Recovery and Empowerment (CARE) Court.**[63] CARE Court will provide mental health and substance use disorder services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need. CARE Court is not for everyone experiencing homelessness or mental illness; rather, it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity – to serve these

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[59] DHCS, "CalAIM Justice-Involved Advisory Group Kickoff Meeting," October 2021. Available at https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-Justice-Involved-Advisory-Group-Kickoff-Deck10272021.pdf.

[60] "California State Budget Summary – 2022-23," Health and Human Services. Available at https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

[61] Ibid.

[62] DHCS, "Housing and Homelessness Incentive Program," March 2022. Available at https://www.dhcs.ca.gov/services/Pages/Housing-and-Homelessness-Incentive-Program.aspx.

[63] "Governor Newsom's New Plan to Get Californians in Crisis Off the Streets and into Housing, Treatment, and Care," March 2022. Available at https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf.

Californians before they enter the criminal justice system or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship. It connects a person in crisis with a court-ordered CARE Plan for up to 12 months, with the possibility of extending for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services, including a housing plan.

Other Initiatives to Strengthen the Continuum of Care

- **CalAIM Enhanced Care Management (ECM).**[64] As a key part of CalAIM, ECM is a new statewide Medi-Cal benefit available to select populations of focus that will address clinical and nonclinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet beneficiaries wherever they are – on the street, in a shelter, in their doctor's office or at home. Beneficiaries will have a single lead care manager who will coordinate care and services among the physical, behavioral, dental, developmental and social services delivery systems, making it easier for them to get the right care at the right time.

  Effective July 1, 2023, the ECM benefit will launch statewide for the Children and Youth Involved in Child Welfare population of focus. The Children and Youth Involved in Child Welfare population of focus includes children and youth who meet one or more of the following conditions:

  - Are under age 21 and are currently receiving foster care in California
  - Are under age 21 and previously received foster care in California or another state within the past 12 months
  - Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
  - Are under age 18 and are eligible for and/or in California's Adoption Assistance Program
  - Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months

- **CalAIM Community Supports.**[65] Community Supports are new services provided by Medi-Cal MCPs as cost-effective alternatives to traditional medical services or settings. Community supports are designed to address social drivers of health (factors in people's lives that influence their health). All Medi-Cal MCPs are encouraged to offer as many of the 14 preapproved Community Supports as

[64] DHCS, "CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program." Available at https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices.
[65] Ibid.

possible, which are available to eligible Medi-Cal members regardless of whether they qualify for ECM services.

- **Recovery Incentives: California's Contingency Management (CM) Program.**[66] CM is an evidence-based treatment that provides incentives to treat people living with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests negative for stimulants. While CM has been tested using other sources of funding, California is the first state in the country to receive federal approval to offer CM as a Medicaid benefit through the Recovery Incentives Program.
- **Medication-Assisted Treatment (MAT) Expansion Program.**[67] The California MAT Expansion Project aims to increase access to MAT, reduce unmet treatment need, and reduce opioid overdose-related deaths through the provision of prevention, treatment and recovery activities. The California MAT Expansion Project focuses on populations with limited MAT access, including those in rural areas and American Indian and Alaska Native Tribal communities.
- **Behavioral Health Continuum Infrastructure Program (BHCIP).**[68] BHCIP 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. A portion of the funding is available for increased infrastructure targeted to children and youth aged 25 and younger.
- **CalBridge Behavioral Health Navigator Pilot Program.**[69] The CalBridge Behavioral Health Navigator Pilot Program provides grants and technical assistance totaling $40 million to acute care hospitals to support hiring trained behavioral health navigators in EDs to screen patients and, if appropriate, offer intervention and referral to mental health or SUD programs. Training and technical assistance are provided by California Bridge, a program that supports screening and treatment of SUD in EDs, including MAT for opioid use disorder. The program is funded by California's Home- and Community-Based Services (HCBS) Spending Plan.

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[66] DHCS, "DMC-ODS Contingency Management." Available at https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx.

[67] DHCS, "The California MAT Expansion Project Overview." Available at https://www.dhcs.ca.gov/individuals/Pages/MAT-Expansion-Project.aspx.

[68] DHCS, "The Behavioral Health Continuum Infrastructure Program." Available at https://www.dhcs.ca.gov/services/MH/Pages/BHCIP-Home.aspx#:~:text=The%20Behavioral%20Health%20Continuum%20Infrastructure%20Program%20(BHCIP)%20provides%20the%20Department,expand%20the%20community%20continuum%20of.

[69] DHCS, "Medicaid Home- and Community-Based Services (HCBS) Spending Plan: Quarterly Reporting for Federal Fiscal Year 2021-2022," October 2021. Available at https://www.dhcs.ca.gov/Documents/HCBS-Spending-Plan-Q2-Final-Report.pdf.

- **988 Crisis Call Hotline.**[70] DHCS invested $20 million in California's network of emergency call centers to support the launch of the new national 988 hotline for people seeking help during a behavioral health crisis.
- **Medi-Cal Community-Based Mobile Crisis Intervention Services.[71]** The 2022-23 California State Budget designated $1.4 billion ($335 million in general funds) to add qualifying community-based mobile crisis intervention services as a Medi-Cal covered benefit through the Medi-Cal behavioral health delivery system.
- **CalHOPE.**[72] CalHOPE delivers crisis support for Californians experiencing stress and trauma. Services include individual and group crisis counseling and support, individual and public education through media, community networking and support, connection to resources, and media and public service announcements. Expanding CalHOPE to support children and youth access to virtual behavioral health services and interactive tools is a key component of CYBHI.[73]

Behavioral Health Delivery System Reforms

- **CalAIM Behavioral Health Payment Reform.**[74] DHCS plans to transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. This shift will enable counties to participate in broader delivery system transformation, engage in value-based payment arrangements with other delivery system partners, and make long-term investments in mental health and SUD delivery systems at the local level.
- **CalAIM No Wrong Door.**[75] DHCS is adopting a "no wrong door" approach to help enrollees more easily and quickly access mental health and SUD services. Beneficiaries will receive clinically appropriate and covered services regardless of the delivery system through which they seek care. Services rendered in good faith will be reimbursed by the provider's contracted plan during assessment.
- **CalAIM Screening and Transition Tools.**[76] DHCS worked with stakeholders to develop standardized screening and transition tools that are specific to

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[70] DHCS, "California Dedicates $20 Million to Support New Mental Health '988' Crisis Hotline," September 2021. Available at https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2021/21-06-988-Line.pdf.

[71] "California State Budget Summary – 2022-23," Health and Human Services. Available at https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

[72] "CalHOPE." Available at https://www.calhope.org/Pages/default.aspx.

[73] CalHHS, "Children and Youth Behavioral Health Initiative," May Revision 2021-22. Available at https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.

[74] DHCS, "CalAIM Behavioral Health Workgroup." Available at https://www.dhcs.ca.gov/provgovpart/Pages/bhworkgroup.aspx.

[75] DHCS, "Behavioral Health Stakeholder Advisory Committee (BH-SAC) meeting," October 21, 2021. Available at https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf.

[76] Ibid.

individuals under the age of 21 for use by county mental health plans (MHPs) and MCPs across the state.[77]

- **CalAIM Updated Specialty Mental Health Services (SMHS)[78] and DMC/DMC-ODS Criteria.** DHCS updated criteria for accessing SMHS and DMC/DMC-ODS services to streamline beneficiaries' access to care. The updated criteria will cover services during the assessment period, allow treatment without confirmed diagnosis, and expand specialty mental health access criteria to include experience of trauma, such as homelessness, child welfare or juvenile justice involvement.
- **CalAIM Documentation Redesign.**[79] DHCS updated and modernized SMHS and DMC/DMC-ODS documentation requirements to focus on appropriate oversight, reduce administrative burden on clinicians and maximize resources for direct client care. Key updates include replacing the static, point-in-time treatment plan with the dynamic problem list, using standardized domain-driven assessments, requiring overall leaner documentation, and determining disallowances based on fraud, waste and abuse.
- **Behavioral Health Integration (BHI) Incentives Program.**[80] As authorized under Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care, the objective of the BHI Incentives Program is 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.

[77] DHCS, "Assessing the Continuum of Care for Behavioral Health Services in California," January 2022. Available at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.
[78] Ibid.
[79] Ibid.
[80] DHCS, "Behavioral Health Integration Incentive Program Application." Available at https://www.dhcs.ca.gov/provgovpart/Pages/VBP_BHI_IncProApp.aspx.

Appendix 2: CMS Implementation Plan Milestones

The Centers for Medicare & Medicaid Services' (CMS) approval of Section 1115 demonstrations to support individuals living with serious mental illness (SMI)/serious emotional disturbance (SED) is contingent on states meeting a series of milestones. The milestones are listed below.

Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity, including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving federal financial participation (FFP) for services provided to beneficiaries.
- Establishment of an oversight and auditing process that includes unannounced visits to ensure participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements, as well as a national accrediting entity's accreditation requirements.
- Use of a utilization review entity (e.g., 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.
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment 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).
- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for comorbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address comorbid 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).

Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive predischarge care coordination services to

help transition beneficiaries out of these settings and into appropriate community-based outpatient services as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment).

- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings, and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available.
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to.
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries living with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers).
- Implementation of strategies to develop and enhance interoperability and data sharing among physical, SUD and mental health providers, with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries living with SMI or SED.

Increasing Access to Continuum of Care, Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability.
- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of nonhospital, nonresidential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers, as well as ongoing community-based services.
- 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.
- 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 help determine appropriate level of care and length of stay.

Earlier Identification and Engagement in Treatment, Including Through Increased Integration

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