From: DHCS BH-CONNECT
To: [redacted]
Subject: RE: [External]Where is the BH Draft Waiver Posted?
Date: Tuesday, August 1, 2023 9:29:00 AM

Hello,
Thank you for contacting the BH-CONNECT team. The draft BH-CONNECT demonstration application is live now for public review and comment. All information regarding the draft application and public comment period will be posted on the BH-CONNECT website. You may continue to send questions or feedback related to the BH-CONNECT demonstration to BH-CONNECT@dhcs.ca.gov.
Regards,
The BH-CONNECT Team
Department of Health Care Services

From: Diane VanMaren [redacted]
Sent: Tuesday, August 1, 2023 8:43 AM
To: DHCS BH-CONNECT <BH-CONNECT@dhcs.ca.gov>
Subject: [External]Where is the BH Draft Waiver Posted?

Hello DHCS,

I see the public meeting notice but no Draft Waiver.

Where is it located please?

Thank you.
Diane

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]Public Comment on BH-CONNECT and CalAIM Transitional Rent Services
Date: Thursday, August 3, 2023 5:38:57 PM
Attachments: Outlook-Logo Desc.png

Dear Sir/Madame

I am so happy to see that DHCS CALAIMs is proposing a Transitional Rent Amendment. California is in crisis for housing and especially affordable housing. As a retiree, by the Grace of God go I. When I was a young black mother with a husband suddenly disabled by a heart attack and caring for 4 children, housing was more that 40 percent of our income. What a struggle! I understand how families are burdened with housing cost, and today the scarcity of housing is worse than ever. But I am proud to be living in California where leaders are seriously trying to solve this problem that has so many tentacles of social problems and issues.

As I work with homeless women, and mothers with children, I know they deserve better, and this state can provide it.

Thank you,

Linda R. Johnson
Program Director, Mothers and Baby Homes
[redacted]
Because We Believe a
Healing Home is the First Step!
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]Negative consequences
Date: Thursday, August 10, 2023 2:51:59 PM

Thank you for taking public comment on the State's promotion of a social service sanctuary State.

We see the devastating consequences of promoting Behavorial and Mental health issues, and the problems are getting worse.

Instead of social services, we need work programs. More people need to be working. Both for a persons community, and for themselves. A person is likely to have depression or substance abuse problems if they don't have a productive job.

Stop dealing with the consequences and begin fixing the problems.

Government should NOT be providing health care services. (Period)

Thanks for taking my comments,
Branden Bieber
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]"BH-CONNECT Demonstration"
Date: Saturday, August 12, 2023 10:55:24 AM

I say NO! No more funding until you INCLUDE those for whom you are funding programs in the planning and processing. Stop the sanism and tolkenism that is running the healthcare services in the state!

I have NEVER seen such direct and blatant disregard for the rules, regulations and legislative intent at the same time, millions and millions of tax dollars are being ripped off literally!!!

I live in a "Supported" housing project under MHSA! What A JOKE!!! I mean we LITERALLT have people JUMPING OFF THE BUILDING TO THEIR DEATH AND NO ONE GIVES A SHIT!!!!

I found over 1.1 MILLION in PAID FOR but UNBUILT amenities and WE HAVE NO PORTABILITY! WE ARE PRISONERS HERE IN SPITE OF CALFHA SAYING WE SHOULD BE ABLE TO MOVE< AND WE HAVE NO REMEDY!

THIS IS AWEFUL! SINFUL! STOP FUNDING EVERY HSIPR BRAIN IDEA SOME IDIOT COMES US WITH AND THEY GUT AFTER A COUPLE YEARS ANYWAY!!!

THIS IS OUR LIVES PEOPLE!!!

Diana Heineck

SHAME ON ALL OF YOU FOR LETTING THIS HAPPEN TO CITIZENS WHO WORKED HARD AND PUT INTO THE SYSTEM! SHAME ON ALL OF YOU!!!

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]Public release of August 11, 2023 BH Connect PowerPoint Slides presentation
Date: Tuesday, August 15, 2023 1:26:58 PM

Good afternoon:

It is now Tus.,, Aug. 15, 2023 and the PowerPoint slides from the DHCS Zoom public presentation this past Fri., Aug. 11, 2023. When will they finally be posted on the DHCS website? From my family member participant perspective, failure to post these slides on the DHCS website is a deliberate attempt to stifle much needed public discussion and comment. If they are not posted shortly, will contact my state senator and assembly member and let them know what's going on. Do I make myself clear? Stop the stalling!

Douglas Dunn

Sent from Mail for Windows

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Friday, August 18, 2023 9:09:54 PM

[redacted]

To whom it may concern,

I strongly believe that the proposed new Medicaid demonstration project under Sections 1115 of the Social Security Act to expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with serious mental illness and serious emotional disturbance is going to drastically improve the overall health outcome of the Medi-Cal recipients. Being a Medi-Cal recipient myself, I understand where there is a gap in the series available for the community. I personally believe that poor mental health can greatly influence and impact your quality of life and your health outcome. People who request government aid, already cannot afford the basics, so they definitely would not be able to afford seeking any decent mental help. I think allowing these resources to be covered by our insurance, would help solve the root of many issues at both the community level and the personal level including homelessness and substance use. I strongly support this investment in building out the full continuum of care or behavioral health, with a special focus on populations more at risk.

Sincerely,
Sonia Solano

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Friday, August 18, 2023 9:41:40 PM

[redacted]

To whom it may concern-

I am writing to express my enthusiastic support of the proposed application for the new Medicaid Section 1115 Demonstration to increase mental health services for medical members. As a recipient of Medical, I have experienced the difficulty of accessing mental health services, as the county mental health services offered to me in a time of need were extremely under-resourced and in high demand. Mental health is a pivotal component of individual and community health, and I would be thrilled if emotional support services were as readily available to medical recipients as primary care and emergency care is. The increase in cost, paid for by the tax-payers dollar, can be justified by the millions of dollars that will be saved preventatively by mental health services. With available mental health care, our communities will be safer, happier and more resilient.

Thank you,
Sophie Smith
Solano County Resident

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH CONNECT Demonstration--Public Comment Letter from Sycamores
Date: Thursday, August 24, 2023 5:28:48 PM
Attachments: [redacted]

[redacted]

Dear DHCS representatives,

Hello! My name is Wendy Wang and I work for Sycamores, a nonprofit organization that provides an array of mental health services in Southern California. I am writing to submit our public comments on the BH CONNECT Demonstration application. Please see our formal letter attached.

If you have any questions or concerns about our feedback, please contact me at [redacted]

Best regards,
Wendy

August 24, 2023

Mr. Tyler Sadwith
Deputy Director, Behavioral Health
California, Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: BH-CONNECT Demonstration

Dear Deputy Director Sadwith,

Sycamores appreciates the opportunity to provide its public comments on the Department of Health Care Services' proposed BH-CONNECT Section 1115 application. As a nonprofit organization based in Southern California, Sycamores provides an array of services along the behavioral health continuum of care including in-person mobile crisis response under the 9-8-8 network. Although serving multiple age groups, Sycamores specializes in serving youth and families in the foster care system and transition age youth (18-25 years old) who are experiencing homelessness. We support the overarching vision of the BH-CONNECT which is to expand access and to strengthen the continuum of community-based behavioral health services for Medi-Cal beneficiaries who have serious mental illness (SMI) or serious emotional disturbance (SED) and/or substance use condition (SUD). The DHCS' Demonstration is ambitious and contains multiple components to achieve its goals. Given the complexity and scale of the Section 1115 application, Sycamores supports the proposed "phase in" approach for implementation.

Sycamores respectfully submits the following observations and questions for your consideration.

Existing Federal Medicaid Authorities-Evidence Based Practices

DHCS intends to clarify coverage requirements for evidence-based practices for children and youth under Medi-Cal EPSDT including Multi-Systemic Therapy (MST), Family Functional Therapy (FFT), Parent Child Interactive Therapy (PCIT) and other modalities.

While clarification of coverage requirements is important, Sycamores urges DHCS to consider the comprehensive resources necessary to scale these practices statewide and sustain implementation of FFT, MST, CIT, and other practices. We strongly recommend that DHCS set aside a percentage of the Demonstration funds or identify other state funding streams to support counties and their contract provider networks to implement the specified modalities.

- As designed, MST provides 24/7 treatment access to consumers. What additional implementation support will be given to ensure appropriate staffing, sustain the treatment team(s), technical support for technology, and other logistical support to sustain the delivery of these services?
- MST training protocols require 5-day training and weekly consultation calls and supervisor training protocols. How will counties and their contract provider networks have access to timely training and timely reimbursement for training costs?
- Family Functional Therapy may involve a 3-year (3-phases) implementation. The training protocol requires 11 days of training and additional weekly consultations all in the first year. What is the

plan for the state and counties to cover the full cost of the trainings since trainings will take time away from staff who are providing direct care to consumers?

- Parent Child Interactive Therapy (PCIT)'s protocols involve a 10-hour web course, additional post-web-course skill building, one hundred training hours and case completion. Because of the model, counties and their contract providers network will need funds for the required room set-up, reliable equipment for the bug-in-the-ear technology for coaching, appropriate toys, and other materials. Will DHCS provide the funding for this infrastructure?

Given the workforce crisis in the public specialty behavioral health system, identifying evidence based practices that rely on both professionals and paraprofessionals through a train-the-trainer approach will be prudent. The selection of FFT, MST, and PCIT relies on clinicians which will make it more difficult to sustain long term given the shortage of clinicians. The sustainability of these three identified EBPs rests on the abilities of counties and their community based providers to recruit and retain their workforce. DHCS must strongly consider allocating a percentage of the Workforce Initiative in this Demonstration to community-based providers so that they can elevate the salaries of staff who agree and are trained in a range of modalities. Under the current reimbursement system, nonprofit organizations that contract with counties' behavioral health departments are not able to offer competitive salaries or benefits when compared to school districts, health plans, or county departments. Unless the underlying factors of the workforce crisis are addressed, requirements for the "scaling up" of specified EBPs that rely on clinicians are unrealistic.

- The FFT model requires a team of 3 to 8 therapists all with master's degrees.
- MST requires a team of clinicians and supervisors.
- PCIT can only be implemented by clinicians and train-the-trainers who are also clinicians/supervisors.

Existing Federal Medicaid Authorities- Assessment at Point of Entry into Child Welfare

DHCS seeks to create an initial child welfare/specialty mental health assessment at entry point into child welfare. Stakeholders need additional details to fully understand the purpose and goal for this assessment.

- Is DHCS referencing an additional assessment tool or an existing tool that is being used like the CANS?
  The selection of any new assessment tool needs to be done in partnership with CA Department of Social Services, local counties' child welfare agencies, community based providers that specialize in serving foster youth, and other stakeholders. The selection of any tool must ensure that the design of the research validated tool aligns with the express purpose of this component.
- Given the target population, Sycamores recommends a trauma screening tool such as the UCLA Brief Screen for Child/Adolescent Trauma and PTSD.
- We are concerned that any additional assessment tool will increase the administrative/documentation requirements of counties and their contract provider network. This would be contrary to the "spirit" of the documentation re-design efforts under CalAIM.

Preliminary Evaluation Plan for BH-CONNECT Demonstration

We support the need for a clear and succinct evaluation plan where the hypotheses clearly align with the evaluation approach.

- Regarding the ED utilization and lengths of stay amongst Medicaid beneficiaries with SMI/SED, how will the proposed evaluation approach properly acknowledge that California is still building out its crisis care infrastructure at the local level. If DHCS begins the evaluation for this hypothesis in Year 1, will it see any significant change in the data because the newly launched and newly programs in the crisis infrastructure have not been operational for long. Therefore, DHCS and the

selected evaluation firm should engage in meaningful conversations with counties about the timing of this specific evaluation component.

- Regarding the outcomes for children/youth involved in child welfare over the course of the demonstration, has the DHCS considered foster youth cases where there is no active family involvement or no permanency plan?

Cross-Sector Incentive Program for Children/Youth Involved in Child Welfare

We support the establishment of the cross sector incentive program that will promote innovation and improve consumer outcomes through closer cross sector collaboration.

- As written, the Demonstration explicitly mentions Managed Care Plans, county behavioral health delivery systems, and county child welfare systems. There is no explicit language about contracted community based providers that work in concert with counties' behavioral health and child welfare departments to help consumers and families toward more positive outcomes.

Activity Stipends for Foster Youth

We appreciate the inclusion of activity stipends for current and former foster youth.

- Sycamores urges DHCS to create a streamlined process for how community based providers can access these activity stipends for the foster youth and former foster youth who they serve?
- We join other children's advocates to urge you to repeal the minimum age requirement. For young children, specific sensory activities have shown to have important benefits.
- Sycamores suggests that DHCS release a comprehensive list of all the categories eligible for reimbursement as activity stipends. If this does not occur, we are concerned that there may be an uneven interpretation across regions about what activities are allowable.
- We believe that equipment and team uniform costs associated with sports participation be allowable expenditures.

Transitional Rent Services

Sycamores applauds DHCS for proposing to cover transitional rent services for up to six months for eligible Medi-Cal beneficiaries who are homeless or at-risk of homelessness and who meet other specified criteria.

- We want to ensure that the eligibility criteria categories are broad enough to recognize the life circumstances unique to Transition Age Youth (18-25 years old) who are currently experiencing homelessness or "at risk" of homelessness and meet the mental health access criteria.
- DHCS must have broad definition of what constitutes "transitional housing."
- Under transition rent services, we seek clarification that this includes first month rent and last month's rent, security deposits, and application fees. These costs have been a significant barrier for many consumers who are seeking to secure and retain affordable housing.
- Given the shortage of affordable housing across California, especially in high cost of living counties such as Los Angeles County, DHCS should require health plans that "opt in" to offering transitional rent services to demonstrate how they have engaged with counties' behavioral health departments, cities, municipalities and local Continuums of Care to ensure that Medi-Cal beneficiaries who receive these transitional rent services will not be in peril once the six months of rent services over. We fear that unless there are these strategic local conversations, these Medi-Cal beneficiaries might experience greater housing instability or lose their housing.

Short Term Residential and Inpatient Psychiatric Stays in Institutions of Mental Diseases

Sycamores supports DHCS' request to "exercise" the flexibility granted by federal CMS to waive the length of stay requirements under the Section 1115 SMI/SED guidance for foster children at Short Term

Residential Treatment Programs (STRTPs) that are Qualified Residential Treatment Programs (QRTPs) in certain circumstances.

We should all remember that the federal Medicaid Institutions of Mental Diseases exclusion provisions were enacted decades before the creation of STRTPs (under California's Continuum of Care Reform) or QRTPs (as part of FFPSA). Therefore, Medicaid's provisions were established without any fore thought about the program design or target needs of youth served in STRTPs or QRTPs. The flexibility extended under this 1115 SMI/SED waiver is the federal Administration's vehicle, offered by CMS, given the absence of a long-term legislative solution by Congress to exempt Qualified Residential Treatment Programs from the Medicaid Institutions of Mental Diseases (IMD) exclusion. If CMS approves California's request for flexibility under the Section 1115 SMI/SED, it would be time limited. Additionally, any flexibility granted under this 1115 SMI/SED waiver will not fully address the dearth of available residential treatment beds across California's child welfare system.

With the reduction of hundreds of STRTP beds due to the DHCS Medicaid IMD determination process, California DHCS must work, in concert with DSS, to create a written statewide plan for how CA intends to meet the needs of foster youth under Medi-Cal EPSDT that need a short-term residential intervention?

Thank you for your consideration of Sycamores' feedback.

Sincerely,

Wendy Wang, MPP
Chief Public Policy and Advocacy Officer


Sycamores
a better life

From: Lucero, Katherine [redacted]
To: Cooper, Jacey [redacted]; Sadwith, Tyler [redacted]
Cc: [redacted] DHCS BH-CONNECT
Subject: [External]BH CONNECT Comment
Date: Saturday, August 26, 2023 4:39:09 PM
Attachments: [redacted]

[redacted]

Dear Chief Deputy Director Cooper and Deputy Director Sadwith-

Please accept this letter of comment on the draft BH-CONNECT Demonstration Request submitted on behalf of the Office of Youth and Community Restoration (OYCR). We appreciate your consideration of our suggestions which highlight areas where juvenile justice youth can be more fully woven into the continuum of trauma informed care set forth by this initiative.

Respectfully,

Judge Katherine Lucero (ret.)
Director
The Office of Youth & Community Restoration
California Health and Human Services Agency
1215 O Street, 11th Floor
Sacramento, CA 95814
[redacted]

(She, Her, Hers)

Department of Health Care Services
Director's Office
Attention: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Dear Chief Deputy Director Cooper and Deputy Director Sadwith:

Please accept this letter of comment on the draft BH-CONNECT Demonstration Request submitted on behalf of the Office of Youth and Community Restoration (OYCR).

We should like to start by expressing our appreciation for DHCS' work in developing innovative approaches for the delivery of behavioral health services in California.

However, we feel that BH-CONNECT as drafted misses an important and possibly fleeting moment of opportunity to extend services to one of the most vulnerable populations of children and youth in California – those involved in the juvenile justice system, and especially those who as a result of Juvenile Justice Realignment will be in great need of services and supports in Year 1 and Year 2 of the demonstration.

As you know, California enacted SB 823 in 2020 with the express intent of transferring care and services for children and youth in the juvenile justice system from a correctional to a health-focused agenda. As Governor Newsom said, "The system should be about helping kids imagine and pursue new lives … unpack trauma and adverse experiences."

Specifically, what we urgently recommend is that children and youth under probation supervision who are not subject to inmate exclusion provisions of Medicaid – thus, youth in diversion programs, home supervision, pre-disposition detention after January 1, 2015, and post-detention less restrictive programs -- be included at the outset of the demonstration as eligible for the cross-sector incentive program, and for the activity stipend for children and youth (for, as the draft notes, non-traditional therapeutic interventions are cited as benefiting youth in the juvenile justice as well as the child welfare systems.) To accomplish those inclusions, the management level foster care liaisons in managed care plans in Year 0 of the demonstration should also be tasked with interfacing with county juvenile probation departments.

Similarly, while not all probation departments utilize the CANS tool for screening and assessment, OYCR anticipates recommending it as a best practice and to the extent it is adopted, we believe the demonstration should include probation CANS use at entry to the juvenile justice system to maximize opportunities for eligible services to be provided to children and youth across both behavioral health, and child welfare

services, if appropriate, before untreated conditions result in further penetration to carceral levels of care.

We are pleased to see that DHCS will be seeking clarification of EBP standing of MST, FFT and PCIT, as well as intensive care, and high-fidelity wraparound as EPSDT services, as these are well supported in serving youth and families involved in juvenile justice system.

Finally, in the section on transitional rent services we recommend that transitions from juvenile justice facilities be specifically included as "correctional facilities" may be considered adult facilities.

Please feel free to contact us to elaborate on any of these recommendations, and to assist with any specific wording or language that would be helpful.

Respectfully,

[redacted]

Hon. Katherine Lucero (ret.)
Director
Office of Youth and Community Restoration
California Health and Human Services Agency

Copies:
Michelle Baass, DHCS Director
Dr. Mark Ghaly, CHHSA Secretary

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Saturday, August 26, 2023 5:55:53 PM

[redacted]

To whom it may concern,

Thank you for the opportunity to comment on the Medicaid Section 1115 Demonstration, BH-CONNECT. I am writing as a resident of the third district of Santa Barbara County. I am commenting on this demonstration because my community will be greatly impacted by this demonstration if it is to be accepted by my county. I am writing in support to BH-CONNECT. I would like to emphasize the short-term residential and inpatient psychiatric stays in institutions for mental diseases on BH-CONNECT. Providing such a service can help those individuals who are at risk for homelessness due SMI or SED. Mental health is a large risk factor for homelessness so by providing inpatient stays it can attempt to reach individuals as an upstream factor. I also want to emphasize the importance of children welfare in the BH-CONNECT and how supporting these children, especially in high-risk cities for behavioral changes, can overall improve children's futures.
Overall, the incentives are not very laid out for BH-CONNECT, but the main points are great. I hope you're focusing on making all these services viable and easily accessible to communities. Allow for members of the community to know about the services and not keep them hidden from individuals who would greatly benefit from BH-CONNECT.

Sincerely,
Claudia Aguirre, MSPAS/MPH Student
Resident of the third district of Santa Barbara County

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Sunday, August 27, 2023 6:24:43 PM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouse is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need.
It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation.
Thank you
Liz Evans

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Sunday, August 27, 2023 9:35:23 PM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Alexis Selwood

Alexis Selwood, PhD
Psychotherapist
[redacted]
www.alexisselwood.com

Faculty
The Sanville Institute for Clinical Social Work and Psychotherapy
[redacted]
www.sanville.edu

Sanville Psychotherapy Service
[redacted]

California Clubhouse
Founding & Working Group
www.californiaclubhouse.org

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Monday, August 28, 2023 9:10:13 AM

[redacted]

Please help our mentally challenged people in California!

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

--
Thanks, I hope you have a splendid day. Peggy

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Monday, August 28, 2023 9:55:22 AM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.
At a time in California's history where we are starting to allocate funds to help the mentally ill and society as a whole, Clubhouse is a great model of treatment for the mentally ill, for those who care for them, and the rest of society. It's not just a place to stay for the night...

Wishing you the best.
Melissa Seligman

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH Connect Demonstration - Transitional Rent Services
Date: Monday, August 28, 2023 1:47:10 PM
Attachments: [redacted]

This Message Is From an External Sender
This message came from outside of your organization. Please be cautious with links and attachments.

Report Suspicious

Hello – Forwarding comments from Anthem Blue Cross concerning transitional rent services. Thank you.

Beth A Maldonado
Director II, Medicaid Compliance
21215 Burbank Blvd, Woodland Hills, CA 91367
[redacted]

Anthem

August, 31, 2023

To: Department of Health Care Services, Director's Office, Attn: Jacey Cooper and Susan Philip

Re: Public Comment on CalAIM Section 1115 Transitional Rent Services Amendment

Anthem Blue Cross appreciates the opportunity to provide public comment on the proposed CalAIM Section 1115 Transitional Rent Services Amendment. Anthem has been working to address the housing needs of Medi-Cal members experiencing homelessness for several years including through the implementation of CalAIM and the Housing and Homelessness Incentive Program (HHIP). Based on experiences from these efforts, the two most significant challenges our members and providers face are finding a rental unit in the community that is affordable and having the ability to access financial resources to help with paying the rent.
While the proposed Transitional Rent Services do not address the housing supply issue in California it will allow Managed Care Plans (MCP's) the ability to help support rental assistance needs combined with offering the wraparound supportive services through Enhanced Care Management (ECM) and Community Supports (CS). Anthem applauds DHCS for seeking federal approval and taking action to move this vital proposed service forward and is committed to being a partner in this effort.

To assist DHCS in further developing the program if approved, Anthem would like to offer the below questions/concerns as well as recommendations:

Questions/Concerns:

- There are currently several federal programs (ie HUD Continuum of Care, HUD Emergency Solutions Grants, Housing Choice Vouchers, and others) and state programs (ie Homeless Housing Assistance and Prevention program, CalWORKS Housing Support Program, Housing and Disability Advocacy Program, and others) that provide both permanent and temporary tenant-based rental assistance. How will Transitional Rent Services align or differ from these existing rental assistance programs?
    - Will Transitional Rent Services be subject to Fair Market Rents (FMR)?
    - What/if will be any required tenant portion of Transitional Rent Services?
    - Will there be Housing Payment Standards? Will these be adjusted to each rental market?
    - Will units be subject to Housing Quality Standard inspections or Health and Safety inspections?
    - Will utilities or a utility allowance be considered?
    - Will there be any requirement on the length of the lease (ie requiring a 12 month lease)?

- In the proposed language, there is no mention of connection to or collaboration with the homeless Coordinated Entry System (CES). Will there be an expectation to align Transitional Rent Services with local CES's processes?
- Given the high-cost housing market across California and that the proposed target populations will have extremely low incomes, fixed incomes, or struggling to find employment, there is significant concern that six months of rental assistance may not be enough to stabilize an individual or family in their housing. Other similar models such as Rapid Re-Housing (RRH) programs have historically struggled to have success with short-term rental assistance programs (3-6 months) and many communities across the state are adjusting RRH programs to provide deeper subsidies and for longer durations of up to 24 months (and in some cases longer).
    - Is DHCS intending to structure this program similar to a RRH program design that combines both temporary rental assistance and supportive services?
    - Is DHCS intending that Transitional Rent Services will serve as a bridge/transition to other more permanent rental assistance sources such as an HCV or a Permanent Supportive Housing program?

Recommendations:

- **Allow for flexibility with rental assistance requirements to best meet the member and community needs including:**
    - Flexibility with the type of housing for the individual whether it's a traditional apartment or other settings such as a sober living home, shared housing with roommates, independent living facilities, or other non-traditional rental housing.
    - Flexibility with lease requirements and allow for short-term leases such as a month-to-month lease.
    - Flexibility on rent costs. Allow for rent to be above FMR however encouraging MCP's and providers to consider long-term sustainability of the member in the unit beyond the Transitional Rent Services.
    - Flexibility with tenant portions of the rent. DHCS should encourage MCP's to have members contribute to the rent depending on their situation however allow for flexibility and use a progressive engagement model based on each members needs that does not use a set required portion (ie member pays 30% of their income to rent). Allow for Transitional Rent Services to cover 100% of the rent if the member has zero income and do not require a minimum contribution.
    - Flexibility with covering other housing costs such as utility costs and other costs that may come rental housing.
- **Allow Flexibility to MCP's in Administering Transitional Rent Services:**
    - Similar to CS Housing Deposits, allow for health plans to work with potential providers to determine best approach with offering the service and working with providers including determining an "administrative fee" to cover internal operations among providers to administer rent payments.

  - Allow MCP's to work with providers to determine best way to authorize the length, amount, and reimbursement timeframes of Transitional Rent services based on each individual member and provider.
- **Expand Target Populations:**
  - While the first part of the proposed eligibility criteria includes HUD's At-Risk of Homelessness definition, the second proposed eligibility criteria does not include individuals or families who may be transitioning from a rental unit or imminently losing their current housing. The second eligibility criteria only includes those exiting an institutional setting including a shelter or those living unsheltered and would exclude those who are solely at risk of homelessness and losing their housing. DHCS should consider adding a setting such as "At-risk of transitioning from rental housing to homelessness within 14 days" as one of the secondary eligibility criteria.
  - Add additional criteria to allow for individuals who are currently enrolled in a federal or state funded RRH programs to receive Transitional Rent Services if reached the time limit in the federal/state program and have do not have the ability yet to take on the full monthly rent payments.
- **Allow for Longer Than Six Months of Rental Assistance:**
  - Often times in communities across California, six months of rental assistance is not enough to stabilize a household. To ensure housing stability of members and to maintain relationships with community-based landlords, DHCS should consider allowing for additional months of rental assistance on a case-by-case basis.
- **Collaboration and Partnership with Continuum's of Care (CoC) and Public Housing Authorities:**
  - DHCS should encourage MCP's to collaborate with CoC CES processes as much as possible to ensure non-duplication of rental assistance services. CES can assist the MCP with identifying members who may need Transitional Rent Services and help support connection.
  - DHCS should encourage use of the Homeless Management Information System (HMIS) to track who is receiving Transitional Rent services and encourage MCP's to work with CoC/HMIS lead agencies to set up Transitional Rent Services in HMIS similar to other federal and state rental assistance programs.
  - DHCS should encourage MCP's to engage with local Public Housing Authorities (PHA) to educate on the model and determine if there can be local partnerships to help connect members to other longer term permanent rental assistance at the end of the Transitional Rent Services program.
- **Encourage Best Practices and Innovations:**
  - Similar to other CalAIM CS housing services, DHCS should encourage the use of best practices including Housing First, Harm Reduction, Trauma-Informed Care, Motivational Interviewing, and others. DHCS should consider other best practice strategies and program design concepts such as those within the Rapid Re-Housing Toolkit from the National Alliance to End Homelessness (NAEH).

- DHCS should encourage MCP's to use innovative strategies within the Transitional Rent Services program. This may include encouraging partnerships with entities serving as a centralized landlord engagement entity in the community that is supporting the acquisition of rental units and supporting lease up that could include a master leasing approach. DHCS should encourage the use of shared housing/roommates as a viable strategy to ensure housing costs remain affordable and members have additional social supports. Lastly, DHCS should encourage various approaches/levels of subsidy (highlighted above in flexibility of tenant portion) that include concepts such as a shallow subsidy model.

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Monday, August 28, 2023 4:49:17 PM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

This initiative makes me proud to live in California.

Sincerely,

Karen Heselton
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Monday, August 28, 2023 5:03:57 PM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Thank you.

Sincerely,

Steve Heselton

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH Connect Demonstration
Date: Monday, August 28, 2023 5:32:20 PM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago and now there are over 320 successful Clubhouses operating throughout the world. Please see this website http://www.clubhouse-intl.org for further information.

Please confirm receipt of this email and let me know how you will proceed.

Thank you,

[redacted]

Diane Rabinowitz
President, NAMI El Dorado County
w: http://www.namieldoradocounty.org
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Monday, August 28, 2023 6:48:51 PM

[redacted]

Hello and greetings.
It is my understanding that one of the programs under consideration for support is Clubhouse International. I am extremely glad to hear this, since in my experience, the Clubhouse model is one of the most effacacious methods of assisting and rehabilitating the seriously mentally ill population. As you may be aware, the Clubhouse Model provides a safe, clean space for individuals with menal illness to be during daytime hours. Although not mandatory, members, (individual with mental health diagnoses,) are encourages to participate in a "work order day," that is very much like the workday you and I experience in the workplace. Through these activities, those individual affected by mental illness learn social, occupational and emotional coping skills that will eventually prepare them for gainful employment and long term relationships with others. One enormous benefit of a Clubhouse to bothe the individuals seeking to participate in Clubhouse and the residents of the surrounding community and nearby residential areas is that it provides a p-lace that is off of the street, and is not a venue for illicit sales of drugs, alcohol, and other harmful behaviours. Essentially, a Clubhouse gives those individual with mental health diagnoses a bplace where they are surrounded by like minded, (stable) individuals where they are able to adapt to, and learn vital skills for, the workplace, while being removed from the open-air narcotics markets found in other locations where the mentally ill and/or unhoused congregate. I, having a lifetime of lived experience as a person with mental illness, intermittant incarceration, and severe isolation, highly reccommend that this program be chosen to receive support in the form of funding.

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Monday, August 28, 2023 8:40:21 PM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Pierce T. Selwood

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Monday, August 28, 2023 10:41:28 PM

[redacted]

Department of Health Care Services Director's Office

Attn: Jacey Cooper and Tyler Sadwith

P.O. Box 997413, MS 0000

Sacramento, California 95899-7413

Department of Health Care Services Director's Office

Attn: Jacey Cooper and Tyler Sadwith

P.O. Box 997413, MS 0000

Sacramento, California 95899-7413

Good evening,

I am writing to support the new Medicaid Section 1115 Demonstration to increase access to and improve mental health services for Medi-Cal members statewide.

Mental health services should be easily accessible to people that need it. As a professional with experience working with individuals with substance use disorders (SUD) and serious mental illness (SMI), it is concerning how limited resources are available for them and how difficult it is to access them. This expansion will offer much-needed support to the individuals with SMI and SUD and the healthcare workers helping them.

Thank you for your time.

Sincerely,

Janine Solomon

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 9:07:01 AM

[redacted]

Dear DHCS,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government.

The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community.

As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Thank you,
April Manger

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]Fwd: BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 10:10:15 AM

[redacted]

BH-CONNECT@dhcs.ca.gov

Dear DHCS,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community.

As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary

treatment, instead it offers an on going recovery process.

It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Thank you!

Kathryn Shea

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 10:27:33 AM

[redacted]

Dear DHCS,

We strongly support the decision to include the availability of Clubhouse services in the state's application to the federal government.

The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. Clubhouses create a community that supports members, reduces isolation and has a proven track record of success.

Housing El Dorado fully supports NAMI El Dorado's efforts in El Dorado County to establish and grow a Clubhouse program. We've extensively reviewed the Clubhouse model and continue to actively support and endorse the development of this proven social and vocational rehabilitation program.

Thank you for your consideration,

Frank

--
Frank Porter
Vice-President
Housing El Dorado
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 10:34:27 AM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.
Thank you,
George Tyree

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 10:41:54 AM

[redacted]

Dear DHCS ,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Thank You,

Seriah Patterson

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 11:16:00 AM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.
Jacob D. Fortes

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 11:21:28 AM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.
Thank you,

Rebecca Arana

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 11:26:18 AM

[redacted]

Dear DHCS ,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT
Date: Tuesday, August 29, 2023 11:49:47 AM

[redacted]

Dear DHCS
Dear DHCS,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they integrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 11:59:36 AM

[redacted]

Dear DHCS ,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Thank You,

Sylvia Flores

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 12:41:16 PM

[redacted]

Dear DHCS,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

From: [redacted]
To: [redacted] DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]Re: BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 12:47:17 PM

[redacted]

Wonderfully written! Thank you!

Sent from Yahoo Mail for iPhone

On Tuesday, August 29, 2023, 10:27 AM, Frank Porter <[redacted]> wrote:

> Dear DHCS,
>
> We strongly support the decision to include the availability of Clubhouse services in the state's application to the federal government.
>
> The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. Clubhouses create a community that supports members, reduces isolation and has a proven track record of success.
>
> Housing El Dorado fully supports NAMI El Dorado's efforts in El Dorado County to establish and grow a Clubhouse program. We've extensively reviewed the Clubhouse model and continue to actively support and endorse the development of this proven social and vocational rehabilitation program.
>
> Thank you for your consideration,
>
> Frank
>
> --
> Frank Porter
> Vice-President
> Housing El Dorado
> [redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 12:55:50 PM

[redacted]

Dear DHCS,

I strongly support the decision to include the availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead, it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Best,
Laz Dombovic
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Tuesday, August 29, 2023 1:48:05 PM
Attachments: [redacted]

[redacted]

Greetings, To whom it may concern;

I have attached for you public comments acknowledging BH-CONNECT. Please let me know when you've received this email.
I appreciate California's efforts.

Sincerely,

Bruce Wheatley
Wheatley Institute

August 29, 2023

Attn: Directors Office - Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

California's efforts to modernize the public health system are long overdue. This public comment requests the 1115 demonstration waiver finance a school-linked continuum of community-based behavioral healthcare services at California community schools. The upstream approach will modernize the public health system and increase access, equity, and quality for Medi-Cal members living in vulnerable zip codes.

Achieving California's Behavioral Health Community-Based Organized Network of Equitable Care requires the comprehensive transformation of the Public Health and Education Systems. Pursuing a scientific and evidenced-based approach is essential to erecting a branded Behavioral Healthcare Component (BHC) within each Local Education Agency Department of Student Support Services. Financing a sustainable BHC will require the reallocation of the Children and Family Act, Mental Health Service Act, and Local Control Funding Formula and Accountability Planning to increase access to comprehensive and integrated Behavioral Healthcare delivered at California Community Schools. Financed and operationalized to co-exist within the current K-12 Education, Instruction, and Management/Governance framework, the BHC will increase access for low-income children and families walking to the nearest elementary, intermediate, or high school to visit their primary care physician.

However, Primary Care Physicians will not relocate to community schools without adequate reimbursement for Medicare & Medicaid Billable Services. Thus, physicians remain close to Medical Centers to serve an affluent resident population with premium insurance. Reallocating public financing to create equitable systemic changes will reduce the fragmented ecosystem of network providers, delivering marginalized primary care, often duplicating administrative processes, and creating multiple subsystems at enormous cost to public health. The three public policies generate over $3 Billion in tax revenue annually, impacting less than 20% of California's population is simply ineffective.

Whole-School District Transformation simplifies BH-CONNECT objectives, establishing the basis of a Behavioral Healthcare Medical System Continuum within the LEA to expand the scope of required MH/SUD services to effectively achieve parity in alignment with the Federal Patient Protection Affordable Care Act.

The journey to create equitable system changes is multifaceted and complex, requiring simultaneous system-level changes at the policy and governance/accountability level, administration and service delivery level, and workforce and community stakeholder engagement level.

We recommend combining MHSA Community Planning with LCAP Community Engagement to organize the contract provider and community-based organization networks within each County's Cultural Competence/Diversity Equity Inclusion Committee Structures. The State of California must lead the transformation of BH-CONNECT, embracing the 1964 Civil Rights Executive Order for Cultural Competence. To date, the policy objective has yet to be achieved, given the health, education, and income disparities impacting the quality of life for African Americans. As the murder of George Floyd and the Coronavirus pandemic have initiated the American Rescue Plan Act to build back a system infrastructure that is equitable for all, the African American population becomes central to modernization to a Culturally Proficient Behavioral Healthcare Medical System Continuum.

I appreciate your consideration.

Sincerely,

[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Wednesday, August 30, 2023 8:15:50 AM

[redacted]

Dear DHCS ,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Wednesday, August 30, 2023 8:28:07 AM

[redacted]

Dear DHCS ,

I have been involved in the Clubhouse movement for over 40 years, first as a staff worker at Fountain House in New York City and for the last 15 years as a supporter and Board President of The Meeting Place Clubhouse in San Diego.

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse — Fountain House — was opened 75 years ago.

Regards,
Cynthia Fissel

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Wednesday, August 30, 2023 12:20:38 PM

[redacted]

Dear DHCS ,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

The clubhouse model is a viable, rehabilitative, long-term model to replace the dysfunctional state hospital systems that were shut-down in the 1980's without an alternative system in place. Part of our homeless crisis includes the lack of community based long-term rehabilitative services and access to these services. As a family member of loved ones with severe mental illness, a professional in the field of mental health, and volunteer in my community, I ask for your support in requesting assistance for the Clubhouse program.

Sheryl Trainor, MS, OTR/L

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Wednesday, August 30, 2023 3:05:25 PM

[redacted]

Dear DHCS,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouse is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 Years ago.

Thank you,

Donna Rutherford

[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Wednesday, August 30, 2023 4:56:05 PM

[redacted]

Dear DHCS,

I am on the Board of Directors of The Meeting Place Clubhouse (TMP) of San Diego, accredited by Clubhouse International. My 40 y.o. son has suffered periodic episodes of mental illness since age 19, and TMP has proven absolutely critical to his ever-improving long-term recovery. Initially, his TMP membership provided him the opportunity to do meaningful daily work and develop social relationships while reintegrating into the broader community. Via its job placement services, he became independently employed by T.J. Maxx. TMP encouraged him to become certified as a Peer Support Specialist and hired him to the staff of its Warmline community call-in service. He now works in the same capacity for the National Alliance on Mental Illness (NAMI) in San Diego. He today fully understands and accepts the constraints of his illness, has regained the self-confidence and zest for life he lost when first afflicted, and looks forward to a stable and productive future. Without TMP's accredited program, this most likely wouldn't be so. Therefore, I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government.

Sincerely,
Murray H. Smith

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]Proposed state limitations on allowed use of the 30-day IMD Mei-Cal Reimbursement Exclusion Waiver for persons 21-64 years of age
Date: Wednesday, August 30, 2023 5:01:39 PM

[redacted]

Good afternoon:

In the two public Zoom presentations, Aug. 10 and 24, I was personally extremely disheartened by how the DHCS intends to totally unnecessarily restrict the use of this most vital potentially life-saving tool as much as possible for Severely Mentally Ill (SVMI) loved ones such as ours. As a result of great pressure from Disability Rights California (DRC), DHCS proposes to limit the application of this portion of the waiver to just hospital adult psychiatric beds for a maximum of two consecutive 5270 up to 30 days involuntary stay each. Like other portions of the behavioral health care system, this would create unnecessary and unintended sub-acute care "human log jams" for the very highest required level of our adult loved one's psychiatric care especially for the desperately needed 43-bed adult psychiatric wards at the Contra Costa Regional Medical Center (CCRMC) in Martinez.

Here is why the situation is so very dire throughout the state and especially here in Contra Costa County:

As I forcefully stated on the August 10 Zoom meeting, this county is one of the "top 10" populations of persons judicially adjudged Incompetent to Stand Trial (IST) in the state. As a result, it is in line to receive $9M to either construct or refurbish for nearly 100 persons for their 18-month Average Length of Stay (ALOS). This means these 100 beds are really needed right now. However, such housing does not need to be "up and running" until June 30, 2028. On page 4 (see attached), this same report states that the *"DSH is currently developing new IMD (Institute of Mental Diseases) and sub-acute capacity across the state. These beds will be available as a stepdown stabilization option for felony IST clients transitioning from jail to the community-based restoration or diversion programs and can also be used when IST clients receiving treatment in these community programs need a higher level of care. Together, these programs will support a comprehensive continuum of community placement and housing options for individuals deemed IST on felony charges across the state."*

This Dept. of State Hospital (DSH) IST Diversion and Community Based Restoration Infrastructure Project Request for Proposals (RFP) directly speaks to the continuing desperate paucity of such critically needed time limited locked facility beds throughout the state. In fact, the county Behavioral Health Director has publicly stated that she previously attempted to get the state to agree to a test with another nearby county to demonstrate long-term cost savings if the federal IMD Medicaid (Medi-Cal) Reimbursement Exclusion for person 21-64 years of age was conditionally lifted for a set period of years (3-6). However, the state would not agree to this "Demonstration Trial."

We family members of all cultures, ethnicities, and languages are desperate for any even short-term locked facility fully Medi-Cal funded options for our Gravely Mentally Ill loved ones from so that they do not either wind up dead on the streets without treatment or endlessly "trapped" in the criminal justice system!!!

Hope you are honestly listening and will carefully consider these most heart-felt families concerns in this most important Section 1115 Demonstration Waiver application.

Sincerely,

Douglas Dunn
[redacted]
former Vice Chair of the Contra Costa Mental Health Commission and Chair of its Finance Committee
Chair, NAMI Contra Costa Legislation Committee

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 3:20:22 AM

[redacted]

Dear DHCS ,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government.
The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community.
As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need.
It does not focus on temporary treatment, instead it offers an on going recovery process.
It creates a community that supports members and reduces isolation.

Thanks so much for your consideration!

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT and Transitional Rent Services Feedback from CCJBH
Date: Thursday, August 31, 2023 7:23:17 AM
Attachments: [redacted]

[redacted]

Hello DHCS Team,

The Council on Criminal Justice and Behavioral Health (CCJBH) has reviewed DHCS' California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration and Proposed Amendment to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration Related to Transitional Rent Services, and respectfully submits the attached recommendations to help strengthen the demonstration application specific to the complex needs of the behavioral health and justice-involved population.

We thank you for this opportunity and invite you to let us know if you have any questions!

Kindly,
Brenda Grealish

Brenda Grealish
Executive Officer
Council on Criminal Justice and Behavioral Health
California Department of Corrections and Rehabilitation
Office of the Secretary—Jeff Macomber
[redacted]

CCJBH
Council on Criminal Justice and Behavioral Health
20 YEARS of building bridges to prevent incarceration

August 31, 2023

Department of Health Care Services
Director's Office
Attn: Jacey Cooper, Susan Philip and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Submitted via email to BH-CONNECT@dhcs.ca.gov

RE: Recommendations for the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration and Proposed Amendment to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration Related to Transitional Rent Services

Dear DHCS Team:

On behalf of your colleagues at the Council on Criminal Justice and Behavioral Health (CCJBH), thank you for the opportunity to provide recommendations in support of the proposed California Department of Health Care Services (DHCS) California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration application. We applaud DHCS' efforts to purse this waiver to continue building upon the state's ongoing behavioral health initiatives to ensure a robust continuum of care, and are pleased to see that much of the feedback we provided in our January 12, 2023, letter in response to the initial California Behavioral Health – Community Based Continuum concept paper is reflected in this updated proposal. We now offer the below suggestions for consideration in the final application that is submitted to the Centers for Medicare and Medicaid Services (CMS), as well as for implementation of the demonstration, when approved.

Suggestions Specific to Children/Youth

The following recommendations would strengthen the BH-CONNECT demonstration waiver application given DHCS' focus on addressing equity gaps in the behavioral health system related to California's children and youth:

- **Add language to the application to specify that the demonstration will also benefit the subpopulation of youth who are concurrently involved in the child welfare system and the juvenile justice system (hereafter referred to as dually-involved youth).**[1] This addition will make it clear that dually-involved youth will not be excluded from the benefits of the BH-CONNECT demonstration due to their justice system involvement. It will also serve to notify county child welfare, behavioral health, and probation departments that the BH-CONNECT demonstration benefits, including the activity stipends and the initial behavioral health assessment at the entry point into child welfare or the juvenile justice systems, will be available to these children/youth. Accordingly, probation should be included as a cross-agency accountability and coordination partner to ensure comprehensive, coordinated case planning and service delivery.
- **Include all justice-involved children/youth who are on Medi-Cal in the BH-CONNECT demonstration waiver.** Since approximately two-thirds of justice-involved children/youth are also involved in child welfare at some point in their lives (most of which occurs non-concurrently, as shown in the studies cited above), and there are justice-involved children/youth who do not have child welfare involvement, and many of these children/youth are Medi-Cal beneficiaries, CCJBH's stance, as conveyed in our January 12, 2023, letter, remains centered on ensuring that the initial BH-CONNECT proposal ensure that *all* justice-involved youth who are on Medi-Cal have the opportunity to benefit from the services that have been specified in the waiver application for the child welfare population (e.g., activity stipends, collaborative cross-agency assessment).[2] This would be an important action towards addressing longstanding equity gaps in our state, particularly for those children/youth who are deeply affected by abuse, trauma and poverty.
- **Include County Probation Departments as a key system to benefit from the Statewide Cross-Sector Incentive Program.** While CCJBH appreciates DHCS' acknowledgement that at least the cross-sector incentive program will be assessed in future years for potential opportunities to expand to include juvenile justice, if the application submitted to CMS continues to focus only on children/youth with child welfare involvement (open or closed case), it is still important to acknowledge that probation departments will still be heavily involved in the lives of dually-involved youth. As such, identifying County Probation Departments in the application will serve to formally recognize their role as an important BH-CONNECT system partner to "share responsibility for improvement in behavioral

[1] As reported in the Dual system youth and their pathways in Los Angeles County: A replication of the OJJDP Dual System Youth Study (2021), 47.8% of dual system youth in Los Angeles County interacted with both the child welfare and juvenile justice systems concurrently. For more information, see Dual System Youth: At the Intersection of Child Maltreatment and Delinquency (2019).

[2] Optimally, in the future, the activity stipends will also be made available to at-promise youth who are on Medi-Cal, the latter of which could be identified within the student behavioral health efforts given the fact that many at-promise youth in need of the "extracurricular activities that support physical health, mental wellness, healthy attachment and social connections" often first come to the attention of educators within the school environment.

health outcomes among children/youth involved in child welfare," and allow them to have an opportunity to be incentivized to collaboratively participate in the case planning and service delivery that is necessary to achieve positive outcomes for the dually-involved youth population.

- **Establish a link between BH-CONNECT and AB 2083.** It would be helpful to articulate in the application the link between the BH-CONNECT demonstration and the existing AB 2083 children's system of care mandate, which was established to ensure interagency coordination for youth in foster care. At a minimum, this model could be expanded to incorporate the Managed Care Plans' (MCP) Management-level Foster Care Liaison to address the complex needs of youth who are in foster care, including those who are dually-involved (even though the MCPs are not statutorily required to participate in AB 2083). It could also be used as a model for cross-sector collaboration for all children/youth served by the BH-CONNECT demonstration.
- **Leverage CCJBH's Evidence-Based and Emerging Practices and Programs Compendium as a resource to identify additional therapeutic modalities.** As part of the effort to clarify coverage requirements for evidence-based practices for children and youth under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), additional therapeutic modalities that could be considered are those that have been identified as part of CCJBH's contract with the RAND Corporation on the Evidence-Based and Emerging Practices and Programs Compendium. This compendium, which will become publicly available in fall 2023, was developed to support youth who were recently realigned under SB 823 to county probation from the California Department of Corrections and Rehabilitation's Division of Juvenile Justice, which closed as of June 30, 2023, although many of the treatments/interventions are applicable to a broader population of justice-involved youth. The Centers of Excellence, could be an optimal resource to provide technical assistance for the behavioral health treatments identified in the compendium.

Transitional Rent Services

The inclusion of transitional rent services in in the BH-CONNECT demonstration application is critical to address the housing needs of California's most vulnerable citizens, in general, and will serve as a life-saving and life-changing resource for the justice-involved population. Therefore, CCJBH also offers the following recommendations to ensure clarity and to maximize implementation of this new benefit:

- **Include "Are transitioning out of a youth correctional facility" under the eligibility criteria for the Transitional Rent Services**. Adding this language will help to minimize any confusion that might result from implementers misinterpreting "correctional facility" as only being applicable to the adult justice-involved population.

- **Leverage resources that identify best practices for housing the BH/JI population.** As reflected in CCJBH's Feedback Response to the U.S Interagency Council on Homelessness' Federal Strategic Plan, justice-involved individuals face numerous, often insurmountable, barriers when trying to secure housing, facing stigma/fear, rejections based on criminal background checks, high up-front costs, ineffective in-reach and community coordination, among other barriers. Given the persistence of these barriers during the implementation of the Transitional Rent Services benefit, to help mitigate these known risks, DHCS could prepare for implementation by convening relevant subject matter experts[3] to identify strategies and develop accompanying guidance to address identified barriers.[4]

General Suggestions

CCJBH also offers the following general recommendations to strengthen the BH-CONNECT demonstration waiver application and implementation efforts:

- **Stratify data analyses and reporting, as specified in the Preliminary Evaluation Plan for BH-CONNECT Demonstration, by the justice-involved adult population, as well as the dually-involved child/youth population.** Although the preliminary evaluation plan includes a hypothesis that pertains to the justice-involved adult population and children/youth involved in child welfare, given the demonstration's overarching goals related to improving outcomes for these populations, it is necessary to stratify the data to examine the justice-involved experiences in relation to the remaining measures outlined in the evaluation approach (i.e., emergency department utilization and lengths of stay, readmissions to acute care / residential settings related to serious mental illness/serious emotional disturbance, community-based crisis and other behavioral health services utilization, and care coordination). In addition, the outcomes for child welfare could be stratified for dually-involved youth (at a minimum). This would also align with the goals and objectives, and help to inform implementation, of the CalAIM Behavioral Health Linkages that will be implemented in April 2024.

[3] Such partners at the State level could include the California Department of Housing and Community Development, California Interagency Council on Homelessness, California Department of Social Services, Board of State and Community Corrections, and Department of State Hospitals and, at the local level, Public Housing Authorities, Continuums of Care and the local/community Housing Department. Any convenings should also include individuals with lived experience and the providers that traditionally serve them to ensure a comprehensive examination of the issues.

[4] For more information, see the Council on State Governments Justice Center's Report that was produced for CCJBH, Reducing Homelessness for People with Behavioral Health Needs Leaving Prison and Jails, and accompanying webinar series, Building Blocks for Coming Home: How California Communities Can Create Housing Opportunities for People with Complex Needs Leaving the Justice System, both of which could be used as resources to identify best practices to inform housing-related demonstration efforts for justice-involved individuals.

- **Add language that would allow for specialized training to the clinical behavioral workforce to ensure capacity and competency to meet the complex needs of the justice-involved child/youth and adult populations.** In addition to expanding the workforce to include justice-involved peers, there is also need for highly-trained clinicians who have the skills to provide trauma-informed behavioral health treatment to the justice-involved population (and those who are at-risk of becoming justice-involved). Examples include, but are not limited to, the need for behavioral health clinicians to receive high-quality training to treat psychosis, address those who suffer from anosognosia, understand the efficacy and long-term benefits of long-acting injectables for anti-psychotics and medication assisted treatment for substance use disorder, and how to work collaboratively with justice system partners (e.g., training in evidence-based corrections). DHCS could partner with the Department of State Hospitals on the identification of such training needs given their expertise and experience in working to serve the felony incompetent to stand trial population.
- **Add language to the section on the fidelity reviews to require that the findings be used to develop and implement a continuous quality improvement process.** This will ensure that findings from initial fidelity reviews are addressed, and that an infrastructure is established to ensure that fidelity is maintained throughout the demonstration period.
- **Explain how decisions will be made regarding the reinvestment of incentive dollars for both the Statewide and County Opt-in Incentive Programs.** Although the draft application states that both the Statewide and County Opt-In incentives must be reinvested in behavioral health service provision or capacity expansion, it does not specify a process for making decisions about the allocation of funding within these areas. For example, will DHCS be approving how incentives are reinvested in these areas? Will it be up to county discretion? Will there be a stakeholder process? Optimally, such decisions on how to reinvest in behavioral health services or capacity expansion will be data-driven and informed by stakeholder input.

Again, CCJBH appreciates this opportunity to provide feedback on the BH-CONNECT, including the Transitional Rent Services proposal, and we look forward to continuing to support DHCS' efforts to strengthen the state's behavioral health continuum of care.

Respectfully,

[redacted]

Brenda Grealish
Executive Officer
Council on Criminal Justice and Behavioral Health

cc:
Jeff Macomber, Secretary, California Department of Corrections and Rehabilitation
Michelle Baass, Director, California Department of Health Care Services
Stephanie Clendenin, Director, California Department of State Hospitals
Diana Becton, J.D., Contra Costa County District Attorney
Enrico Castillo, M.D. Psychiatrist and Associate Vice Chair for Justice, Equity, Diversion and Inclusion, University of California, Los Angeles
Anita Fisher, Representing Consumer/Family Member Perspective, San Diego County
Tony Hobson, PhD, Behavioral Health Director, Colusa County
Mack Jenkins, Chief Probation Officer, Ret. San Diego County
Stephen V. Manley, Santa Clara County Superior Court Judge
Danitza Pantoja, PsyD, Coordinator of Psychological Services, Antelope Valley Union High School District
Scott Svonkin, Director of Intergov. Relations, Los Angeles County Probation
Tracey Whitney, Deputy District Attorney, Mental Health Liaison, Los Angeles County District Attorney

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration -CAHP Comments
Date: Thursday, August 31, 2023 9:39:49 AM
Attachments: [redacted]

[redacted]

Dear DHCS,
Thank you for the opportunity to provide feedback on the BH-CONNECT Demonstration. We look forward to working with you on this effort going forward.

Kate

Kate Ross
California Association of Health Plans
[redacted]
www.calhealthplans.org

From: Philip, Susan [redacted]
Sent: Tuesday, August 1, 2023 3:40 PM

[redacted]

Subject: DHCS Public Comment on BH-CONNECT and CalAIM Transitional Rent Services

Plan Partners:

On August 1, 2023, the Department of Health Care Services (DHCS) began a 30-day public comment period to solicit feedback on a new Section 1115 demonstration request, entitled the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration. DHCS also began a 30-day public comment period to solicit feedback on a proposed amendment to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration related to transitional rent services. The public comment period for both is through August 31, 2023. This email provides background information, links to public comment materials, and information about how to provide feedback during the public comment period.

BH-CONNECT Background

DHCS is seeking approval to implement key features of the BH-CONNECT demonstration, which aims to expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED). BH-CONNECT will amplify the state's ongoing behavioral health initiatives, and is informed by the findings from DHCS' comprehensive 2022 assessment of California's behavioral health landscape, *Assessing the Continuum of Care for Behavioral Health Services in California*.

The BH-CONNECT demonstration builds upon unprecedented investments and policy transformations currently underway in California that are designed to expand access to community-based behavioral health care and improve outcomes for Medi-Cal members living with the most significant mental health and substance use needs. California has invested more than $10 billion and is implementing landmark policy reforms to strengthen the behavioral health care continuum through initiatives like the Children and Youth Behavioral Health Initiative, Behavioral Health Continuum Infrastructure Program, Behavioral Health Bridge Housing program, CalAIM Justice-Involved Initiative, Behavioral Health Payment Reform, mobile crisis and 988 expansion, and more. California's proposed goal for the BH-CONNECT demonstration is to complement and amplify these major behavioral health initiatives to **establish a robust continuum of community-based behavioral health care services and improve access, equity, and quality for Medi-Cal members living with SMI and SED, particularly populations experiencing disparities in behavioral health care and outcomes.**

The BH-CONNECT demonstration aims to expand Medi-Cal service coverage, drive performance improvement, and support fidelity implementation for key interventions proven to improve outcomes for Medi-Cal members experiencing the greatest inequities, including children and youth involved in child welfare, individuals with lived experience with the criminal justice system, and individuals at risk of or experiencing homelessness. The BH-CONNECT demonstration will standardize and scale evidence-based models so Medi-Cal members with the greatest needs receive upstream, field-based care delivered in the community; avoid unnecessary emergency department visits, hospitalizations, and stays in inpatient and residential facilities; reduce involvement with the justice system; and report improved status. To achieve these goals, the BH-CONNECT demonstration includes some components that will be implemented on a statewide basis and other components that will

be implemented on a county opt-in basis.

DHCS is soliciting public input on the Section 1115 demonstration application. A full draft of the proposed BH-CONNECT demonstration application and initial notice of public interest are posted on the DHCS BH-CONNECT website.

DHCS is requesting Section 1115 demonstration expenditure and waiver authorities for specific features of the BH-CONNECT demonstration. In parallel with the expenditure and waiver authorities requested in the application, DHCS will work with the Centers for Medicare & Medicaid Services (CMS) to implement other features of the BH-CONNECT demonstration that do not require Section 1115 demonstration authority, but may require a new State Plan Amendment or be implemented with state-level guidance. Features of BH-CONNECT that DHCS is requesting as part of the Section 1115 demonstration include:

- Workforce initiative to invest in a robust, diverse behavioral health workforce to support Medi-Cal members living with SMI/SED and/or a substance use disorder (SUD) *(implemented statewide)*.
- Activity stipends to ensure children and youth involved in child welfare have access to extracurricular activities that support health and well-being *(implemented statewide)*.
- Cross-sector incentive program to support children and youth involved in child welfare who are also receiving specialty mental health services *(implemented statewide)*.
- Statewide incentive program to support behavioral health delivery systems in strengthening quality infrastructure, improving performance on quality measures, and reducing disparities in behavioral health access and outcomes *(implemented statewide)*.
- Incentive program for opt-in counties to support and reward counties in implementing community-based services and evidence-based practices for Medi-Cal members living with SMI/SED and/or a SUD *(available at county option)*.
- Transitional rent services for up to six months for eligible high-need members who are experiencing or at risk of homelessness *(available at county option)*.
- Federal financial participation for care provided during short-term stays in institutions for mental diseases *(available at county option)*.

In addition, DHCS will work with CMS to implement other features of the BH-CONNECT demonstration that do not require Section 1115 demonstration authority, including expanding the continuum of community-based services and evidence-based practices (EBPs) available through Medi-Cal, strengthening family-based services and supports for children and youth, providing training and technical assistance to support fidelity implementation of EBPs, and more. Additional details are available on the DHCS BH-CONNECT website.

CalAIM Transitional Rent Amendment Background

To improve the well-being and health outcomes of Medi-Cal members during critical transitions or who meet high-risk criteria, DHCS is seeking an amendment to the CalAIM Section 1115 demonstration to provide up to six months of transitional rent services to eligible individuals who are homeless or at risk of homelessness and transitioning out of institutional levels of care, congregate residential settings, correctional facilities, the child welfare system, recuperative care facilities, short-term post-hospitalization housing, transitional housing, homeless shelters or interim housing, as well as those who meet the criteria for unsheltered homelessness or for a Full Service Partnership (FSP) program.

Transitional rent services will be available for a period of no more than six months; must be cost-effective; and will be provided only if it is determined to be medically appropriate using clinical and other health-related social needs criteria. Transitional rent services will be voluntary for Medi-Cal managed care plans to offer and for Medi-Cal members to use.

Public Comment Materials
The following public comment materials are posted on the DHCS BH-CONNECT webpage and DHCS CalAIM 1115 Demonstration & 1915(b) Waiver webpage. DHCS will update these pages throughout the public comment period and application process:

- Proposed BH-CONNECT Section 1115 Application
- Proposed CalAIM Section 1115 Transitional Rent Services Amendment Application
- Public Notice
- Abbreviated Public Notice
- Tribal and Designees of Indian Health Programs Public Notice

Opportunities to Comment
Written Comments
Comments will be accepted via U.S. mail or electronic mail.

For written comments related to BH-CONNECT, please indicate "BH-CONNECT Demonstration" in the subject line of the written message and send to the below address:

Department of Health Care Services
Director's Office
Attn: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Comments may also be emailed to BH-CONNECT@dhcs.ca.gov, and please indicate "BH-CONNECT Demonstration" in the subject line of the email message.

For written comments related to Transitional Rent Services amendment, please indicate "CalAIM Section 1115 Transitional Rent Services Amendment" in the subject line of the written message and send to the below address:

Department of Health Care Services
Director's Office
Attn: Jacey Cooper and Susan Philip
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Comments may also be emailed to 1115waiver@dhcs.ca.gov, and please indicate "CalAIM Section 1115 Transitional Rent Services Amendment" in the subject line of the email message.

To ensure consideration prior to submission of the BH-CONNECT demonstration application and CalAIM Section 1115 Transitional Rent Services Amendment to CMS, comments must be received no later than 11:59 PM (Pacific Time) on August 31, 2023. Please note that comments will continue to be accepted after August 31, but DHCS may

not be able to consider those comments prior to the initial submission of the BH-CONNECT demonstration application and CalAIM Section 1115 Transitional Rent Services Amendment to CMS.

Public Hearings

DHCS will host the following public hearings to solicit stakeholder comments. The public hearings will take place in person and have online video streaming and telephonic conference capabilities to ensure accessibility.

Friday, August 11 – First Public Hearing

- 10 – 11:30 AM PT
- Department of General Services
  - 1500 Capitol Ave. (Building 172), EEC Training Rooms, Sacramento, CA 95814
- Register for Zoom conference link: https://manatt.zoom.us/webinar/register/WN_6XzvB4XsSD2MRHnKMYdMGw#/registration
  - Please register in advance if you plan to attend in person or if you plan to attend by Zoom to receive your unique login details and a link to add the hearing to your calendar.
- Call-in information: 646-931-3860
  - Webinar ID: 939 8473 0250
  - Passcode: 081123
  - Callers do not need an email address to use the phone option and do not need to register in advance.

Thursday, August 24 – Second Public Hearing

- 9:30 – 11:30 AM PT
- Department of Health Care Services
  - 1700 K Street, Room 1014, Sacramento, CA 95814
- Register for Zoom conference link: https://zoom.us/webinar/register/WN_eqqbAdsGRVuCiImQGc-Y-g
  - Please register in advance if you plan to attend in person or if you plan to attend by Zoom to receive your unique login details and a link to add the hearing to your calendar.
- Call-in information: 646-558-8656
  - Webinar ID: 913 8468 8826
  - Passcode: 478151
  - Callers do not need an email address to use the phone option and do not need to register in advance.

For individuals with disabilities, DHCS will provide free assistive devices, including language and sign-language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of training or meeting materials into braille, large print, audio, or electronic format. To request alternative format or language services, please call or write:

Department of Health Care Services
Director's Office
P. O. Box 997413, MS 0000, Sacramento, CA 95899-7413
(916) 440-7400
Email: 1115Waiver@dhcs.ca.gov

Please note that the range of assistive services available may be limited if requests are received less than ten working days prior to the meeting.

Susan Philip, MPP | Deputy Director
Health Care Delivery Systems
California Department of Health Care Services
[redacted]

California Association of Health Plans

CAHP Comment Tracking Document on DHCS' BH-Connect Demonstration

CAHP member Medi-Cal managed care plans (MCPs) welcome the opportunity to provide feedback to DHCS. Please see the comprehensive feedback from MCPs provided in the table below.

Page of Draft Proposal	Current Language	CAHP Member Feedback
N/A	General Comment	The MCP recommends DHCS utilize the existing Community Supports Policy Guide, and any new definitions as a part of BH Connect align with existing requirements and restrictions.
N/A	General Comment	Regarding the crossover between SMI and the mild-to-moderate population, specifically if a member transitions from one to the other – can DHCS clarify what measures are in place to ensure a member continues to be housed if the eligibility or funding pool changes?
22 - 23	Statewide Incentive Program	The MCP recommends incentive funding as a part of the BH Connect Demonstration Amendment be distributed to primary care sites and community-based organizations (CBOs) working with impacted populations. Similarly, for the workforce development funds, it will be important for the targeted entities to be inclusive of primary care sites and CBOs. The care of individuals with SMI/SED and/or a substance use disorder (SUD) will continue to shift to an integrated model with PHM at PCP/CBO locations and away from highly specialized centers.
37	Inclusion of a management-level Foster Care Liaison within MCPs to enable effective oversight and delivery of ECM, attend Child and Family Team meetings, ensure managed care services are coordinated with other services, and serve as a point of escalation for care managers if they face operational obstacles.	Please provide guidance on how the role of the foster care liaison will differ from the existing managed care plan role and responsibilities for services provided to the Katie A class and other foster care beneficiaries.

Page of Draft Proposal	Current Language	CAHP Member Feedback
	Initial child welfare/specialty mental health behavioral health assessment at entry point into child welfare.	

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 9:51:38 AM
Attachments: [redacted]

[redacted]

I am writing in my personal capacity to strongly advocate for inclusion of Clubhouse services in the state application to the federal government 1115 application. Clubhouse services are unique in that they are set up for people to regain control over their lives in the face of mental illness. Clubhouse International sets rigorous standards for programs to ensure that they meet the standards set by successful programs. Clubhouses are empowering programs that give people social connection, purpose, and a chance to develop/redevelop skills needed for community reintegration and competitive employment. These are the most impactful skills that people can work on to improve quality of life and improve their prognosis from what could otherwise be devastating illness. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an ongoing recovery process. I have seen numerous cases of individuals make substantial change and progress in their lives because of involvement in Clubhouse programs. Because of this experience with so many of my patients I joined the Board of Directors for the California Clubhouse in San Mateo County. Please include increased funding for Clubhouse programs going forward. Sincerely,

———————————

Jacob S. Ballon, M.D., M.P.H.
Clinical Professor
Co-Division Chief - Division of General Adult Psychiatry and Psychology
Co-Director, INSPIRE Clinic
Department of Psychiatry
Stanford University
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 10:24:50 AM
Attachments: [redacted]

[redacted]

August 31, 2023

Tyler Sadwith, Deputy Director
Department of Health Care Services
Sent Via Email: BH-CONNECT@dhcs.ca.gov

Re: BH-CONNECT Demonstration

Dear Deputy Director Sadwith:

Thank you for the opportunity to provide feedback on the BH-CONNECT 1115 Waiver Application. As advocates for California's most vulnerable children and youth in foster care and juvenile justice systems, the Youth Law Center (YLC) provides these comments on the impact of this proposal on these children and youth. We understand the critical importance of a robust and accessible behavioral health system to the well-being and health of system impacted youth and their families and support DHCS's efforts to use waiver authority to build out and enhance the continuum of care where existing Medicaid law does not allow. YLC supports DHCS's ongoing efforts and future plans to expand community-based behavioral health services for Medi-Cal beneficiaries in the target populations of children and youth. However, we cannot support DHCS's plan to seek a limited waiver of the IMD exclusion and waiving the length of stay requirements for STRPS that are also IMDs. We do not believe these exemptions and exceptions are needed or that they serve the best interests and well being of children and youth. We believe there are many ways that DHCS can promote expansion of community-based services without accepting Medicaid dollars for IMD care. We hope our comments are helpful in fine tuning the waiver application so that it is tailored to meet the special needs of system impacted children and youth.

A.

DHCS Should Include the Activity Stipend in the Application and Highlight a Requirement for Stakeholder Involvement in Implementation to Ensure Broad Access

We support DHCS's proposal related to funding enrichment activities to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful effects of trauma. We agree that providing these services and support will greatly promote behavioral health, wellness, and help young people heal from trauma and believe these interventions must be easily accessible to young people.

Youth Law Center, along with our partners at California Youth Connection, are eager to collaborate with DHCS to further develop this proposal and ensure that funds are accessible to young people across the state. We appreciate the additional detail that has been provided in the application, however, we ask that the final proposal include a requirement that DHCS include community stakeholders such as youth in and with experience in foster care and caregivers in implementation planning to help ensure that it is as accessible as possible to youth and families.

We also encourage DHCS to clarify the degree to which Medi-Cal and the EPSDT guarantee are currently able to cover enrichment activities and non-traditional interventions even without a waiver. These clarifications will assist in stretching resources as far as possible and will also help identify if and how this proposal could expand over time to cover other young people, such as those involved in the juvenile justice system. Finally, we request clarification on why the stipend begins at age 3.

B.

Waiving the IMD Exclusion will Harm Children and Youth who Deserve Community Based Care

We strongly oppose waiving the Institutions for Mental Disease–IMD–exclusion through Section 1115 because of the great potential harmful impact on children and youth involved in the child welfare and juvenile justice systems. We are concerned that waiving the IMD exclusion will increase the risk of institutionalization for these young people. It is clear that children and youth do best with families in the community with treatment and care provided in that setting and that large residential mental health facilities for young people are particularly susceptible to low quality services and instances of abuse in the form of unnecessary and excessive use of restraint and seclusion. CMS has indicated that its interest in waivers is to test the allegation that the IMD exclusion is a factor causing the over-reliance on emergency departments to respond to mental health needs and is an impediment to providing access to needed acute care. It is premature to test this proposition when recent legislative changes have not been fully implemented.

Waiving the IMD exclusion is not only at odds with longstanding Medicaid law, it is also at odds with recent changes in federal child welfare law, the Family First Prevention Services Act, and state law that has aimed to reduce institutional care and ensure that when it is used, it is of high quality, short term, and focused on a transition to a less restrictive setting. California

has worked hard to strike the right balance to ensure that young people have the best chance at a family and community based care and treatment while providing limited, but available options when clinical care is needed in residential settings.

To the extent that short term residential clinical care is needed, options have been provided through the legislative process. In the last three years, the legislature has developed standards and requirements for Short Term Residential Therapeutic Programs (STRTPs) so they are aligned with federal law and eligible for IV-E reimbursement. It has also created the option of the Medicaid reimbursable Psychiatric Residential Treatment Facility (PRTF) in state law, which can provide clinical care in larger residential facilities through the passage AB 2317. While we have concerns about the use of PRTFs for children in foster care, AB 2317 includes protections for these children and youth that are not addressed in the proposal to waive the IMD exclusion for facilities that meet the size, facility, and program criteria for institutions designed primarily for the treatment of mental disease but do not/cannot meet the PRTF criteria. In addition, the legislature has allocated funds to help IMDs reduce their size and meet the requirements of STRTPs to maximize federal reimbursement and assist providers in the transition further reducing the need for a waiver.

This shift of resources to institutions and from community based care is reinforced by the application's proposal to provide incentives to "opt-in counties." We understand that the intention is to provide support for counties who opt in to also build their community based continuum. However, it is not clear why such incentives should not be used to build the community based continuum for all counties, including those committed to reducing the use of institutional care and not opting in.

We are also concerned that the proposal does not include specifics on the process for granting waivers and how, if waivers are granted, quality of care will be ensured. We believe that the milestones and reporting that CMS requires are inadequate to sufficiently improve quality in IMDs and think the State should go further.

California has worked hard to invest in and move stakeholders–advocate, service providers, agency staff, and the court–in the direction of reducing the use of institutional care in foster care and has committed to providing and growing legally required community based options. Allowing a waiver of the IMD exclusion will undo the progress we have made and will make further progress even more difficult. California and DHCS should prioritize heavily investing in efforts to increase mental health community-based provider capacity and availability with a focus on providers that serve young people impacted by the child welfare and juvenile justice systems. In addition, we urge DHCS to provide more rigorous oversight of county MHPs to ensure that they are fulfilling their obligation to provide or arrange for Speciality Mental Health Services, which is another strategy to build community based care.

C.

Exemption From The Length-of-Stay Limitations on Stays in STRTPs that are IMDs

We strongly oppose the proposal to reverse state policy and allow unlimited lengths of stay for the first two years for young people in STRTPs that are IMDs. The waiver application provides no rationale for this request.

As mentioned above, children do best with family and in family-like settings, and the harm from ongoing institutionalization of children has been well-documented. If children must be placed in inpatient or residential settings, it should be short term; a placement lasting years should not be contemplated. Regardless of how CMS is interpreting its own guidance, we strongly urge DHCS to not request an exception to the 30-day average length-of-stay in STRTPs. DHCS has offered no reasons why it wants to permit long-term stays and what problem the State is seeking to address. We do not believe such authority is appropriate or necessary. Existing provider efforts to reduce the size of STRTPs to under 16 beds and other efforts to keep children and youth in foster care in family and community settings instead of group residential care is the direction the State should be pursuing.

Thank you for the opportunity to provide feedback. We look forward to partnering with you as California moves forward with the waiver application.

Sincerely,

Jenny Pokempner, Youth Law Center

1-Cal. Health Care Found., Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions (Sept. 2021), https://www.chcf.org/publication/medi-cal-behavioral-health-services-demand-exceeds-supply-despite-expansions/; Jocelyn Wiener, Unanswered Cries: Why California Faces a Shortage of Mental Health Workers (Sept. 8, 2022), https://calmatters.org/health/2022/09/california-shortage-mental-health-workers/.
2-CMS, Letter to Medicaid Directors, November 12, 2018, at page 12.
3-P.L. 115-123 (2018).
4- These requirements have been codified at WIC 16501.1 (d), 4096 (g), and 361.22.
5- American Academy of Pediatrics, et al, The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care (Jan. 18, 2022), https://familyfirstact.org/sites/default/files/QRTP%20and%20IMD%20One%20Pager.pdf; Think of Us, Away From Home Youth Experiences of Institutional Placements in Foster Care (July 2021), https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf

August 31, 2023

Tyler Sadwith, Deputy Director
Department of Health Care Services
Sent Via Email: BH-CONNECT@dhcs.ca.gov

Re: BH-CONNECT Demonstration

Dear Deputy Director Sadwith:

Thank you for the opportunity to provide feedback on the BH-CONNECT 1115 Waiver Application. As advocates for California's most vulnerable children and youth in foster care and juvenile justice systems, the Youth Law Center (YLC) provides these comments on the impact of this proposal on these children and youth. We understand the critical importance of a robust and accessible behavioral health system to the well-being and health of system impacted youth and their families and support DHCS's efforts to use waiver authority to build out and enhance the continuum of care where existing Medicaid law does not allow. YLC supports DHCS's ongoing efforts and future plans to expand community-based behavioral health services for Medi-Cal beneficiaries in the target populations of children and youth. However, we cannot support DHCS's plan to seek a limited waiver of the IMD exclusion and waiving the length of stay requirements for STRPS that are also IMDs. We do not believe these exemptions and exceptions are needed or that they serve the best interests and well being of children and youth. We believe there are many ways that DHCS can promote expansion of community-based services without accepting Medicaid dollars for IMD care. We hope our comments are helpful in fine tuning the waiver application so that it is tailored to meet the special needs of system impacted children and youth.

A. DHCS Should Include the Activity Stipend in the Application and Highlight a Requirement for Stakeholder Involvement in Implementation to Ensure Broad Access

We support DHCS's proposal related to funding enrichment activities to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful effects of trauma. We agree that providing these services and support will greatly promote behavioral health, wellness, and help young people heal from trauma and believe these interventions must be easily accessible to young people.

Youth Law Center, along with our partners at California Youth Connection, are eager to collaborate with DHCS to further develop this proposal and ensure that funds are accessible to

young people across the state. We appreciate the additional detail that has been provided in the application, however, we ask that the final proposal include a requirement that DHCS include community stakeholders such as youth in and with experience in foster care and caregivers in implementation planning to help ensure that it is as accessible as possible to youth and families.

We also encourage DHCS to clarify the degree to which Medi-Cal and the EPSDT guarantee are currently able to cover enrichment activities and non-traditional interventions even without a waiver. These clarifications will assist in stretching resources as far as possible and will also help identify if and how this proposal could expand over time to cover other young people, such as those involved in the juvenile justice system. Finally, we request clarification on why the stipend begins at age 3.

B. Waiving the IMD Exclusion will Harm Children and Youth who Deserve Community Based Care

We strongly oppose waiving the Institutions for Mental Disease–IMD–exclusion through Section 1115 because of the great potential harmful impact on children and youth involved in the child welfare and juvenile justice systems. We are concerned that waiving the IMD exclusion will increase the risk of institutionalization for these young people. It is clear that children and youth do best with families in the community with treatment and care provided in that setting and that large residential mental health facilities for young people are particularly susceptible to low quality services and instances of abuse in the form of unnecessary and excessive use of restraint and seclusion.[1] CMS has indicated that its interest in waivers is to test the allegation that the IMD exclusion is a factor causing the over-reliance on emergency departments to respond to mental health needs and is an impediment to providing access to needed acute care.[2] It is premature to test this proposition when recent legislative changes have not been fully implemented.

Waiving the IMD exclusion is not only at odds with longstanding Medicaid law, it is also at odds with recent changes in federal child welfare law, the Family First Prevention Services Act,[3] and state law that has aimed to reduce institutional care and ensure that when it is used, it is of high

[1] Cal. Health Care Found., Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions (Sept. 2021), https://www.chcf.org/publication/medi-cal-behavioral-health-services-demand-exceeds-supply-despite-expansions/; Jocelyn Wiener, Unanswered Cries: Why California Faces a Shortage of Mental Health Workers (Sept. 8, 2022), https://calmatters.org/health/2022/09/california-shortage-mental-health-workers/.

[2] CMS, Letter to Medicaid Directors, November 12, 2018, at page 12.

[3] P.L. 115-123 (2018).

quality, short term, and focused on a transition to a less restrictive setting. California has worked hard to strike the right balance to ensure that young people have the best chance at a family and community based care and treatment while providing limited, but available options when clinical care is needed in residential settings.

To the extent that short term residential clinical care is needed, options have been provided through the legislative process. In the last three years, the legislature has developed standards and requirements for Short Term Residential Therapeutic Programs (STRTPs) so they are aligned with federal law and eligible for IV-E reimbursement.[4] It has also created the option of the Medicaid reimbursable Psychiatric Residential Treatment Facility (PRTF) in state law, which can provide clinical care in larger residential facilities through the passage AB 2317. While we have concerns about the use of PRTFs for children in foster care, AB 2317 includes protections for these children and youth that are not addressed in the proposal to waive the IMD exclusion for facilities that meet the size, facility, and program criteria for institutions designed primarily for the treatment of mental disease but do not/cannot meet the PRTF criteria. In addition, the legislature has allocated funds to help IMDs reduce their size and meet the requirements of STRTPs to maximize federal reimbursement and assist providers in the transition further reducing the need for a waiver.

This shift of resources to institutions and from community based care is reinforced by the application's proposal to provide incentives to "opt-in counties." We understand that the intention is to provide support for counties who opt in to also build their community based continuum. However, it is not clear why such incentives should not be used to build the community based continuum for all counties, including those committed to reducing the use of institutional care and not opting in.

We are also concerned that the proposal does not include specifics on the process for granting waivers and how, if waivers are granted, quality of care will be ensured. We believe that the milestones and reporting that CMS requires are inadequate to sufficiently improve quality in IMDs and think the State should go further.

California has worked hard to invest in and move stakeholders–advocate, service providers, agency staff, and the court–in the direction of reducing the use of institutional care in foster care and has committed to providing and growing legally required community based options. Allowing a waiver of the IMD exclusion will undo the progress we have made and will make further progress even more difficult. California and DHCS should prioritize heavily investing in efforts to increase mental health community-based provider capacity and availability with a

[4] These requirements have been codified at WIC 16501.1 (d), 4096 (g), and 361.22.

focus on providers that serve young people impacted by the child welfare and juvenile justice systems. In addition, we urge DHCS to provide more rigorous oversight of county MHPs to ensure that they are fulfilling their obligation to provide or arrange for Speciality Mental Health Services, which is another strategy to build community based care.

C. Exemption From The Length-of-Stay Limitations on Stays in STRTPs that are IMDs

We strongly oppose the proposal to reverse state policy and allow unlimited lengths of stay for the first two years for young people in STRTPs that are IMDs. The waiver application provides no rationale for this request.

As mentioned above, children do best with family and in family-like settings, and the harm from ongoing institutionalization of children has been well-documented.[5] If children must be placed in inpatient or residential settings, it should be short term; a placement lasting years should not be contemplated. Regardless of how CMS is interpreting its own guidance, we strongly urge DHCS to not request an exception to the 30-day average length-of-stay in STRTPs. DHCS has offered no reasons why it wants to permit long-term stays and what problem the State is seeking to address. We do not believe such authority is appropriate or necessary. Existing provider efforts to reduce the size of STRTPs to under 16 beds and other efforts to keep children and youth in foster care in family and community settings instead of group residential care is the direction the State should be pursuing.

Thank you for the opportunity to provide feedback. We look forward to partnering with you as California moves forward with the waiver application.

Sincerely,

[redacted] Youth Law Center

[5] American Academy of Pediatrics, et al, The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care (Jan. 18, 2022), https://familyfirstact.org/sites/default/files/QRTP%20and%20IMD%20One%20Pager.pdf; Think of Us, Away From Home Youth Experiences of Institutional Placements in Foster Care (July 2021), https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf .

From: [redacted]
To: DHCS BH-CONNECT; [redacted]
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 12:12:24 PM
Attachments: [redacted]

[redacted]

Greetings,

Please see the attached.

Best,

Chad Costello

August 31, 2023

Submitted via E-Mail

Department of Health Care Services
Director's Office
Attn: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: BH-CONNECT DEMONSTRATION

Dear Chief Deputy Director Cooper and Deputy Director Sadwith:

On behalf of the California Association of Social Rehabilitation Agencies (CASRA), I appreciate the opportunity to comment on the BH-CONNECT Demonstration application that was posted on August 1, 2023. CASRA's 26 non-profit member organizations provide a wide range of community-based care and support to individuals served by the public behavioral health system in 32 of California's counties.

As stated in our 01.13.22 comment letter on the then CalBH-CBC Demonstration Concept Paper, we continue to oppose the expansion of involuntary care, and we are very concerned that the approval of this waiver by CMS may lead to more individuals being subjected to treatment against their will. The homelessness crisis in California has only worsened since the release of the Concept Paper and so too has the political pressure to address the crisis by focusing on behavioral health rather than the issue's root causes – poverty and the lack of affordable housing. We remain concerned that the submission of the BH-CONNECT Demonstration application may be premature given California's recent and planned investments in behavioral health care infrastructure and the fact that many of these much-needed resources are still several years away from being completed.

With that as context and fully realizing that the application will move forward and that CMS is likely to approve it, CASRA would like to make the following comments on the application:

Use of the term "Residential" is too broad

The stated goal of BH-CONNECT is to help create a "robust continuum of community-based behavioral health care services" with a related goal of "ensuring that services are provided in the least restrictive setting appropriate for a member's needs". CASRA fully shares these goals. Given this, we are deeply concerned about the inclusion of "residential facilities" as part of the same group of services as "unnecessary emergency department visits", "hospitalizations" and "stays in inpatient … facilities" as services that should be avoided. This occurs on pages 4 and 5. On page 28, residential settings are lumped in with inpatient settings.

We assert that "residential facilities" is an overly broad term that includes a range of facilities/program types that differ in their focus and purpose. For instance, crisis residential

treatment programs (CRTs) are residential in nature, though short-term. They are also voluntary. Their purpose is to serve as a voluntary alternative to more intrusive settings such as psychiatric hospitals, and to divert individuals from potentially traumatizing environments such as emergency rooms. Furthermore, CRTs are community based, with many of those programs utilizing homes in residential neighborhoods, giving clients the opportunity to come and go and interact with neighbors and to be a part of the community.

Currently, many counties in California overutilize involuntary treatment settings because they lack alternatives, or rather the "robust continuum" of services that BH-CONNECT will hopefully motivate them to create. Should BH-CONNECT be successful in this endeavor there will be more crisis stabilization units, more CRTs, more residential treatment programs, essentially more voluntary short-term and long-term options. Because of this, we should hope to see an INCREASE in the use of these types of programs as the utilization of more restrictive settings such psychiatric inpatient units and hospital emergency rooms decreases.

In addition, the first paragraph on page 7 states "… to ensure care provided in residential and inpatient settings is short-term and high-quality". We think it important to point out that not all residential settings are designed to be short-term. Some voluntary residential treatment programs are intended to be longer term because the clients using those programs need a longer period of treatment. A client

Crisis residential treatment programs <u>are</u> community-based crisis services

The first row of the table on page 15 indicates that an underlying hypothesis that would support a conclusion that BH-CONNECT is having its intended effect would be for "utilization of community-based crisis services over the course of the demonstration". We think it vitally important that the Department and/or the evaluator include crisis residential treatment programs as one of those community-based crisis services. All too often these programs are erroneously lumped in with involuntary psychiatric inpatient programs.

As stated in our 01.13.22 comment letter on what was then referred to as the CalBH-CBC Concept Paper, in order to build a full continuum of care, the individual elements of that continuum must be defined and understood and the language referring to those elements must be used with precision. We once again include the attached taxonomy entitled "A Bed by Any Other Name" in the hope that it can provide some clarity with respect to the adult/older adult portion of the continuum of care.

<u>"Cover" vs. "Provide"</u>

On page 4, the document states "The BH-CONNECT demonstration aims to expand Medi-Cal service coverage". On page 28, as part of the "Demonstration Request" the document states in relation to counties opting in to receive FFP for short-term stays in IMDs "to participate, a county must agree to cover a full array of enhanced community-based services and EBPs …" CASRA would like to point out that there is a vast difference between covering services and ensuring those services are actually provided. Coverage without access is meaningless. We've seen numerous examples of this in the behavioral health parity space with private health plans that know they are legally required to cover a set of services, so do so on paper, but when it comes down to it don't necessarily provide them or instead make it difficult for beneficiaries to access those services, which has a similar effect.

Because of this, we are concerned that counties who elect to exercise the option to receive FFP for services provided during short-term hospital stays in IMDs, may exhibit similar behavior. We are glad to see language on page 29 such as "building networks to deliver newly required, enhanced community-based services" and "implementing community-based care options" " and "demonstrate increased utilization rates of community-based services and EBPs" since these go beyond just "cover" and we look forward to working with the Department through the stakeholder process to develop the measures best suited to holding the counties accountable for providing the range of required services.

Page 12 Diagram

We acknowledge the difficulty in creating a simple visual representation of the connections and interactions of the numerous behavioral health initiatives either currently underway or soon slated for implementation. However, we continue to be deeply concerned that "Recovery Services" have been relegated to just one the seven boxes in the central circle. This would seem to indicate that recovery occurs outside of and apart from the other identified services, when in fact a recovery-based approach and emphasis should be the focus throughout the entire continuum of services. Even a locked, involuntary inpatient setting can choose to incorporate a recovery-focused approach. California has spent billions of dollars of MHSA funding over the past nineteen years to help transform the entire public behavioral system into one that embraces and supports recovery, the diagram should represent this.

Similarly, if California is committed to embracing Peer Support Services and Peer Support Specialists then they should not be confined to one of the service boxes. Peer Support Services should be embedded in all elements of the services continuum rather than cordoned off into one service element.

These issues could be partially addressed by adding to the "Note" on the bottom of the page

Thank you again for the opportunity to comment on the BH-CONNECT application. Should you or any of your staff have questions about any of the above, please feel free to contact me at [redacted]

Sincerely,

[redacted]

Chad Costello
Executive Director

cc: Stephanie Welch, Deputy Secretary of Behavioral Health, California Health & Human Services Agency

A Bed by Any Other Name

Adults and Older Adults

Taxonomy

Respite	**Residential Treatment Continuum of Care** *(Licensing Entity)* *(Medicaid Certification/Reimbursement Eligibility)*					**Custodial Care** *(Licensing Entity)*		**Housing**	
←	***(No lease/rental agreement/deed - No tenant rights present)***					→		***(Lease/rental agreement/deed – tenant rights present)***	
Short Term	**Acute Care**		**Rehabilitative/Recovery**		**Log Term**	**Long Term**		**Housing w/Supportive Services (Long Term)**	**Housing w/out Supportive Services (Long Term)**
Voluntary*	Voluntary	Involuntary	Voluntary	Involuntary	Involuntary**	Voluntary		Voluntary	Voluntary
Peer Respite	*Acute in-patient (DPH) (Title 9 & SMHP)*	*Acute in-patient (DPH) (Title 9 & SMHP)*	*Transitional (DSS/CCL) (Title 9 & SMHP)*	*Mental Health Rehabilitation Center (DHCS)*	*State Hospital (DPH)*	*Adult Residential Facility (DSS /CCL)*		*Agency-owned/ leased apartment*	*Agency-owned/ leased unit*
Transitional	*Crisis Residential (DSS/CCL) (Title 9 & SMHP)*	*Psychiatric Health Facility (DHCS) (Title 9 & SMHP)*	*Long-term Residential Treatment (DSS/CCL) (Title 9 & SMHP)*		*Skilled Nursing Facility/STP (Special Treatment Program) (DPH)*	*Residential Care Facility for the Elderly (DSS/CCL)*		*Single Room Occupancy*	*Single Room Occupancy*
Emergency Shelter	*Crisis Stabilization (Less than 24-hours) (Title 9 & SMHP)*					*Skilled Nursing Facility (DPH)*			*Market leased rented unit*
Motel/ Hotel									*Self-owned/leased/rented unit*

DHCS = California Department of Health Care Services DPH = California Department of Public Health DSS/CCL = California Department of Social Services – Community Care Licensing

*Mental Health Urgent Care Center (MHUC) not included due to being less than 24 hours *(not licensed, but certified by Medi-Cal)*

** Institute for Mental Disease (IMD) is a Medicaid specific term that refers to the prohibition of Medicaid eligibility for 24-hour treatment programs in excess of 16 beds. The IMD exclusion applies to ALL 24-hour treatment settings whether community-based or institutional. It is most commonly used as shorthand for skilled nursing facilities.

= Community-Based
= Institutional
= Custodial

Rev: 07.09.21

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 12:40:11 PM

[redacted]

Dear DHCS,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community.
We have recently formed the Clubhouse Coalition California. Why did we form the Coalition? Because the role of Clubhouse is so important. It is very difficult to form and fund new clubhouses, as well as sustain existing ones. The Coalition works to support expansion of Clubhouses and their services. Our goal is to partner with the State, to create a vital network of clubhouses throughout the state of California. This supports those with SMI by providing a necessary program to complete the continuum of care.
Thank you,
Patricia O'Brien
Treasurer
Clubhouse Coalition California

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 12:52:31 PM

[redacted]

Dear DHCS,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community.
We have recently formed the Clubhouse Coalition California. Why did we form the Coalition? Because the role of Clubhouse is so important. It is very difficult to form and fund new clubhouses, as well as sustain existing ones. The Coalition works to support expansion of Clubhouses and their services.

Our goal is to partner with the State, to create a vital network of clubhouses throughout the state of California. Our vision is the daily, ongoing support for those with SMI by providing a necessary program to complete the continuum of care.
Thank you for recognizing Clubhouse services in your application,
Juliana Fuerbringer
Board President
Clubhouse Coalition California

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 12:59:29 PM

[redacted]

Hello DHCS,
I am an active member and activist in the mental health community. I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community.

As a social and vocational rehabilitation program -- ***as Clubhouse notes -- that is free, voluntary, and for life,*** Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation.

The first Clubhouse was opened 75 years ago. Please help spread them throughout California!
Thank you, Neil

Neil Murphy
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 1:28:44 PM
Attachments: [redacted]

[redacted]

Dear DHCS,

As a longstanding Board Member of Clubhouse International, a global network of over 330 Clubhouses in over 35 countries, I strongly support the decision to include the availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community.

As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment. Instead, it offers an ongoing recovery process. It creates a community that supports members and reduces isolation.

Working together, we hope to see Clubhouses in California receive additional Federal funding as part of the state's application.

Thank you for your efforts.

Sincerely,
Norma J. Arnold

Norma J. Arnold | Board Member
[redacted]

Clubhouse International
Creating Community: Changing the World of Mental Health

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 1:38:09 PM

[redacted]

Good afternoon again, Ms. Cooper, Mr. Sadwith, and related DHCS staff:

I am resubmitting my comments, this time with the correct Subject Line Title: BH CONNECT Demonstration. What follows is a slightly corrected version of my submission yesterday. Hope these comments are taken seriously.

In the two public Zoom presentations, Aug. 11 and 24, I was personally extremely disheartened by how the DHCS intends to totally unnecessarily restrict the use of this most vital potentially life-saving tool as much as possible for Severely Mentally Ill (SVMI) loved ones such as ours. As a result of great pressure from Disability Rights California (DRC), DHCS proposes to limit the application of this portion of the waiver to just hospital adult psychiatric beds for a maximum of two consecutive 5270 up to 30 days involuntary stay each. Like other portions of the behavioral health care system, this would create unnecessary and unintended sub-acute care "human log jams" for the very highest required level of our adult loved ones psychiatric care especially for the desperately needed 43-bed adult psychiatric wards at the Contra Costa Regional Medical Center (CCRMC) in Martinez.

Here is why the situation is so very dire throughout the state and especially here in Contra Costa County:

As I forcefully stated at the August 11 Zoom meeting, this county has one of the "top 10" populations of persons judicially adjudged Incompetent to Stand Trial (IST) in the state. As a result, it is in line to receive $9M to either construct or refurbish for nearly 100 persons for their 18-month Average Length of Stay (ALOS). This means these 100 beds are really needed right now. However, such housing does not need to be "up and running" until June 30, 2028. On page 4 (see attached), this same report states that the *"DSH is currently developing new IMD (Institute of Mental Diseases) and sub-acute capacity across the state. These beds will be available as a stepdown stabilization option for felony IST clients transitioning from jail to the community-based restoration or diversion programs and can also be used when IST clients receiving treatment in these community programs need a higher level of care. Together, these programs will support a comprehensive continuum of community placement and housing options for individuals deemed IST on felony charges across the state."*

This Dept. of State Hospital (DSH) IST Diversion and Community Based Restoration Infrastructure Project Request for Proposals (RFP) directly speaks to the continuing desperate paucity of such critically needed time limited locked facility beds throughout the state. In fact, the county Behavioral Health Director has publicly stated that she previously attempted to get the state to agree to a test with another nearby county to demonstrate long-term cost savings if the federal IMD Medicaid (Medi-Cal) Reimbursement Exclusion for person 21-64 years of age was conditionally lifted for a set period of years (3-6). However, the state would not agree to this "Demonstration Trial."

We family members of all cultures, ethnicities, and languages are desperate for any even short-term locked facility fully Medi-Cal funded options for our Severely Mentally Ill loved ones from so that they do not either wind up dead on the streets without treatment or endlessly "trapped" in the criminal justice system!!!

Hope you are honestly listening and will carefully consider these most heart-felt families concerns in this most important Section 1115 Demonstration Waiver application.

Sincerely,
Douglas Dunn
parent of a Gravely Mentally Ill loved one
former Vice Chair of the Contra Costa Mental Health Commission and Chair of its Finance Committee
Chair, NAMI Contra Costa Legislation Committee

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 1:43:16 PM
Attachments: [redacted]

Hello,

The California Behavioral Health Planning Council (CBHPC) has reviewed the BH-CONNECT Section 1115 Demonstration Application and has provided recommendations for the Demonstration in the attached letter.

We thank the Department of Health Care Services for the opportunity to respond to the BH-CONNECT Demonstration. Should you have any questions pertaining to our comments, you may contact CBHPC's Executive Officer, Jenny Bayardo.

Best,

Ashneek S. Nanua
(she/her/hers)
Health Program Specialist II
[redacted]
Office hours: 8:00 am–4:30 pm

California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

CHAIRPERSON
Deborah Starkey

EXECUTIVE OFFICER
Jenny Bayardo

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Sacramento, CA 95899-7413

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MS 2706

August 31, 2023

Attn: Jacey Cooper and Tyler Sadwith
Department of Health Care Services
Director's Office
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: BH-CONNECT Demonstration

Dear Ms. Cooper and Mr. Sadwith:

The California Behavioral Health Planning Council (CBHPC) thanks the Department of Health Care Services (DHCS) for the opportunity to comment on the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, for which DHCS intends to submit a Medicaid Section 1115 Waiver Application to the Centers for Medicare and Medicaid Services (CMS). Pursuant to state law, the Council serves as an advisory body to DHCS, the Legislature, and the Administration on the policies and priorities that this state should be pursuing in developing its behavioral health system. Our membership includes persons with lived experience as consumers and family members, professionals, providers, and representatives from state departments whose populations touch the behavioral health system. Their perspectives, particularly those provided by individuals with lived experience as members of our committee, are essential to our view on the challenges and successes of behavioral health services and best practices in California.

The CBHPC appreciates the department's efforts in creating the BH-CONNECT Demonstration and stakeholder process as this proposal strives to expand access, capacity, equity, and build out the continuum of community-based behavioral health services in California. The Planning Council's Systems and Medicaid Committee (SMC) wrote a letter of recommendations in January 2023 in response to the concept paper for this proposal. The Council asks DHCS to review the letter prior to submitting the waiver application to CMS, as well as during the policy development and implementation stage of the programs outlined in the proposal. In addition to the recommendations provided in the January 2023 letter, the SMC provides comments and recommendations for the BH-CONNECT 1115 Demonstration Waiver Application in the categories below:

California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

CHAIRPERSON
Deborah Starkey

EXECUTIVE OFFICER
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Activity Stipends

The SMC appreciates the inclusion of activity stipends to provide children and youth in child welfare with extracurricular activities that support physical and mental health as well as promote healthy attachment and social connections. We ask that the eligibility criteria for these stipends be broadened to include siblings and family members of children involved in the child welfare system so that the kinship and family connectedness remains intact through experiences of trauma. Providing flexibility for these activity stipends may help in the reduction of disparities as normal development activities defined in the proposal vary between different cultural and ethnic groups. In regard to the scope of services for the activity stipends, the SMC requests the addition of "bi-cultural, cross-cultural celebrations and festivals" as an activity in order for children of a particular culture, race, or tribe to become educated and stay connected to their roots.

Statewide Incentive Program

Specific measurements stated in the scope of the Statewide Incentive Program include a follow-up after an emergency department (ED) visit for mental illness. The SMC recommends that a follow-up visit for a substance use disorder ED visit be added to the proposed measures for the Statewide Incentive Program.

Option to Cover Enhanced Community-Based Services

Addition of Community-Defined Evidence Practices (CDEPs)

The SMC appreciates efforts in the BH-CONNECT Demonstration to expand the continuum of community-based services and evidence-based practices (EBPs) available through the Medi-Cal program. In addition to the use of EBPs, the committee recommends that Community-Defined Evidence Practices (CDEPs) be added to this initiative. The use of CDEPs would help contribute to DHCS' access and equity goals, as these interventions equitably address disparities and gaps in care. We encourage DHCS to refer to the California Reducing Disparities Project (CRDP) for examples of CDEPs.

Addition of EBPs Specific to Substance Use Disorder (SUD)

Page 13 of the BH-CONNECT 1115 Demonstration Application states that California's goal for the demonstration is to strengthen the state's continuum of community-based behavioral health services to better meet the needs of Medi-Cal members living with SMI/SED and/or an SUD. Therefore, the SMC recommends that an EBP specific to the SUD-only populations be included in the list of county opt-in community-based services. An example of an SUD-specific EBP may be the expansion and support of Medication-Assisted Treatment (MAT) including linkage to Centers of Excellence (COEs) that

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support SUD populations. Additionally, the inclusion of SUD-only interventions such as the one described may help support linkage to resources provided by the 988 Suicide Prevention and Crisis Hotline, as well as assist in the reduction of ED visits.

Regional Models

The SMC recommends that the state enable counties to use regional models to implement EBP services as many small, rural counties may not have the resources to implement the opt-in community-based services. Please refer to the SMC's January 2023 letter for more information on this topic.

Centers of Excellence (COEs)

The SMC recognizes that Centers of Excellence will provide technical assistance to counties implementing specific EBPs. The committee asks DHCS to clarify the process and requirements for organizations to be deemed as COEs as well as how the COEs will operate. We also ask that DHCS clarify whether the definition for COEs is based on a federal definition or state definition and whether there is a sustainability plan for the COEs to operate on a continuous basis. The SMC recommends that technical assistance be provided as a statewide effort for counties to implement the EBPs.

Workforce Initiative

The SMC commends the department for requesting expenditure authority to support and expand the behavioral health workforce, as a diverse and culturally-responsive workforce is needed to ensure the successful implementation of the services and programs in the BH-CONNECT Demonstration. The choice of EBPs utilized for counties opting into the enhanced community-based services in the demonstration and the fidelity of these EBPs are also tied to issues around the workforce shortage, as an adequate supply of providers and staff are needed to implement these services. In regard to workforce, the committee recommends that workforce funding be available to all individuals who need it. This includes individuals outside of the provider classification such as Executive Directors and administrative staff, as workforce shortages and needs exist beyond the provider level. The SMC also asks that the state include the concept of recovery in behavioral health workforce training programs similar to the provision of recovery as defined in the Mental Health Services Act (MHSA).

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Additionally, the committee recommends that DHCS set aside funding to invest in and build out the workforce for historically marginalized populations, such as Black, Indigenous, and People of Color (BIPOC), to allow the opportunity for them to start programs in their communities as these individuals best understand and respond to their community's needs. This set-aside funding would be helpful as compared to the current funding sources which are difficult for the average person to navigate and utilize. Please refer to the SMC's January 2023 letter for additional comments regarding the workforce initiative as it pertains to questions around how counties that opt into supported employment may conduct long-term services after job placement.

Transitional Rent Services

The committee appreciates that individuals living with behavioral health conditions who have housing needs may be granted up to six months of rental assistance. If the Department of Housing and Urban Development (HUD) definition of homelessness is the federal definition, the SMC recommends that there be a state definition for more flexibility as the federal definition may exclude a large group of people from eligibility. We ask DHCS to review additional considerations regarding transitional rent services in the committee's January 2023 letter.

Federal Financial Participation (FFP) for Short-Term Stays in Institutes for Mental Disease (IMD)

The SMC appreciates DHCS' intention to build out a full continuum of community-based behavioral health care in California. We support this notion as community-based services reduce the need for institutionalization and utilization of IMDs. The committee is seeking clarification on what will occur if an individual resides in an IMD past the 60-day FFP reimbursement period. We also ask the state to distinguish between residential treatment and inpatient treatment in subsequent guidance.

Expansion of Cross-System Approach to Adult and Older Adult Populations

The committee commends DHCS for the inclusion of a Foster Care Liaison within Managed Care Plans (MCPs) to enable effective oversight and delivery of Enhanced Care Management (ECM), attend Child and Family Team meetings, ensure the coordination of Managed Care services with other services, and serve as a point of escalation for care manager in the face of

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operational obstacles. We believe this is an excellent cross-system approach that is valuable to navigate challenges that beneficiaries face when navigating care between MCPs and county Mental Health Plans (MHPs). The SMC would like to see this concept expanded to the adult and older adult population to better serve all populations in need. Additionally, we ask DHCS to refer to the SMC's January 2023 letter for additional considerations for the expansion of services to the older adult population, such as the establishment of initial behavioral health assessments at the point of entry.

In addition to the recommendations above, the committee requests that the state engage in meaningful stakeholder processes throughout the design and implementation of the BH-CONNECT Demonstration. It is highly encouraged that the state involves consumers and family members in the development of policies related to this waiver. We hope that the recommendations put forth in this letter are taken into consideration as the Department of Health Care Services finalizes the BH-CONNECT 1115 Demonstration Waiver Application to the Centers for Medicare and Medicaid Services.

The Planning Council appreciates the opportunity to submit comments and asks to be included in future conversations hosted on this topic. For questions, please contact CBHPC's Executive Officer, Jenny Bayardo, [redacted]

Sincerely,

[redacted]
Deborah Starkey
Chairperson

cc: Paula Wilhelm, Assistant Deputy Director of Behavioral Health
California Department of Health Care Services

Erika Cristo, Assistant Deputy Director of Behavioral Health
California Department of Health Care Services

Ivan Bhardwaj, Acting Chief, Medi-Cal Behavioral Health Division
California Department of Health Care Services

From: [redacted]
To: DHCS BH-CONNECT; [redacted]
Cc: [redacted]
Subject: [External]NHeLP"s BH-CONNECT State Comments
Date: Thursday, August 31, 2023 2:06:42 PM
Attachments: [redacted]

[redacted]

Hi Jacey and Tyler -

Attached please find our comments on the BH-CONNECT Section 1115 Demonstration proposal.

As always, please let me know if you have any questions or would like to discuss our comments further.

Best,

Kim

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Kim Lewis (*she/her/hers*)
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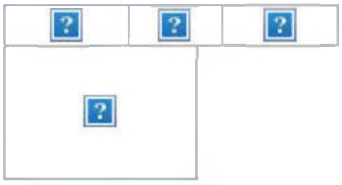

August 31, 2023

Department of Health Care Services
Director's Office
Attn: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
Sent via email: BH-CONNECT@dhcs.ca.gov

RE: BH-CONNECT Demonstration

Dear Director Cooper and Deputy Director Sadwith,

On behalf of the National Health Law Program (NHeLP), we am writing to provide our comments and feedback on the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration draft proposal.[1] NHeLP is a public interest law firm that protects and expands the health care rights of low-income and underserved individuals in California and across the Country.

We begin by emphasizing that we strongly support the overall goals of BH-CONNECT as set forth in this proposal. We commend the ongoing efforts the Department of Health Care Services (DHCS) has made to strengthen California's behavioral health system, particularly for individuals on Medi-Cal with the highest needs and experiencing the greatest disparities. DHCS has made unprecedented investments in expanding behavioral health services and supports for Medi-Cal beneficiaries through California Advancing and Innovating Medi-Cal (CalAIM), including efforts to build out a comprehensive continuum of care for beneficiaries with the highest level of behavioral health needs. We appreciate that BH-CONNECT seeks to continue this work by expanding the range of community-based mental health services available to

Medi-Cal beneficiaries, especially evidence-based practices (EBPs). We also are pleased to see the Department acknowledge that there are still significant gaps remaining in the current continuum of care available to Medi-Cal members living with SMI/SED, particularly among children and youth and agree that strengthening the statewide continuum and improving accountability are critical steps to achieve these goals.

We also understand that the focus populations of this demonstration will be Medi-Cal members living with significant behavioral health needs, including child welfare involved youth, individuals who are experiencing (or at risk of experiencing) homelessness, and individuals who are justice involved. We certainly appreciate the focus on these particular high need groups, and appreciate that the proposed benefit expansions will also reach other Medi-Cal members when they need them. We also strongly endorse the aim of reducing use of institutional care by those individuals most significantly affected by significant behavioral health needs.

We appreciate the additional clarity in this proposal compared to the Concept Papers we have reviewed previously, as to what DHCS is proposing to cover under 1915(b) and 1115 waiver authority (including expenditure authority) versus what will be covered through State Plan Amendments, and how the waiver authorities will interact with those State Plan Amendments. As discussed in more detail below, however, we strongly encourage DHCS to adopt a statewide approach to implementing new benefits, instead of allowing counties to determine what benefits they will cover at their option. Our detailed comments and feedback on the various components of the draft proposal are below.

Existing Medicaid Authorities

We appreciate DHCS's clarification that it intends to use existing authority to advance several components of the BH-CONNECT proposal:

- Clarifying coverage requirements for evidence-based practices for children and youth under EPSDT;
- Requiring managed care plans to establish a management-level Foster Care Liaison.

[1] Cal. Dept. Health Care Servs., *The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BHCONNECT) Section 1115 Demonstration* (2023), https://www.dhcs.ca.gov/provgovpart/Documents/Proposed-BH-CONNECT-1115-Application.pdf (hereinafter *Proposal*).

- Establishing an initial child welfare/specialty mental health assessment when children and youth enter the child welfare system.
- Engaging Centers of Excellence to offer training and technical assistance to behavioral health delivery systems and providers to support fidelity implementation and delivery services.

See Proposal at 8. In particular, we support the inclusion of children and youth proposals that will be provided statewide as part of the state's existing federal Medicaid authority. We appreciate that DHCS is clarifying that Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT) and potentially additional therapeutic modalities must be covered statewide under EPSDT. We recommend that DHCS develop a list of additional alternative therapeutic modalities that can potentially be covered under Medi-Cal, such as art therapy, movement therapy, music therapy, and equine therapy. These non-traditional treatment modalities show promise in treating mental health conditions often faced by youth, including foster youth, and are often preferred to traditional talk therapy by youth.[2] If they cannot be covered under current authority then DHCS should consider seeking federal approval to cover them.

We also strongly support implementing a specialty mental health assessment at the entry point to the child welfare system. We emphasize, however, that this is a service that should already be available under EPSDT and paid for by Medi-Cal. These services must be available to all children on Medi-Cal, as medically necessary, and not just those "entering child welfare."

We support the establishment of Centers of Excellence to offer training and technical assistance to behavioral health delivery systems and providers to support fidelity implementation and delivery of EBPs and community-defined evidence practices for Medi-Cal members living with SMI/SED and/or a SUD. But requiring the behavioral health plans and providers of these EBPs and community-defined evidence practices will require clear direction and expectation by DHCS so that they are relied on and utilized to ensure quality and fidelity practice, and desired outcomes, are being delivered throughout the state.

[2] For example, for children who have experienced trauma, these interventions are often the most appropriate modality to address sensory/motor integration needs of children who are often overly stimulated by touch and sound and other external stimuli. These interventions can be critical in helping children find calming ways to integrate the stimuli and prevent overstimulation. These interventions also enable youth to develop skills and/or adaptive replacement behaviors, decreasing their dependence on formal services over time.

Section 1115 Waiver Hypotheses and Evaluation Plan

For the Secretary to approve a project pursuant to § 1115, the project must:

- be an "experimental, pilot or demonstration" project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.

Discussing each of these limitations a bit further:

First, the state must propose to conduct an "experimental, pilot, or demonstration" project. This demands a "novel approach" to program administration. *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

Second, the project must promote the Medicaid Act's objectives. Congress has made clear that the purpose of Medicaid is to enable states "to furnish[] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1; 1396d(a) (defining "medical assistance" as provision of, or payment for, specified health care and services). Thus, the "central objective" of the Medicaid Act is "to provide medical assistance." *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting "promoting health" as an independent objective because the Medicaid Act is "designed … to address not health generally but the provision of care to needy populations" through a health insurance program).

Third, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b-1396w-5. *See* Social Security Act, § 1115(a)(1)). Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of "such project" are "regarded as expenditures under the State plan" and, thus, paid for under the same statutory formula that applies for a state's expenditures under its State plan. *Id.* § 1115(a)(2). Section 1115(a)(2) does not create an independent "expenditure authority" for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the

contrary, it is a "clean-up" provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

Fourth, section 1115 allows approvals only "to the extent and for the period necessary" to carry out the experiment. *Id.* § 1115(a); *see also id.* §§ 1115(e)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers).[3] Congress did not enact section 1115 to permit the Secretary to make long-term policy changes.

As discussed in more detail below, NHeLP has serious questions about whether this proposal constitutes a genuine experiment. For the waiver as a whole, DHCS states that the proposal "will test whether the granted waiver and expenditure authorities increase access to community-based behavioral health services and improve outcomes for Medi-Cal members living with SMI/SED and/or a SUD." *Proposal* at 13. Yet, as described in more detail below, many of its proposed hypotheses and evaluation methodologies designed to test this hypothesis fall short.

In addition, NHeLP continues to oppose the proposed extension of existing waivers of statewideness, and amount, duration, and scope and comparability. Behavioral health delivery system and access problems are a statewide problem and therefore the solutions must be statewide. Beneficiaries should not be penalized with less access to behavioral health services simply because of the county they live in. We remain concerned about DHCS's continued decision to make benefits available on a county "opt-in" approach through the 1115 waiver and 1915(b) waiver. This approach adds to the statewide confusion and complexity about what benefits are available to whom and where. It is particularly concerning that DHCS is continuing to allow this level of variation in the behavioral health delivery system at the same time it is working through CalAIM to standardize benefits and enrollment in managed care. We provide additional comments about DHCS's proposed hypotheses and evaluation plans for various components of the demonstration in more detail below.

[3] In 2017, a CMS Informational Bulletin announced the intent "[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*" Section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, section 1115's limitation of approvals to experimental, pilot, or demonstration projects (not for "routine" projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy).

BH-CONNECT Features Available Statewide

As discussed above, we oppose the use of Expenditure Authority to ignore the requirements of the Medicaid Act. Notwithstanding those legal concerns, we offer the below comments on the various components of the proposal as a matter of policy.

Workforce Initiative to Ensure Access to Critical Medi-Cal Behavioral Health Services

We believe the workforce initiative component of the demonstration is one of the most critical aspects of the proposed demonstration. As the rest of the nation, California faces mounting challenges with regards to lack of availability of behavioral health providers and services.[4] It is effectively meaningless for Medi-Cal to cover certain services if no or few providers are available to deliver them. The situation is particularly stark when it comes to community-based mental health services, which is why it is essential that California implement a proactive approach to address provider infrastructure. This initiative could also serve to ensure continuous improvement in availability of community-based services in light of the expansion of residential beds for beneficiaries with SMI/SED. To that end, we appreciate the examples provided by DHCS regarding long-term investments to expand the pipeline of behavioral health professionals and short-term investments to support recruitment efforts for key behavioral health services. Because of their emphasis on community-based services, we believe those are the types of investments that should be prioritized as part of this initiative.

Despite our general support, however, we caution that by the way it is currently described, the workforce initiative continues to be too open-ended in a way that allows for investment in less effective, and sometimes harmful, services and settings, such as residential and institutional behavioral health care. The hypothesis for this initiative is that the availability of behavioral health providers will increase over the course of the demonstration. DHCS proposes to collect data specific to the initiative to determine whether its hypothesis is correct: (1) the number of providers expanding clinical capacity attributable to the behavioral health workforce initiative; and (2) the number of new college/university slots funded through behavioral health workforce initiative. *Proposal* at 17. We urge DHCS to explicitly limit the funding tied to the workforce initiative to efforts to increase availability of Medi-Cal covered home and community-based services. Because the evidence shows that such care settings are significantly more

[4] Jocelyn Wiener, *Unanswered Cries: Why California faces a shortage of mental health workers*, CALMATTERS, Sept. 8, 2022, https://calmatters.org/health/2022/09/california-shortage-mental-health-workers.

effective and appropriate for individuals living with SMI/SED, we see no reason why DHCS would even entertain the idea of investing in increased long-term or short-term availability of residential beds. We are encouraged by the investment examples provided by DHCS, but in order to fully support this initiative we would like to see a more explicit commitment to using the fundings exclusively to incentivize effective and evidence supported community-based services.

Activity Stipends

We support DHCS's proposal to develop a new stipend for children aged three and older involved with the child welfare system to be used for activities and supports to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful physical and mental health effects of trauma. We agree that children and youth involved in the child welfare system need access to after-school and extracurricular activities that support physical health, mental wellness, healthy attachment and social connections to support social and emotional development, promote and enhance long-term mental health and prevent substance use. That said, we strongly suggest that the stipends be available to keep kids who are at risk of coming into foster care or child welfare involvement altogether as these activities can be an effective way to improve outcomes and mitigate the impact of poverty, trauma and poor health for all low-income children and youth, not just those involved in child welfare. For example, children and youth at risk of juvenile justice involvement should also have access to these activities and supports. Broadening it will have a more equitable impact on the Medicaid BIPOC population who are at particularly high risk and have worse outcomes. We also want to know if these funds will be expected to pay for non-traditional therapeutic interventions that we identified earlier in our comments. We believe those interventions can and should be covered under EPSDT or separately requested to be covered through BH-CONNECT given purely extracurricular activities and supports are different than non-traditional therapeutic interventions. Finally, we question why younger children are not eligible as well.

DHCS must ensure that the stipend funding is not used to pay for services that should be paid for with other Medicaid funds for covered services under EPSDT. We also would want Title IV-E funds to be utilized for activity stipends where such funds can be utilized so these Medicaid funds are available for other children and youth that need them. More details about how these funds will be distributed and monitored is also needed.

Finally, the hypothesis for this waiver request states that outcomes for children and youth involved with child welfare will improve over the course of the demonstration.

Proposal at 16. Yet the evaluation says nothing about outcomes at all, but merely seeks to review claims and utilization data. *See id.* If the Department wants to claim and demonstrate success with these stipends, it needs to look at and measure true outcomes, not mental health access or penetration rates.

Cross-Sector Incentive Program for Children Involved in Child Welfare

DHCS is proposing the Cross-Sector Incentive Pool to establish a program for cross-agency collaboration to address the needs of children and youth involved in child welfare who are living with or at high-risk for SED. While we strongly support greater accountability, data-sharing and establishing outcome measures for children and youth in the child welfare system, we don't understand how this is different from what ECM is supposed to be providing for this population, which is similar if not the same. Is this just for children and youth involved in child welfare who are in fee-for-service Medi-Cal? Or will this program even be available for those youth not enrolled in MCPs? We still need to understand how these incentives will work to improve outcomes and accountability between MCPs, county behavioral health and child welfare agencies, who will be responsible for this program and how it will achieve what the MCP's ECM benefit hasn't yet been given time to accomplish for this ECM target population. This proposal honestly presents more questions than answers. Little information is provided about how the Statewide County Incentive Program will be funded or how benchmarks will be selected. To be successful, DHCS will have to ensure that the incentives provided through this program are sufficiently meaningful to achieve the intended outcomes and not duplicative to existing new CalAIM efforts.

As discussed above, we support the establishment of Centers of Excellence to offer training and technical assistance to behavioral health delivery systems and providers to support fidelity implementation and delivery of EBPs and community-defined evidence practices for Medi-Cal members living with SMI/SED and/or a SUD. But more information is needed to assess the effectiveness of this proposal and clear outcomes need to be developed statewide. The hypothesis proposed for this proposal is that the availability of trainings, technical assistance and incentives will strengthen the provision of community-based care and improve outcomes will increase over the course of the demonstration. *Proposal* at 16. Yet the evaluation doesn't address outcomes, but merely seeks to review training numbers and participation rates in trainings and in fidelity reviews. *Id.* at 16-17. If the Department wants to claim and demonstrate success with these stipends, it needs to look at and measure outcomes of these EBPs based on support from the Centers.

Statewide Incentive Program

We support the statewide incentive program in concept. We believe this is an important component to ensure appropriate implementation of the demonstration features that will be available statewide. We also commend DHCS's commitment to using the statewide incentive program to support and prioritize availability of behavioral health community-based services over institutional care, and emphasizing quality measures that evaluate effective transitions of care, cultural and race, ethnicity and language responsiveness, and other factors that are determinant for provision of quality behavioral health services in appropriate settings. However, while we understand that DHCS intends to establish a stakeholder process to determine the specific measures to be evaluated, we would have appreciated more context and details about what the department envisions before the release of the proposal. To date, DHCS has not articulated a hypothesis for this initiative or described how it will be evaluated. We urge DHCS to engage in such conversations with stakeholders before the demonstration's submission to CMS so that we can provide more informed and in-depth feedback.

BH-CONNECT Features Available at County Option

Again, we strongly encourage DHCS to adopt a statewide approach. Behavioral health delivery system and access problems are a statewide problem and therefore the solutions must be statewide. Individuals should not be penalized with less access to behavioral health services simply because of the county they live in. That is an ongoing approach through the 1115 waiver and 1915(b) waiver which remains a concern to us and also simply adds to the statewide confusion and complexity about what is available, to whom and where. This proposed demonstration builds on that approach by seeking county by county changes and authorizations that will impact some beneficiaries or populations, but not all. It is particularly concerning that DHCS is continuing to allow this level of variation in the behavioral health delivery system at the same time it is working through CalAIM to standardize benefits and enrollment in managed care. Again, notwithstanding the legal concerns discussed above, we offer the below comments on the various components of the proposal as a matter of policy.

Option to Cover Enhanced Community-Based Services

DHCS proposes adding six adult behavioral health services, but limiting the availability of these services to certain counties. These services – Assertive Community Treatment (ACT); Forensic ACT (FACT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Individual Placement and Support (IPS) model of Supported Employment; Community health worker (CHW) services; and Clubhouse services – are

core services for any functioning adult mental health system.[5] In fact, in 2018, the majority of states (33) covered ACT via Medicaid.[6]

We are pleased that DHCS intends to submit a state plan amendment to authorize delivery of ACT, FACT, and CSC for FEP, as well as for Clubhouse Services. We would strongly support such a state plan amendment, and we note that many states cover services such as ACT and FACT as a bundled service without use of a Section 1115 demonstration.[7] Similarly, FEP services may be covered as a Medicaid service, under various Medicaid state plan 1905(a) benefit categories.[8]

We commend DHCS for recognizing the effectiveness of CHW services as an essential community-based service to help provide recovery support for populations most in need of enhanced behavioral health services. However, CHW services have already been established as a benefit under the State Plan and are made available statewide.[9] We recommend that DHCS refrain from categorizing the CHW services as an optional benefit for counties to cover, when CHW services is already required to be available as a benefit in all counties through Medi-Cal managed care and fee-for-service. By categorizing CHW services as optional or adding a "new" or different" CHW benefits, it would only raise concerns and cause confusion that (a) the CHW services benefit is

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[5] *See, e.g.*, Bazelon Center, *Diversion to What?* (2019), http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf (describing evidence bases for ACT, supported employment, peer support, mobile crisis, and supported housing).

[6] Kaiser Fam. Found., *Medicaid Behavioral Health Services: Assertive Community Treatment* (2018), https://www.kff.org/medicaid/state-indicator/medicaid-behavioral-health-services-assertive-community-treatment.

[7] For example, even states with Section 1115 waivers, such as the District of Columbia, still cover ACT as a single rehabilitative service, via state plan authority. *See* D.C. Mun. Regs., tit. 29, § 5210; District of Columbia State Plan Amendment, effective April 1, 2022, https://www.medicaid.gov/medicaid/spa/downloads/DC-22-0005.pdf. While many states reimburse ACT in 15 minute increments, Rhode Island covers ACT as a single bundled *monthly* service. Rhode Island State Plan Amendment, effective 12/1/2021, https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0025-A.pdf; *see also* CMS, Dear State Medicaid Director Letter (Aug. 15, 2007) (SMD # 07-011) (guidance on Medicaid reimbursement for peer support services), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf (noting state plan authority to cover peer services).

[8] CMS, NIMH & SAMHSA Joint Informational Bulletin, *Coverage of Early Intervention Services for First Episode Psychosis* (Oct. 16, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf.

[9] 42 C.F.R. § 440.130(c)(1)–(3); CMS, Approval Letter for Cal. State Plan Amendment # 22-001 (July 26, 2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf.

not already available statewide, and (b) the county MHPs/DMC-ODS plans can deny people with SED/SMI access to CHW service benefits by stating that their county decided not to add the benefit. The option to include CHW services would go against state policy since state plan CHW services must be available to all Medi-Cal members, regardless of their condition. DHCS should ensure and reinforce that the counties are providing Medi-Cal members with access to their CHW benefits similar to any other state plan benefit that is not a part of SMHS/SUD. In addition, MCPs can contract with CBOs and FFS providers who focus on providing support to select populations, such as populations with SED/SMI, by contracting directly with MHPs or SMHS providers. To ensure that Medi-Cal members' access to CHW services is seamless, we recommend that DHCS refrain from complicating and dividing CHW services by carved out systems We strongly agree that these services should be available to Californians who need them, which is why they should be (and in fact are already) available statewide..

We note that DHCS still proposes using Section 1115 to request authority to implement the IPS model of Supported Employment. While it may be more difficult to cover supported employment via 1905(a), numerous states have covered supported employment for individuals with serious mental illness via a 1915(i) state plan amendment, which must be provided on a statewide basis.[10] We urge DHCS to explore this option, which would require the service to be offered statewide.

In short, while DHCS is framing this section of its demonstration as a request to cover additional services, it is in fact a request to restrict coverage of Medicaid services to certain counties. Instead of covering these essential services for all Californians when medically necessary, the proposal would use Section 1115 and 1915(b) waiver authority to *restrict* the availability of these services to certain counties. Allowing the service to be offered piecemeal based on particular counties' willingness to contribute the non-federal share is not an appropriate way to extend such important services to Medi-Cal beneficiaries, nor does it constitute a valid experiment for 1115. Here, DHCS has not articulated how allowing counties to opt-in to providing these important services constitutes a test of some hypothesis, nor could it. Allowing counties to opt in to providing these services does not ensure that there will be any way to make valid

[10] *See generally* CMS, *Making Mental Health Evidence-based Practices Work for Medicaid Beneficiaries: Supported Employment* (Oct. 2009), https://eadn-wc03-6094147.nxedge.io/cdn/wp-content/uploads/sites/default/files/Hendler%20Supported%20employment%20and%20Medicaid10--09%20%282%29.pdf (describing the extent of 1915(i) authority, 1905(a) authority, and managed care authority to pay for supported employment). The District of Columbia, Iowa, Texas, and Ohio all have 1915(i) state plan amendments to provide supported employment to individuals with serious mental illness.

comparisons between those who received the service and those who did not to evaluate their outcomes.

It is also unclear what the evaluation of this proposed demonstration will be under the waiver. The hypothesis in Table 2 merely states: availability and utilization of community-based behavioral health services will increase over the course of the demonstration. *Proposal* at 15. The evaluation is to merely look at claims data to see who accessed the multitude of community based behavioral health services, including these transitional rent services. *Id.* This simple analysis does not demonstrate anything related to the utility or effectiveness of these services, and does not look at outcomes as a result of getting these services. This does not meet the test of a true novel demonstration or experiment.

Moreover, the proposal as currently devised will not promote the objectives of the Medicaid Act. As explained above, these services have been demonstrated to be medically necessary for adults with SMI. Withholding a medically necessary service from beneficiaries based only on the county in which they live does not promote the purpose of Medicaid, which is to enable states "to furnish[] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1; 1396d(a) (defining "medical assistance" as provision of, or payment for, specified health care and services). The "central objective" of the Medicaid Act is "to provide medical assistance." *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id*. at 144 (rejecting "promoting health" as an independent objective because the Medicaid Act is "designed … to address not health generally but the provision of care to needy populations" through a health insurance program).

Limiting Medi-Cal members' access to services based solely on where they live is plainly inconsistent with this objective. The proposal restricts access geographically solely based on a county's choice, and not based on member needs, but cloaks the request as a waiver of statewideness, amount, duration, and scope, and comparability. Instead of restricting services to counties that elect to opt-in, we encourage California to use Section 1905(a) and 1915(i) state plan authority, in addition to leveraging managed care flexibilities, to cover the aforementioned essential services for all Californians on Medi-Cal with behavioral health conditions who need them.

Moreover, as discussed above, the state already can, and is required to, implement these services through EPSDT statewide for beneficiaries under age 21. DHCS must ensure that all counties are delivering these services to beneficiaries under age 21

when necessary to correct or ameliorate their behavioral health conditions. This should be explicit in any final waiver requests, as counties often fail to understand this federal Medicaid obligation, or follow it.

Transitional Rent Services

Housing supports, including services that help individuals find, move into and retain housing, are essential to the treatment and recovery of individuals living with serious behavioral health conditions. For example, immediate access to housing and support from a mental health team has been shown to decrease inpatient days for homeless individuals with schizophrenia or bipolar disorder.[11] Housing assistance and supports are an important benefit as a part of the existing optional Community Supports available currently through MCPs under CalAIM. We understand housing supports are particularly critical for high-need members who are homeless and living with SMI/SED and/or SUD, especially those at risk of or transitioning out of institutional care or congregate settings, correctional facilities, or the child welfare system.

However, the federal request for coverage of up to 6 month transitional rent for this population is not particularly clear. Despite the clear efficacy of the goals of this proposal, there are still many unanswered questions, such as: What exactly is included in this "service"? Will this be provided by the counties, by the MCPs or both? How will it fit with other housing efforts underway, including CalAIM Community Supports, the Behavioral Health Bridge Housing (BHBH) Program, the Mental Health Services Act (MHSA) funded housing by counties, the Housing and Homelessness Incentive Program (HHIP) that is available to MCPs, and the Homeless Housing Assistance and Prevention Grant Program (HHAP) for cities and counties?

While Medicaid can't pay for housing, it can pay for a range of services that help enrollees find or maintain stable housing so those support services are critical to addressing the needs of the unhoused Medi-Cal members with serious behavioral health conditions. This particular proposal should put more emphasis on pre-tenancy services (e.g., tenant screening and housing assessment, assisting with the housing application process and housing search, ensuring that housing units are safe and ready for move-in, assisting in arranging for and supporting move-in, including related transportation and moving expenses) and tenancy sustaining services (e.g., identifying

[11] Loubière A. Tinland, et al, *Effectiveness of a Housing Support Team Intervention With a Recovery-Oriented Approach on Hospital and Emergency Department Use by Homeless People With Severe Mental Illness,* 29 EPIDEMIOLOGY & PSYCH. SCI. e169 (2020); https://doi.org/10.1017/S2045796020000785.

and addressing behaviors that may jeopardize housing, education and training on the role, rights, and responsibilities of the tenant and landlord, individualized case management and care coordination).[12] We also request clarity on how DHCS will ensure that the necessary behavioral health supports will be provided to ensure these Medi-Cal recipients maintain successful housing, especially when ACT, FACT, CSC for FEP, IPS Supported Employment, CHW services, and clubhouse services are also only going to be available at county option, and it appears that some of these services are not required to be in place with the transitional rent services. Transitional rent services without these other supports will not be successful or achieve the intended outcomes. We also need to underscore the ongoing need to invest in permanent supportive housing to ultimately solve this ongoing overreliance on institutional care. Permanent supportive housing is a proven solution to homelessness for the highest need populations by pairing housing with case management and supportive services.

Just as for Enhanced Community-Based Services, for Transitional Rent Services as well it is unclear what the evaluation of this proposed demonstration will be under the waiver. The hypothesis in Table 2 merely states: availability and utilization of community-based behavioral health services will increase over the course of the demonstration. *Proposal* at 15. The evaluation is to merely look at claims data to see who accessed the multitude of community based behavioral health services, including these transitional rent services. *Id.* This simple analysis does not demonstrate anything related to the utility or effectiveness of these services, and does not look at outcomes as a result of getting these services. This does not meet the test of a true novel demonstration or experiment. We urge DHCS to provide more details about the evaluation before submitting the proposal to CMS.

Short-Term Residential and Inpatient Psychiatric Stays in IMDs

As we have repeatedly expressed in the past, NHeLP remains strongly opposed to waiving the IMD exclusion through Section 1115 in all circumstances, but particularly for SMI/SED.

Here, California is not proposing a genuine experiment. With respect to the proposal to draw down federal matching funds (FFP) for mental health services in IMDs, this is not an experiment, and it certainly is not a new idea or approach to addressing the needs of enrollees. As we have noted in our previous comments on such waivers, for almost 30

[12] Ctrs. Medicare & Medicaid Servs., *Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)* (2021), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf.

years, CMS has granted states authority to waive the IMD exclusion, despite the illegality of such waivers. The first waiver was granted in 1993, and as of 2009, CMS phased out all but one of these projects, precisely because they were no longer "innovative or experimental."[13]

Although over the past several years CMS has encouraged states to apply for mental health-related section 1115 waivers that would allow for FFP for services provided in IMDs, CMS has not provided any justification for its change in position.[14] With almost 30 years of waivers, it is no longer plausible to claim that providing FFP for services to individuals residing in IMDs is a bona fide experiment or demonstration. Section 1115 does not offer HHS a permanent "back door" to provide funding for settings that Congress explicitly carved out of Medicaid.

We remain concerned that waiving the IMD exclusion will increase the risk of institutionalization for Medi-Cal beneficiaries with SMI/SED, undermining hard-won civil rights for people with disabilities and decades of federal and state policy initiatives stressing the importance of increasing community integration. We understand and appreciate that DHCS is proposing to tie funding for residential services at IMDs to certain activities to improve access to community-based services, including coverage of the full array of enhanced community-based services that would otherwise be optional for counties. However, the fact remains that the availability of funds for IMDs will likely incentivize the use of these facilities because of the concept of "bed elasticity," where supply drives demand.[15] That is, if the beds are available, they will be filled, siphoning resources that could be used to improve and expand community-based services. But when beds are not available, other options adequately meet individuals' needs.[16]

In addition, adding new community-based services, while important, is not sufficient to avoid the risk of institutionalization that waiving the IMD exclusion carries. California faces a long-standing problem regarding lack of community-based mental health

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[13] U.S. Gov. Accounting Office, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies* 29 (2017), https://www.gao.gov/assets/690/686456.pdf.

[14] See CMS, Dear State Medicaid Director Letter, SMD #18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf [hereinafter "SMD #18-011"].

[15] Martha Shumway et al., *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services*, 63 PSYCH. SERVS. 135 (2012), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201000145.

[16] *Id.*

providers, even for services that are already covered by Medi-Cal.[17] In our estimation, lack of providers offering community-based services, not lack of residential beds, is the biggest reason why Medi-Cal beneficiaries often face delays in accessing mental health services and commonly go without services altogether. Spending money on large residential mental health institutions, which often provide subpar care at a higher price tag, will only exacerbate the lack of more cost-effective community-based services. California and DHCS should prioritize heavily investing in efforts to increase mental health community-based provider capacity and availability.

While our concerns with the proposed IMD exclusion waiver for SMI/SED extend to all Medi-Cal beneficiaries, we are particularly troubled about the impact the proposal could have on children and youth. It has been widely documented that large residential mental health facilities for minors are particularly susceptible to low quality services and instances of abuse in the form of unnecessary and excessive use of restraint and seclusion.[18] What has been less discussed is the fact that waiving the IMD exclusion for children and youth fixes a nonexistent legal problem. Not only is federal funding available for smaller facilities where the risk of harmful institutionalization is lower, but Congress has also specifically allowed states to use federal funding for inpatient psychiatric care in larger institutions for beneficiaries under 21 as part of the optional "psych under 21" Medicaid benefit. In turn, HHS has specified three settings that would normally be considered IMDs as eligible for FFP for provision of inpatient behavioral health treatment for individuals under 21: a psychiatric hospital; a psychiatric unit of a general hospital; and a psychiatric residential treatment facility (PRTF), with PRTFs being the *only* type of large standalone residential facility where FFP is allowed.[19]

Because California has adopted the "psych under 21" benefit, Medi-Cal beneficiaries under 21 may already receive inpatient and residential mental health care. As publicly expressed by supporters of increased residential bed availability, the only thing standing in the way of access to these services was California's failure to establish the parameters for PRTFs within the State. That concern is no longer at issue since Governor Newsom signed AB 2317 into law last year, enabling the establishment, licensing, and regulation of these facilities. We fail to comprehend what an IMD

[17] *See, e.g.,* Dep't of Just., Letterto Gov.Janet Mills Re: United States' Investigation of Maine's Behavioral Health System for Children Under Title II of the Americans with Disabilities Act (June 22, 2022), https://www.justice.gov/opa/press-release/file/1514326/download.

[18] Cal. Health Care Found., *Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions* (2021), https://www.chcf.org/publication/medi-cal-behavioral-health-services-demand-exceeds-supply-despite-expansions; Wiener, *supra*, note 3.

[19] 42 C.F.R. § 441.151.

exclusion waiver for children and youth with SMI/SED will achieve that the establishment of PRTFs within the State, which stands on much firmer ground under federal Medicaid law, will not achieve. We urge DHCS to clarify why an IMD exclusion waiver is still needed in the context of children and youth and to reconsider, at a minimum, restricting the proposal to adult beneficiaries.

We also oppose the request to exercise flexibilities regarding average and maximum length-of-stay requirements as applied to children and youth involved in the child welfare system and who reside in STRTPs that are Qualified Residential Treatment Programs (QRTPs). Children do best in family-like settings, and the harm from ongoing institutionalization of children has been well-documented.[20] If children must be placed in inpatient or residential settings, their length-of-stay should be minimized; we are unaware of any literature supporting the contrary assertion. DHCS has offered no reasons why it wants to permit long-term stays and what problem the State is seeking to address. We do not believe such authority is appropriate or necessary and believe existing provider efforts to reduce the size of STRTP facilities (to under 16 beds) and other efforts to keep foster children and youth in family and community settings instead of group residential care is the direction the State should be pursuing instead. Addressing the gaps in community based behavioral health services for foster youth is the best way to do that.

We are also concerned that the focus on improving IMD "quality" throughout the proposal is not sufficient. In our experience, the milestones and reporting that CMS requires are inadequate to sufficiently improve quality in IMDs. However, the State can go further in requiring counties to improve quality in the IMDs. For example, the State could require participating IMDs implement programs that reduce the use of seclusion and restraint, as well as actions to address racial disparities in the use of seclusion and physical and chemical restraint. Evidence shows that being Black and male, lacking private insurance, and being homeless increases the risk of being physically

[20] Am. Acad. Ped., et al, *The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care* (2022), https://familyfirstact.org/sites/default/files/QRTP%20and%20IMD%20One%20Pager.pdf; Think of Us, *Away From Home Youth Experiences of Institutional Placements in Foster Care* (2021), https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf.

restrained.[21] Abundant anecdotal evidence suggests that this happens in IMDs as well, although they are not as well studied as EDs. At the very least, the State could require IMDs to publicly report disaggregated seclusion and restraint data periodically, and require corrective action when necessary. We are disappointed that such data requirements were not included in the proposal.

Moreover, we caution against the effect that the proposed IMD policy could have on non-IMD counties' decision on whether to participate in the expansion of mental health services. As we understand the proposal, since counties have the option to adopt IMD and other mental health services coverage, we believe counties will have an incentive to decline the expansion of services and instead send beneficiaries to IMDs in counties that are participating in the program. This result will essentially amount to out-of-county patient dumping and a way for counties to avoid their responsibility towards beneficiaries. DHCS must clarify how the department is planning to avoid this scenario. Finally, while we are very glad to see that the financing plan requires non-supplantation, and that reinvestment of any money saved must go into community based settings, it is unclear if or how this will be enforced. We urge DHCS to share more detailed information about how the department envisions to enforce this requirement and what exactly it would entail. In principle, we support requirements to ensure that funding for community-based mental health services is, at a minimum, maintained and preferably expanded. However, as we have explained above, the mere availability of an increased number of beds will inevitably lead to more (in many situations unnecessary) institutional care. As such, the requirements to non-supplant and reinvest are steps in the right direction, but insufficient to quell our general opposition to waiving the IMD exclusion. Instead, the state should invest in the important community based behavioral health services without tethering this proposal to an IMD waiver.

Incentive Program for Opt-In Counties

We support the opt-in incentive program component of the demonstration in concept. We agree that effectively rolling out new behavioral health community based services will require significant investment and resources to evaluate outcomes and quality of care in each county. Moreover, we commend DHCS for emphasizing investment in community-based services as part of the incentive program and we believe this opportunity provides an important, albeit not absolute, check on potential overutilization

[21] Ambrose H. Wong, et al. *Association of Race/Ethnicity and Other Demographic Characteristics With Use of Physical Restraints in the Emergency Department*, JAMA NETWORK OPEN, (Jan. 25, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775602.

of institutional treatment in IMDs. Finally, we support making sure that measures being evaluated respond to outcomes rather than processes as the proposal suggests.

However, as with other non-IMD components of the proposed demonstration, we fail to see why participating in the incentive program would be optional for counties. Following our recommendation that DHCS require all counties to provide enhanced community-based behavioral health services, we similarly suggest that this particular incentive program be extended to all counties in order to provide sufficient funding and resources for infrastructure development and quality evaluation as the services are rolled out. In fact, we believe DHCS should combine the opt-in incentive program with the proposed statewide incentive program. In addition, while we understand that DHCS intends to establish a stakeholder process to determine the specific measures to be evaluated, we would have appreciated more context and details about what the department envisions before the release of the proposal. DHCS suggests that participation in this program will be used to evaluate the hypothesis that "[a]vailability of trainings, technical assistance and incentives to strengthen the provision of community-based care and improve outcomes will increase over the course of the demonstration," *Proposal* at 16, but does not explain how this is experimental, or how allowing incentives on an opt-in basis will contribute to the experiment. We urge DHCS to engage in such conversations with stakeholders before the demonstration's submission to CMS so that we can provide more informed and in-depth feedback.

Conclusion

Again, we appreciate the opportunity to weigh in on this proposal and look forward to working with DHCS on the proposal before it is submitted to CMS. As always, let me know if you have any questions.

Sincerely,

[redacted]

Kim Lewis
Managing Attorney,
National Health Law Program

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH- Connect Demostration
Date: Thursday, August 31, 2023 2:52:02 PM
Attachments: [redacted]

[redacted]

Hello,
Thank you for your consideration in regard to the BH- Connect Demonstration. Below is the attached California Youth Connection's recommendation based on feedback from our youth membership.
We look forward to partnering in the future if implementation efforts are needed.

Best Regards,

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Kristina Tanner
Statewide Policy Coordinator
Pronouns: She/Her
California Youth Connection
[redacted]

https://calyouthconn.org | [redacted]

August 17, 2023

Michelle Baass, Director
Department Of Health Care Services
Sent via: email

Re: BH Connect 1115 Waiver Application

Dear Director Baass:

Thank you for the opportunity to provide feedback on the 1115 waiver application for the behavioral health community-based continuum. California Youth Connection is a youth-led organization that develops and grows leaders who empower each other and our communities to transform the foster care and intersecting systems through community-led organizing, legislative, policy, and practice change. We understand and agree about the importance of accessible behavioral health and support services especially for youth that have been impacted by the system. We hope that our comments and recommendations are considered so that this waiver is helping make an impact on meeting the needs of youth that have been impacted by the system.

A.) Waiving the IMD Exclusion

We oppose waiving the Institutions for Mental Disease–IMD–exclusion through Section 1115 because of the great potential harmful impact on children and youth involved in the child welfare and juvenile justice systems. We express concerns regarding the potential ramifications of waiving the IMD exclusion, as it could heighten the risk of institutionalizing these young individuals. It is evident that the optimal well-being of children and youth is achieved within community-based families, where treatment and care are offered within that context. Large residential mental health facilities for young individuals are notably vulnerable to low quality and understaffed services and instances of maltreatment, including unnecessary and excessive use of restraint and seclusion.[1] CMS has expressed its intent to explore waivers to examine the assertion

[1] Cal. Health Care Found., Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions (Sept. 2021), https://www.chcf.org/publication/medi-cal-behavioral-

that the IMD exclusion contributes to an over-reliance on emergency departments for addressing mental health needs, and acts as a barrier to providing essential acute care.[2] However, considering recent legislative changes that haven't been fully integrated, it might be premature to test this idea at this time.

1.) Waiving the IMD exclusion not only contradicts well-established Medicaid law but also goes against recent amendments in federal child welfare legislation, such as the Family First Prevention Services Act,[3] and state law that has been focused on diminishing institutional care. The aim has been to ensure that if institutional care is used, it remains of high quality, short-term in nature, and geared toward facilitating a move to less restrictive settings. California has diligently worked to strike a balance that prioritizes the opportunity for young individuals to receive care and treatment within family and community-based settings, while still providing limited yet available alternatives for clinical care when necessary in residential contexts.To address the need for short-term residential clinical care, carefully vetted options have been introduced through the legislative process. Over the past two years, the legislature has formulated standards and prerequisites for Short-Term Residential Therapeutic Programs (STRTPs) to align with federal regulations and qualify for IV-E reimbursement.[4] Recently, the state legislature introduced the option of a Medicaid-reimbursable Psychiatric Residential Treatment Facility (PRTF) through the passage of AB 2317. This allows for clinical care to be provided in larger residential facilities. While concerns exist about the utilization of PRTFs for children in foster care, AB 2317 includes safeguards for these individuals that aren't addressed in the proposal to waive the IMD exclusion for facilities meeting certain criteria as institutions primarily meant for mental health treatment but falling short of PRTF criteria. Furthermore, the legislature has allocated funds to support IMDs in downsizing and fulfilling STRTP requirements. This proactive measure not only maximizes

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health-services-demand-exceeds-supply-despite-expansions/; Jocelyn Wiener, Unanswered Cries: Why California Faces a Shortage of Mental Health Workers (Sept. 8, 2022), https://calmatters.org/health/2022/09/california-shortage-mental-health-workers/.

2 CMS, Letter to Medicaid Directors, November 12, 2018, at page 12.

3 P.L. 115-123 (2018).

4 These requirements have been codified at WIC 16501.1 (d), 4096 (g), and 361.22.

federal reimbursement but also aids providers in transitioning, thereby further reducing the necessity for a waiver.

2.) The potential adverse repercussions of introducing a waiver option are extensive and could significantly influence counties' choices regarding their involvement in the expansion of community-based mental health services. This might result in an increase in placements of young individuals outside their home counties. The availability of this option could alleviate the pressure on counties to establish a continuum of care based in the community, which is required by both the Americans with Disabilities Act and federal child welfare law. These laws stipulate the necessity of placing youth in the least restrictive and most family-like environment possible. Consequently, there's a higher likelihood that more young people will be placed in locations outside their home of origin and farther away from their families. Such an outcome would counteract years of concerted efforts to bring young individuals closer to their homes and families.

3.) California has devoted significant effort to actively invest in and rally various stakeholders—advocates, service providers, agency personnel, and the judicial system—in the effort to decrease the utilization of institutional care within the foster care system. This commitment involves fostering the development of legally mandated community-based alternatives and is aimed at continuous growth. Introducing a waiver for the IMD exclusion, however, threatens to reverse the strides we've achieved and will inevitably hinder further advancement. It is imperative for California and DHCS to place a strong emphasis on substantial investments into initiatives that enhance the capacity and availability of mental health services within the community. This focus should prioritize providers that cater to young individuals affected by both the child welfare and juvenile justice systems. By doing so, we can effectively bolster the progress already made and create an environment conducive to sustained advancement.

B.) Inclusion of Activity Stipends

We support DHCS's proposal related to funding enrichment activities to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful effects of trauma, and build stability overall for a youth. We agree with providing the services and support that greatly impact youth with lived experience by promoting behavioral health, wellness, lifelong connections, stability, and a place

where youth will feel safe enough to heal through the traumas that they have endured. California Youth Connection, along with our partners at Youth Law Center, are eager to collaborate with DHCS and CDSS to further develop this proposal and ensure that funds are accessible to young people across the state. Our recommendations are as follows:

1.) We urge DHCS to minimize the hurdles to accessing these stipends, considering the youths' preferences and interests. The definition of activities should not be confined solely to physical exercises, but rather expanded to encompass any pursuits that captivate the youth's attention. Research underscores that when young individuals engage in activities aligned with their interests, they can establish enduring connections, encounter fewer shifts in placement, and enhance their prospects for stability. Furthermore, we propose that DHCS institute mechanisms of accountability for service providers, guaranteeing the inclusion of these activities within the case planning process, and promoting widespread awareness of this stipend program throughout the state.
2.) We recommend that DHCS provide greater clarity to ensure California's capacity to leverage both Medi-Cal and Title IV-E funds effectively, supporting a variety of unconventional interventions, including enrichment activities. Furthermore, it would be beneficial to be more specific to what extent Medi-Cal and the current EPSDT guarantee already cover enrichment activities and non-traditional interventions, even without necessitating a waiver. These clarifications would maximize resource allocation and also aid in assessing the possibility of expanding this proposal over time to include other groups of young individuals, such as those within the Juvenile Justice system and or Homeless.

C.) Inclusion of Cross Sector Incentive Pool

We are in support of DHCS's proposed initiative regarding the creation of the Statewide incentive program. This innovative approach seeks to allocate investments to counties, fostering the seamless implementation of both novel and continuous changes. Over the years, the collective voice of youth advocates has been resounding in its call for robust data recording and collection within counties, particularly concerning various critical points of concern. The proposed Statewide incentive program aligns seamlessly with the aspirations of young advocates who have long emphasized the need for robust data

collection and proactive measures. By integrating our recommendations into the program's framework, California can embark on a transformative journey towards a more equitable and responsive foster care system that empowers and supports its younger population.Our recommendations are as follows:

1.) Enhanced Data Collection Mechanisms: We urge for the refinement and enhancement of data collection mechanisms at the county level. By ensuring that data collection is standardized and comprehensive across various dimensions, counties can better identify trends, challenges, and areas that require immediate attention.
2.) Youth-Inclusive Data Metrics: It's imperative that the data metrics adopted are inclusive and considerate of the experiences and perspectives from the youth directly. By incorporating indicators that encompass the diversity of youth experiences, counties can gather insights that accurately portray the challenges faced by individuals within the system.
3.) Capacity Building for Counties: We recommend that the incentive program include provisions for capacity building within counties. This could encompass training personnel to proficiently gather, analyze, and leverage the data accumulated. This approach will not only facilitate well-informed decision-making but also enable the design of interventions that are finely tuned to the unique needs of the children under the county's care.
4.) Collaborative Learning Platforms: The incentive program should consider fostering collaborative learning platforms where counties can share best practices, challenges, and success stories. Such an environment encourages cross-county knowledge exchange, leading to collective growth.
5.) Accountability and Transparency: It is crucial that the program instills a sense of accountability and transparency. Counties should be encouraged to consistently report their progress, setbacks, and strategies employed. This transparency not only showcases efforts but also enables counties to learn from each other's experiences.
6.) Long-Term Sustainability: The incentive program's impact will be maximized by ensuring its long-term sustainability. We recommend exploring mechanisms that guarantee continued support, even as the landscape evolves over time.
7.) Incorporating Young Voices: The active involvement of young advocates and representatives should remain at the core of the incentive program. Involve them

in the design, execution, and evaluation phases. Their lived experiences will provide invaluable insights that can shape more effective strategies.

8.) Feedback Loop and Adaptability: Create a feedback loop that encourages counties to provide insights on the program's effectiveness. This iterative approach allows for adjustments based on real-time feedback, making the program more responsive and impactful.

Thank you again for the opportunity for current and former foster youth to provide feedback. We look forward to partnering in the implementation of these programs as California moves along with this application.

Sincerely,

[redacted]

Kristina Tanner
Statewide Policy Coordinator
California Youth Connection (CYC)

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 3:09:28 PM
Attachments: [redacted]

[redacted]

Hello,

Please find the attached comments from the Steinberg Institute on the BH-CONNECT Demonstration.

Thank you,
Tara

Tara Gamboa-Eastman
Director of Government Affairs
Steinberg Institute
Pronouns: She/Her/Hers
[redacted]

1121 L Street, Suite 300
Sacramento CA 95814
[redacted]
steinberginstitute.org

August 31, 2023

Michelle Baass, Director
Department of Health Care Services
1501 Capitol Ave
Sacramento, CA 95814
Via email

Re: Comments on Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration Project

Dear Director Baass:

We appreciate the Department of Health Care Services' work on this transformational initiative. Pursuing this federal demonstration opportunity will allow California to access additional funding and make critical expansions to the continuum of behavioral health services. The Steinberg Institute respectfully submits the following comments on the updated version of the BH-CONNECT Demonstration Project.

New community-based services are critical expansions of care that will save lives

The proposed suite of new community-based services to be provided by Medi-Cal are necessary expansions of care for our most vulnerable Medi-Cal beneficiaries. We believe the proposed set of services is comprehensive and, if ultimately provided by counties, will save lives. We were particularly pleased to see that the department prioritized the coverage of coordinated specialty care for first-episode psychosis by counties given the high likelihood of individuals experiencing early episodes of psychosis interacting with the behavioral health crisis continuum. This inclusion of coordinated specialty care also aligns with our effort to ensure that this critical program service is explicitly covered by health plans under mental health parity as required by SB 855. Furthermore, we were especially pleased to see that the department prioritized the coverage of Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) by counties as Medi-Cal benefits given how vital these models are to reducing homelessness, excessive hospitalizations, and involvement in the criminal justice system. In addition, the proposed new rent and temporary housing payments reflect a justified focus on the social determinants of health that impact mental health, which complement existing state efforts such as the California Advancing and Innovating Medi-Cal initiative and the current proposal to allow Medi-Cal managed care plans to provide up to six months of transitional rent services.

Demonstration helps ensure that institutional care is provided as a last resort

We are supportive of the state pursuing federal financial participation for services provided to individuals during stays in psychiatric facilities with more than 16 beds. This is a long overdue source of federal funding that will help ensure that individuals

in need of this level of care access treatment. However, we believe that community-based treatment should always be considered as a first option for mental health care. Accordingly, we were pleased to see that the department is strongly committed to building out the continuum of care for community-based services (as required by the federal government) alongside this new federal funding option so that the state does not overly rely on institutional care. In addition, we welcome the department's commitment to ensuring (1) proper parameters are placed on inpatient facilities to ensure high-quality care and (2) linkages to community-based care upon discharge are in place.

Appreciate department pursuing waiver of length of stay requirements for foster youth

The federal government recently made available an option to access federal financial participation for services provided in residential treatment programs for foster youth with more than 16 beds for stays up to two years rather than the 60-day limitation outlined in the overall federal waiver to access this reimbursement. We appreciate the department's commitment to take advantage of this option, which would provide critical additional funding to expand our foster care system by developing a plan for transitioning children out of this level of care over a two-year period.

Appreciate focus on accountability, performance improvement, and standardization

We are supportive of efforts to increase accountability and performance improvement metrics in our behavioral health system. Accordingly, we were pleased to see that the department has made this a priority in the CalBH-CBC demonstration. We believe that the financial incentives available to counties for meeting specified quality metrics developed by DHCS (which are planned to also include metrics related to populations who especially experience disparities in behavioral health care access and outcomes) can help lead to a proper incentive structure in our behavioral health system in which funding is tied to outcomes. In addition, we find that the requirements that (1) counties meet designated time and access standards for the current services they provide before they are allowed to expand services and (2) county financing plans for activities under the waiver are reviewed and approved by the state to be important ways that current systems of care are not forgotten and sufficient fiscal transparency over use of funding included in this demonstration project is put in place. We look forward to seeing further details on these requirements that will be included in county mental health plans and encourage the department to ensure that any specified performance outcomes in this demonstration are as robust as possible. The CalBH-CBC proposal to explicitly add existing models of care such as ACT as bundled Medi-Cal benefits will also help create greater standardization across programs that are currently varied in approach, which will increase state capacity to measure common performance outcomes. Accordingly, we were particularly pleased to see that the department intends to incentivize the ACT model for county Full-Service Partnership programs as well. Applying ACT programs' multidisciplinary team approach combined with assertive outreach in communities to this key county service program (in a standardized way) will do so much for Medi-Cal beneficiaries.

Added workforce initiative is absolutely warranted

We were extremely pleased to see that the department added a major workforce initiative to the BH-CONNECT demonstration project. Behavioral health workforce challenges have reached crisis levels and a focus on this issue is needed to ensure that the state has the proper capacity to implement its major behavioral health initiatives. In addition, we were especially excited to see that this workforce initiative will focus on both long-term workforce pipeline investments and short-term recruitment efforts (such as hiring and retention bonuses) to tackle this major challenge more comprehensively. Accordingly, as part of the BH-CONNECT Evaluation Plan, we encourage the department to take a comprehensive evaluation approach that accounts for the impact of both long-term pipeline investments and short-term recruitment efforts under this demonstration project.

Recommend incorporating tiered funding system for board and care facilities

Board and care facilities are key components of both the continuum of care and the continuum of housing. However, board and care operators who serve individuals with serious mental illness are often unable to cover operating expenses. We encourage the department to incorporate (with funding made available through this

demonstration project and potentially by coordinating with other state entities such as the Department of Social Services) the model for board and care reimbursement currently used for adults with intellectual and developmental disabilities: the "Community Care Facility" (CCF) model. The CCF model provides several tiers of services, supports, and funding based on the needs of the individual.

Thank you for considering our comments on the updated version of this demonstration project. As always, the Steinberg Institute is ready to assist you in any way we can. Please contact Tara Gamboa-Eastman at [redacted] if you have any questions.

Sincerely,

Tara Gamboa-Eastman
Steinberg Institute
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 3:20:49 PM
Attachments: [redacted]

[redacted]

SENT ON BEHALF OF MARVIN J. DEON II, CHIEF LEGISLATIVE REPRESENTATIVE:

Good afternoon,

Attached are the public comments on behalf of the County of Los Angeles, in response to DHCS' solicitation for feedback on the proposed new Medicaid Section 1115 Demonstration, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment.

Thank you,

Marvin J. Deon II
CHIEF LEGISLATIVE REPRESENTATIVE
COUNTY OF LOS ANGELES – CEO
SACRAMENTO ADVOCACY OFFICE
[redacted]

Legislative Affairs & Intergovernmental Relations

COUNTY OF LOS ANGELES
SACRAMENTO LEGISLATIVE OFFICE
1100 K Street, Suite 400, Sacramento, CA 95814
[redacted] Fax: [redacted] ceo.lacounty.gov

CHIEF EXECUTIVE OFFICER
Fesia A. Davenport

CHIEF LEGISLATIVE REPRESENTATIVE
Marvin Deon II

August 31, 2023

Department of Health Care Services
Director's Office
Attn: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: BH-CONNECT Demonstration

Dear Ms. Cooper and Mr. Sadwith,

These comments are submitted on behalf of the County of Los Angeles (County), in response to the solicitation for feedback on the proposed new Medicaid Section 1115 Demonstration. The Demonstration, known as the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), will expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED).

Please refer to the attachment for recommendations and questions from the following County departments:

- Department of Mental Health
- Department of Public Health
- Department of Health Services
- Department of Children and Family Services

We appreciate the opportunity to provide feedback and look forward to engaging further on this important matter. Should you have any other questions, please contact me or Andi Liebenbaum on my team at [redacted] or [redacted]

Sincerely,

[redacted]

Marvin J. Deon II
Chief Legislative Representative

DEPARTMENT OF MENTAL HEALTH (DMH)

Short-Term Residential and Inpatient Psychiatric Stays in Institutions for Metal Disease (IMDs)

- DMH appreciates the State's proposal to draw down federal financial participation (FFP) funding for short-term IMD stays. As length of stay in our residential IMDs greatly exceeds the average length of stay for this proposal, DMH believes it will only be useful for our free standing acute psychiatric hospitals. We have not yet completed our financial analysis to determine what the overall financial impact of this proposal would be, since DMH would also have to take on new costs required by the opt-in provisions.

- There is an opt-in provision that is available to DMH if we agree to certain conditions. These include implementing a full array of community-based evidence-based practices (EBPs), including:
    - Assertive Community Treatment (ACT)
    - Forensic ACT (FACT)
    - Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
    - Individual Placement and Support (IPS) Supported Employment
    - Community Health Worker (CHW) services, and
    - Clubhouse services.

  While DMH has already implemented CSC for FEP and IPS for example, we have not implemented other facets of the requirements mentioned above such as ACT/FACT. ACT/FACT, which may be similar to Fuller Service Partnership (FSP), have more stringent requirements and will likely cost more to implement. Thus, DMH must decide whether we want to add those services to the Specialty Mental Health Services (SMHS) we provide or shift FSP services to function consistent with ACT/FACT guidelines.

Training

- DMH recommends that the State strengthen the proposal by highlighting the need for cultural considerations when it comes to identified practices and trainings. Los Angeles County is incredibly diverse, with 15 threshold languages. We need flexibility to identify existing practices or community defined evidence practices. It is mentioned in the application, but it should be highlighted further in the application.

Transitional Rent

- Housing should not be transitional or limited to 6 months. The funds should be a rental subsidy that is not time limited. Any time-limited housing assistance is not usually in the best interest of the client and causes the client stress and causes disruption in their housing and puts the client at risk of becoming homeless again.

- The application should specify that there is no limit/cap to the number of times that a client can access the transitional rent benefit over their lifetime.

Clubhouse/IPS Services

- DMH supports the opportunity to be able to provide clubhouse and IPS services. As we understand, this gives DMH the option to participate in a demonstration project where we can bill Medi-Cal for IPS and clubhouse. We have several questions about this because it lacks details:
    - How will clubhouse services be defined (i.e. Does a clubhouse need to be certified?)
    - Will the State specify a particular clubhouse program/service model that counties must implement?
    - How is the IPS Supported Employment different or the same as the Supported Employment that is already part of CalAIM?
    - How are fidelity reviews handled if required?
    - What is the length of the demonstration project?

Activity Stipend

- DMH agrees that the activity stipend should be housed with the Mental Health Plan rather than the Managed Care Plans.

- Given the focus on youth involved in child welfare, DMH thinks it would be important for the activities/services to be available to all family members (if in a foster placement, services should be available to caregivers and other youth) so that the youth and others in the home can be supported.

- DMH also recommends that the State include youth voice in the identification of the services and activities.

- Increased flexibility—the State should allow for some variation of allowable activities based on geography and community. There should be flexibility for county planning and the ability for the County to convene meetings with youth to determine what they want or need, or think would help them, within the disparate communities throughout Los Angeles County.

Workforce

- The workforce section needs additional detail. Funding for re-location and other sorts of wraparound re-location services could be extremely beneficial, in addition to loan repayment and sign-on bonuses, efforts to recruit psychologists to California.

- "Scope of Program—The workforce initiative will be used by DHCS for both long- and short-term investments in the behavioral health workforce required to provide Medi-Cal benefits, which may include: Long-term investments to expand the pipeline of behavioral health professionals who can work with Medi-Cal members living with SMI/SED and/or a SUD, such as partnerships with community colleges and public universities to expand allied professional and graduate programs in social work, psychology, and other related programs, and

to build upon recent investments to augment the pipeline of Peer Support Specialists, Community Health Workers, SUD counselors, and other practitioners."

While this is fine, it would take years of investment to pay off. Community colleges are not going to yield much. With payment reform, the higher the degree the greater the reimbursement, so DMH would suggest focusing on Masters and Doctoral level clinicians.

- What is not mentioned is coordination and alignment of the California schools of social work, marriage and family therapist (MFT) and psychology. Graduate institutions need to support public mental health as a viable and preferred employment option for graduating students, starting with student training. The State should consider formally partnering with California schools of social work, MFT, and psychology to expand this pipeline into the public mental health system.

Other Elements

- The State should also consider allowing BH-Connect to cover staff time for EBP activities that are not currently billable. Examples include provider training, fidelity reviews, oversight at the program level and outcome data entry. Bundling costs for an EBP is something to consider as well. For example, Parent-Child Interaction Therapy requires upfront costs related to the delivery of the service (a one-way mirror, headsets to communicate with parent, etc.) that needs to be taken into account in addition to taking staff offline to train and for staff to review sessions as part of the fidelity review.

- Department of Health Care Services (DHCS) should also consider very carefully the Centers of Excellence idea. Many of these practices are proprietary so universities would have to contract with the developers and that can be expensive and very time consuming. Many counties already have long standing contracts in place to train on these practices. Train-the-Trainer models are critical for sustainability of practices too. Other models that the State has required in the past have necessitated extensive provider training and ongoing support from contracted trainers.

DEPARTMENT OF PUBLIC HEALTH (DPH)

General Comments: The following comments apply to all of the materials.

Substance Use Disorder (SUD) Workforce

- While DPH appreciates the State's investments in the behavioral health workforce, most workforce initiatives have not focused specifically on the SUD workforce and significantly more investments, attention and resources have been made to support peer support services and mental health activities. For example, four of seven Behavioral Health Workforce Development Request for Applications (RFAs) were mainly geared towards the peer support workforce.

Moreover, investments in workforce education and training and the BH-CONNECT have also been focused on mental health services, making it unclear if workforce initiative investments will effectively and equitably support the SUD workforce. In particular, the SUD counselor workforce has often been overlooked, yet makeup about 80 percent of Los Angeles County's SUD workforce. In the coming years, laws will be going into effect to strengthen the quality and quantity of the SUD counselor workforce, therefore allocating funds specific for behavioral health paraprofessionals, such as California's registered and certified SUD counselor workforce, will position the State to better meet the demands for SUD treatment services and address the overdose crisis.

Transitional Rent Support to Cover Other Supportive Services

- DPH also appreciates the inclusion of transitional rent in the BH-CONNECT Demonstration. While rental assistance is helpful for those who are eligible to move into and temporarily retain housing, housing support services should expand beyond transitional rent to include other supportive services to ultimately maintain and improve their overall housing status to maximize outcomes in one's recovery. (i.e., utility bills, services to obtain and maintain improved housing status [i.e., case management, legal services, child care, and other supportive services as defined in Paragraph 29 of 42 U.S. Code § 11360]).

Demonstration Evaluation Efforts Should Include SUD Paraprofessionals

- To accurately evaluate the availability of behavioral health providers due to the impact of the demonstration, DPH recommends including SUD paraprofessionals (i.e., registered and certified SUD counselors) and to expand evaluation of other training programs outside of conventional educational institutions such as peer support specialists and registered and certified SUD counselors. For example, California's Department of Health Care Access and Information (HCAI) issued grant funding through their Earn and Learn Grant Program in May 2023. Awardees included colleges, universities, and organizations that directly provide or partner to provide paraprofessional training programs. Exclusion of paraprofessional training programs in the evaluation approach will underestimate the number of trained and available behavioral health providers, further lessening the actual impact of the demonstration on the behavioral health workforce.

Specific Feedback: The following comments apply to specific sections in the draft documents.

Section 1

Goals and Approach

- Suggested edit (p.4-5): "Connect members living with SMI/SED and/or SUD to employment, housing, and social services and supports;
- Suggested edit (p.4-5): "Strengthen the workforce needed to delivery community-based behavioral health services and EBPs to members living with SMI/SED and/or SUD."

Section 2

Table 2. Preliminary Evaluation Plan for BH-Connect Demonstration

Hypothesis: Emergency Department (ED) utilization and lengths of stay among Medicaid members with SMI/SED and/or a SUD will decrease over the course of the demonstration.

- Recommend that DCHS includes SUD as part of its comprehensive evaluation approach and its data sources to evaluate impact.

Hypothesis: Outcomes for individuals who are justice-involved and those who are homeless or at-risk of homelessness will improve over the course of the demonstration.

- Recommend including SUD diagnosis for both components of the evaluation approach.

Hypothesis: Availability of behavioral health providers will increase over the course of the demonstration.

- To accurately evaluate the availability of behavioral health providers due to the impact of the demonstration, recommend including registered and certified SUD counselors and to expand evaluation of other training programs outside of conventional educational institutions.
- Add verbiage to expand evaluation approach of counting college/universities to include other behavioral health training programs that train SUD workforce members such as peer support specialists and registered and certified SUD counselors. For example, California's Department of Health Care Access and Information (HCAI) issued grant funding through their Earn and Learn Grant Program in May 2023. Awardees included colleges, universities, and organizations that directly provide or partner to provide paraprofessional training programs. Exclusion of paraprofessional training programs will underestimate the number of trained and available behavioral health providers, further lessening the actual impact of the demonstration on the behavioral health workforce.
- Under "Data Sources," recommend including data points that distinguish between the type of provider and workforce classification to understand the impact and gather information on registered and certified SUD counselors, as there is limited data collected on this type of paraprofessional.

Section 3

Key Features

- Suggested edit (p.23): DHCS is requesting new authorities, effective January 1, 2025, to strengthen the continuum of community-based care for Medi-Cal members living with SMI)/SED and/or a SUD, including children and youth involved in the child welfare system, individuals and families experiencing or at risk of homelessness, and those who are justice-involved.

Scope of Program

- Suggested edit: (p. 21): replace "paraprofessional training programs" with

"Behavioral Health Training Programs."
- Suggested edit: (p. 21) Short-term investments to support recruitment efforts for key community-based Medi-Cal behavioral health services, such as hiring and retention bonuses, scholarship and loan repayment programs, registration and certification costs for SUD counselors, community health workers, peer support specialists, and other stipends determined by DHCS to be needed to implement BH-CONNECT.

BH-CONNECT Features Available at County Option

- Suggested edit (p.31): To reach this goal, DHCS proposes to provide counties with the option to cover additional evidence-based, community-based services that reduce the need for institutional inpatient and residential care and improve outcomes among individuals living with SMI/SED and/or a SUD.

Transitional Rent Services

- Los Angeles County appreciates the inclusion of transitional rent in the BH-CONNECT Demonstration. While rental assistance is helpful for those who are eligible to move into and temporarily retain housing, housing support services should expand beyond transitional rent to include other supportive services to ultimately maintain and improve their overall housing status to maximize outcomes in one's recovery. (i.e., utility bills, services to obtain and maintain improved housing status [i.e., case management, legal services, child care, and other supportive services as defined in Paragraph 29 of 42 U.S. Code § 11360]).

Section 4

Enrollment

- As the BH-CONNECT demonstration aims to build upon California's commitment to creating a full continuum of care for SUD treatment and recovery services, DPH recommends that this includes state-level statistics on people with a SUD.

Section 6

Table 9. Expenditure Authority Requests

1. Expenditures Related to the Workforce Initiative
- Replace "paraprofessionals" with "registered and certified SUD counselors."

4. Expenditures Related to the Statewide Incentive Program
- The use for this expenditure authority should also call out SUD, to align within the Statewide Incentive Program Demonstration Request described in the Proposed BH-CONNECT 1115 Application.

6. Expenditures Related to Transitional Rent Services
- The use for this expenditure authority should also include "and qualifying individuals with SMI/SE and/or SUD" to align with the waiver authority mentioned in Table 3 earlier in the document.

Section 7

Table 10: BH-CONNECT Demonstration Implementation Timeline

- Under Demonstration Year 2, evidence-based tools should also be provided for members living with a SUD.

DEPARTMENT OF HEALTH SERVICES (DHS)

Emphasis on Community-Based Treatment

- DHS supports the proposed expansion of community-based behavioral health services. However, we request clarification on the specific types of services to be expanded. This information is vital to align our resources and strategies effectively.

Workforce Initiative

- The initiative to develop a robust and diverse behavioral health workforce aligns with DHS's commitment to improving patient care. We believe that this initiative can alleviate staffing shortages, thereby enhancing patient flow in DHS hospitals and jails. It represents a strategic approach to addressing existing gaps in access to behavioral health services and resources within the County.

Cross-Sector Collaboration with Child Welfare

- DHS strongly supports the proposed cross-sector incentive program for children involved in child welfare. Our analysis underscores the importance of such collaboration in improving mental health outcomes for children and youth. This program aligns with our goals and reflects a much-needed approach to integrated and effective care within our community.

Incentive Programs

- While DHS acknowledges the potential benefits of the statewide and opt-in county incentive programs, we seek further clarification regarding the specific clients/patients these programs will serve. Gaining a greater understanding of these details will enable us to assess the alignment with our existing services and identify opportunities for enhancement.

Transitional Rent Services and Short-Term Residential Stays

- DHS commends the focus on addressing the needs of individuals with SMI and SED who are homeless or at risk. Our analysis indicates that these services can significantly reduce the burden on hospital emergency departments and other

acute care services. DHS sees this as a vital component in building a comprehensive and responsive behavioral health system.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS)

Activity Stipend

- Clarity about the interaction of the activity stipend funds with the existing Family Flexible Spending funds, which are available until 2025, would be helpful. If both funding sources will be available, are there rules to using both for the same youth?

  Further clarification would also be helpful in terms of reporting requirements for the activity stipend funding stream. For example, what metrics will be used to determine population mental health: Patient Health Questionnaire 9, Generalized Anxiety Disorder 7, World Health Organization well-being scale, CANS? Are there targets? Are there specific requirements for face-to-face therapeutic services that are lacking at this time?

Cross-sector Incentive Program

- Will community stakeholders who are already providing these types of activities and/or already collaborating with DCFS be chosen to be part of this program?

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 3:37:59 PM

[redacted]

Dear DHCS ,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Thank you,
Erin Elizabeth Ross

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 3:38:34 PM
Attachments: [redacted]

[redacted]

Greetings BH-CONNECT Team.

Attached you will find the County of Santa Clara Behavioral Health Services Department's comments regarding the BH-CONNECT Demonstration. We appreciate the opportunity to provide comment.

Please confirm receipt.

Many thanks,

Amy Carta
Director, Government Affairs, Public Relations and Special Projects
County of Santa Clara Health System
2325 Enborg Lane, Suite 320
San Jose, CA 95128
[redacted]

COUNTY OF SANTA CLARA
Health System

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

August 31, 2023

Jacey Cooper, Chief Deputy Director, Health Care Programs
Tyler Sadwith, Deputy Director Behavioral Health Services
Department of Health Care Services
Director's Office
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

SUBJECT: BH-CONNECT Demonstration

Dear Chief Deputy Director Cooper and Deputy Director Sadwith,

The County of Santa Clara Behavioral Health Services Department (BHSD) appreciates the opportunity to comment on the Department of Health Care Services' Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration. Our County is committed to increasing access to high quality, integrated medical and behavioral health care services and expanding the continuum of care to achieve our vision of better health for all county residents.

Comments on Demonstration

We support the Department of Health Care Services' (Department) goals to expand access to the continuum of care, including community-based and short-term inpatient behavioral health services, and strengthen Medi-Cal by creating a more person-centered, equitable and coordinated approach to maximizing health. Attaining federal approval of a Demonstration Project to increase access to high-quality, culturally sensitive behavioral health services would provide the necessary flexibilities to pilot services.

Maximizing federal matching funds would support the expansion of critically needed capacity across the state and in our county. Locally, our Board of Supervisors and County Executive continue to make significant investments and progress in developing the full continuum of community-based, inpatient and residential care. We look forward to opportunities to draw the federal match to enhance our capacity to do even more.

The proposals included in BH-CONNECT seek to create a more robust continuum of community-based care while also building on investments counties have made in housing, mobile crisis teams and outpatient mental health services for children, youth and adults, including those justice-involved or experiencing homelessness.

The County of Santa Clara's BHSD supports many components included in BH-CONNECT, including Evidence-Based Therapies for Children and Families, Intensive Outpatient Treatment Services and Peer and Recovery Services. The expansion of Community Supports for Supported Employment, Community Health Worker, Transitional Rent, and Clubhouse Services will provide valuable new services to help clients maximize their life potential. Expanding capacity to provide Inpatient and Residential Treatment Services is critical to providing a full continuum of services necessary to assist Californians living with a serious mental illness or serious emotional disturbance. While adding capacity, enhancing quality, coordinating services and improving outcomes must follow, which DHCS addresses in the preliminary evaluation plan. Aligning the reporting requirements between the multitude of programs will support efficiencies in the coming years.

Workforce challenges have a major impact on our collective ability to serve our communities' behavioral health needs. It is critical to invest in short- and long-term solutions to create a robust, culturally and linguistically competent workforce that ranges from peer support counselors and community health workers to licensed professionals at all levels in order for California to best serve our clients and communities. Dedicated funding for workforce is an important component.

The County of Santa Clara's (County) approach as an integrated healthcare delivery system providing patient-centered care aligns with the Department's goals of expanding the continuum and capacity. Our County has already expanded the continuum of community-based care, including Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Assisted Outpatient Treatment, Coordinated Specialty Care for First-Episode Psychosis (CSC for FEP), Supported Employment, mobile crisis services, and expansion of treatment bed capacity, including temporary housing supports.

Our County is investing significant resources to build a new 77-bed psychiatric inpatient facility to serve children, adolescents and adults from the larger Bay Area region. Recently, our County has worked with RAND Corporation to study psychiatric treatment bed needs in Santa Clara County. The results of the study noted a shortage specifically in subacute capacity, such as Skilled Nursing Facilities (SNF), Mental Health Rehabilitation Centers (MHRC), and other facilities classified as Institutions for Mental Diseases (IMD) for our community. To continue expanding capacity in our County, it is critical to maximize federal funds and opportunities, including short-term stays in IMDs for those whom it is

[redacted]

appropriate. This would support further expansion in behavioral health service capacity and services, while also demonstrating the value of such a robust continuum of care to other counties.

Our County is interested in partnering with the Department to develop the infrastructure for increasing bed capacity and may be interested in serving as an early pilot, should the components and financing come together sufficiently to further advance the progress our County is making.

Our County's significant efforts to expand service modalities and capacity, as well as increasing penetration rates and improving outcomes, demonstrate our commitment and investment in expanding the continuum of care. Should DHCS seek to create a pilot to test this model, the following initiatives demonstrate why our County is well-positioned to serve as a pilot of our recent efforts include:

- Supporting the Department's focus on crisis intervention services, our County developed a comprehensive continuum of crisis intervention services and was ready to launch 988 on day one, offering an array of teams including the Mobile Crisis Response Team, Psychiatry Emergency Response Team, Trusted Response Urgent Support Team, and Mobile Response Stabilization Services.
- Launching the Behavioral Health Navigator program in July 2022, which connects individuals and families to County and community resources, guiding them through the behavioral health system. This program ensures access to accurate information, services, and support opportunities for all community members.
- Launching the Assisted Outpatient Treatment (AOT) program in February 2022 to serve the most difficult to engage individuals with complex diagnoses and backgrounds.
- Expanding treatment bed capacity for acute, sub-acute, mental health and substance use residential treatment, social detoxification, and supported shelters.
- Providing significant investment in housing, supported by local Measure A, state and other funds, is expanding housing capacity across the continuum.
- Collaborating with local partners to establish a pipeline that will yield approximately 3,566 new apartments over the next 5 years. Of these, approximately 449 would be set aside for clients with behavioral health needs.
- Expanding school-based behavioral health services by providing grant funding for school districts to develop on-campus wellness centers.
- Developing on-going enhancements to our substance use treatment continuum of care to expand prevention services and public awareness campaigns, increase access

[redacted]

to substance use treatment (especially residential services), and expand collaborative efforts and partnerships countywide.

- Tackling the rising fentanyl crisis by distributing naloxone kits and providing trainings to a wide variety of community environments, including, but not limited to, educational institutions, libraries, carceral facilities, community-based organizations, clinics, mobile services, and more.
- Leveraging partnerships and developing a strategic plan to systematically address workforce challenges. In Fiscal Year 2023, our County distributed 34 sign-on bonuses; engaged over 200 high school students through outreach; created an Unclassified Rehabilitation Counselor code to retain interns and create a pathway to permanent County employment in the behavioral health field; and worked with our County Contracted Providers to implement a staffing survey and partner to promote the behavioral health field.

The examples above provide only a cursory view of the major efforts the County of Santa Clara is undertaking, as much more is in development. As identified in the RAND study, additional treatment beds are needed across the continuum. Our shared goal is for services to be accessible, short-term where appropriate, and for clients to be able to successfully step down to least restrictive, lower levels of care in the community when ready. To accomplish this, infrastructure must be built throughout the state to expand capacity. In addition, a culturally and linguistically diverse workforce is needed to provide services within this infrastructure. These efforts will be undertaken simultaneously with the CalAIM's payment reform and potential shifts in funding associated with SB 326, potentially creating a more challenging environment for some counties to implement optional services.

Recommendations

The Department has taken a wide-ranging approach in BH-CONNECT. We offer recommendations in a few key areas as DHCS revises and finalizes the BH-CONNECT Demonstration. These recommendations would further advance the Department's goals for BH-CONNECT and encouraging additional counties to expand services to the fullest extent.

Statewide Features

Workforce Initiatives

Workforce challenges have a major impact on our collective ability to serve our communities' behavioral health needs. Our County offers many training opportunities, including internships and fellowships. These programs provide an introduction to the specialty mental health system which helps attract new talent. The programs also provide an opportunity to learn of the

challenges upcoming behavioral health professionals face. We offer the following recommendations:

- For many, the cost of education is a barrier. Applying for loans deters many potential students from entering programs. Reducing the upfront cost of education may be more effective in bringing new students into the field. Offering scholarships or loan repayment programs could be a second level approach.
- Providing additional funding to enhance marketing and outreach programs to high schools, colleges and universities to promote the behavioral health field would create better awareness and help instill newfound passions for working in the behavioral health field.
- Streamlining the credentialling and hiring process, especially for those with lived experience, would help bring providers into the workforce to help meet the need more quickly.
- Supporting and enhancing Workforce Development Committees with partners in the public behavioral health workforce system, such as educational organizations and community partners, could recruit students to the field.

Evidence-Based Programs

Across the country, there are many evidence-based programs (EBP) that produce great outcomes and reduce the need for service. Bringing such programs to all regions of the California can benefit our communities. To sustain the gains, infrastructure is necessary to develop on-going training to address staff turn-over, provide updated training and coaching to support providers.

- By creating a statewide infrastructure of regional training centers to support ongoing training on EBP, the state could minimize duplication of efforts, providing much needed support to smaller counties. This would streamline training and support consistency.
- Providing support (reimbursement) to counties sending staff to the EBP training would offset the training time and minimize financial impacts. This would incentivize counties to implement the EBP models and support ongoing training to sustain the model.

Optional Services

IMD Opt-in

We appreciate DHCS's vision of expanding the full continuum of care, including care provided in institutional facilities with more than 16 beds (IMDs). IMDs are a necessary component of care for some clients. The focus on ensuring the care is medically necessary and outcomes is

[redacted]

important. Creating options to step people from an IMD to community care is similarly important.

- Across California, we see increasingly complex cases. As the State expands the definitions of people who are gravely disabled, more MHRC placements will be necessary. Expanding the range of IMD services to include MHRCs would provide critical support in creating a robust continuum of services.
- To create critically needed bed capacity, significant investment in building IMD, MHRC and other treatment beds is needed. Santa Clara is one of the few counties investing in expanding the continuum. These infrastructure investments can be expanded with state and federal funds to develop IMDs and MHRCs at county and state level. With these funds, the state could build sufficient capacity so that counties are not faced with bidding for limited beds or prioritizing among clients.
- Offering reimbursement for short-term stays through federal matching funds will be important to maintaining and expanding capacity. While advocating for sufficient quantity, we call for high quality so that the clients who access care can be supported to achieve good outcomes.

We appreciate DHCS's recognition of the immense amount of change underway with implementation of CalAIM Behavioral Health services, while counties prepare for CARE Court implementation and the Children and Youth Behavioral Health Initiative. The modification of the IMD opt-in component to phase in ACT, FACT, CSC for FEP and Supportive Employment is a positive development. The simultaneous lifts will be significant undertakings for counties, making it difficult for many to partner with the State to bring the vision to life within the next few years.

An option to encourage additional counties to opt-in would be to require a core set of services with optional services with escalating incentives. For example:

- Core Services could include 3 to 4 components of the continuum such as ACT, FACT, CSC for FEP.
- Optional services with escalating incentives could include IPS Supported Employment and Transitional Rent, and could be expanded to peer respite support and expanded low barrier shelter for individuals with behavioral health issues, which is often the first step towards engagement and connection to services.

With CSC for FEP an optional CalAIM Community Support for managed care plans, requiring counties to implement this service may create complications to operationalize.

[redacted]

Developing sufficient incentives will be key to support building the infrastructure required to provide a robust continuum - including residential treatment facilities, housing and inpatient facilities - in a sustainable manner. To encourage involvement of counties across the state, the Department could:

- Allow flexibility and create incentive path to a return on investment that takes county size and structure into consideration. With 58 counties ranging from small to large, a one-size-fits-all approach could impact take up.
- Create incentivize that fit variation amongst county needs.
- Expand the categories of facilities that State infrastructure grant funding can support.

Transitional Rent

The inclusion of Transitional Rent as an option for all counties and a requirement for those opting in to the IMD bundle is an important component to help clients who are at risk of or are experiencing homelessness. Identifying a path for those being released from institutional settings would be extremely beneficial, especially as people may lose their housing while in hospitals, skilled nursing facilities or incarceration. We offer the following recommendations regarding Transitional Rent:

- Design Transitional Rent to meet the specific needs of individuals at-risk-of- or experiencing homelessness. CalAIM includes Post-Hospitalization Short-Term Housing as a Community Support, yet includes a once-in-a-lifetime limit. The cyclical nature of homelessness does not fit with such a limit. Many people cycle between emergency departments, jail stays, emergency housing and unsheltered situations before they are able to stabilize and sustain a home. We strongly recommend that DHCS not include restrictions such as a once-in-a-lifetime cap, limiting access to this important service.
- DHCS may convert several housing-related Community Supports into Medi-Cal benefits beginning in 2024. If the intention is to make Transitional Rent a benefit, clarifying that could increase take up.

Closing Comments

As the Department looks to pilot new benefits and services to expand the continuum of care, especially housing, we recommend exploring ways to fully leverage County General Fund contributions, Mental Health Services Act funding and Realignment support for the full array of programs through Certified Public Expenditures as an adjunct to incentives to developing a sustainable model. This would help identify the true cost of services provided and help set us on a path toward sustainability by maximizing support for the expansion and ongoing implementation of services across the state.

[redacted]

We look forward to partnering with the Department and others in leveraging existing program and developing new solutions to improve access to behavioral healthcare services and contribute to a Healthy California for All.

Sincerely,

[redacted]

Edwin Poon, PhD
Deputy Director, Managed Care
on behalf of Sherri Terao, Ed.D., IFECMH Specialist, RPFM
Director, Behavioral Health Services

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT
Date: Thursday, August 31, 2023 3:59:00 PM

[redacted]

DHCS,
I strongly support the decision to include the availability of Clubhouse services in the State's application to the Federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation that is free, voluntary, and for life (if necessary), Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment; instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. It is therefore a "win" for everyone, both for individuals and the greater community in which they live.

Stephen J. Clavere, Ph.D. PSY9022
Commissioner, El Dorado County
Behavioral Health Commission

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 4:06:52 PM
Attachments: [redacted]

[redacted]

Dear Director Bass:

Please find our joint comments regarding the BH-CONNECT demonstration attached. We urge the state not to use federal Medicaid dollars to cover care in IMDs.

Thank you,

Carolina Valle (She | Her | Hers) [redacted]
Sr. Policy Director
California Pan-Ethnic Health Network (CPEHN)
New Mailing Address: 2991 Sacramento St #298, Berkeley, CA 94702
[redacted]
Website | [redacted]

Register Today! *The Right to Heal: Centering Mental Health Multi-Racial Equity in California is back for a third year!*


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OF COMMUNITY AGENCIES


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MIXTECO INDÍGENA COMMUNITY ORGANIZING PROJECT
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CULTURAL CENTER
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The Cambodian Family


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REMHDCO


Healthy
African
American
Families, II
Protecting the Legacy


California Pan-Ethnic
HEALTH NETWORK

August 31, 2023
Michelle Baass, Director
Department of Health Care Services
Via Email [redacted]

Re: Concept Paper Proposed Section 1115 Demonstration: California Behavioral Health Community-Based Continuum

Dear Director Bass:

On behalf of the California Pan-Ethnic Health Network and the undersigned organizations, we appreciate the opportunity to provide feedback on DHCS's concept paper for the California Behavioral Health Community-Based Continuum Demonstration. The undersigned signatories include members of the Behavioral Health Equity Collaborative and other interested stakeholders. We commend the state's intent to expand access to and strengthen the continuum of care for Medi-Cal beneficiaries living with Serious Mental Illness and Serious Emotional Disturbances. **Specifically, we support the following concepts in the proposed Medicaid Section 1115 Demonstration:**

- **DHCS's intent to examine and address racial disparities** in both access and outcomes among American Indian/Alaskan Native individuals, Black/African American individuals, and other populations experiencing worse health outcomes and inequities related to race, ethnicity, gender identity, and sexual orientation. For far too long, the state has failed to address the overrepresentation of Black/African-American individuals and American Indian/Alaskan Native individuals in the specialty mental health system.[1] We commend the explicit recognition of those who have borne the brunt of our public mental health system's failures, and would like to work with the state to understand, reduce, and eliminate these specific disparities.
- **DHCS's intent to enhance the use of community-based, evidence-based practices** known to reduce the need for institutional care, particularly for individuals who are involved in the criminal legal system, or who are experiencing or at risk of homelessness. The undersigned organizations strongly believe services should be evidence-informed, voluntary, and encompass social factors known to impact mental health and well-being, including housing, social connections, and food. Community care is particularly important in light of growing evidence suggesting inpatient treatment is no more effective than outpatient treatment.[2]
- **DHCS's intent to engage stakeholders on opportunities to incorporate community-defined evidence practices** and cultural adaptations of evidence-based practices to ensure culturally and linguistically centered services given the rich diversity in California's communities. The state is responsible for integrating evidence-based practices into its plans, but these practices have been formed by the dominant medical model for the dominant culture. They have not been effective in addressing inequities in non-dominant populations or cultures (BIPOC communities, LGBTQ+ communities, etc.). We applaud the state for shifting its approach to consider what more can work (and what doesn't).

[1] https://data.chhs.ca.gov/dataset/adult-ab470-datasets

[2] Lessons From Medicaid's Divergent Paths On Mental Health And Addiction Services Christina Andrews, Colleen M. Grogan, Marianne Brennan, and Harold A. Pollack, Health Affairs 2015 34:7, 1131-1138

However, while we agree with the state's intention to expand access to community-based services, we are opposed to tying these efforts up with federal IMD dollars. We urge the state not to use federal Medicaid dollars to cover care in IMDs. California should not rely on IMD stays to provide care to people diagnosed with serious mental illness and serious emotional disturbances. Institutionalization is more stigmatized and less equitable than community care for diverse communities.

Medicaid's long-standing IMD exclusion represents Congress's intent to incentivize states to shift their resources toward community-based behavioral health services, and should be upheld as is. The 2004 Mental Health Services Act represents voters' desire to expand the full continuum of community-based care over restrictive forms of treatment. An expansion of IMDs by the state would ignore these sound federal and state policies to strengthen community-based services and disproportionately harm the Black, Indigenous, People of Color (BIPOC), and Lesbian, Gay, Bisexual, Transgender, and Queer Plus (LGBTQ+) people of California.

We recommend DHCS adopt the following recommendations in place of an IMD expansion.

Ensure accountability. According to the proposal, only beneficiaries whose county of responsibility is an opt-in county can access the expanded set of services. This approach is modeled after the DMC-ODS IMD expansion. However, DHCS should first evaluate the DMC-ODS IMD expansion for its impact on racial disparities before using it as a model. In addition, DHCS should enforce more robust quality and outcomes standards on the existing IMDs, without regard to any expansion.

DHCS should ensure equitable access to existing specialty mental health services. The only way to reduce the need for IMDs and shorten the lengths of IMD stays is to ensure the availability of meaningful alternatives to institutionalization, which is not currently happening uniformly or equitably across the state. Specialty mental health access rates vary significantly by race and ethnicity. DHCS data shows Asian and Pacific Islander, and Latino communities are less likely than enrollees from other racial and ethnic groups to receive five or more mental health services from a specialty mental health plan. Conversely, Black/African American people are more likely to be diagnosed with serious mental illness compared to their white counterparts, and have one of the highest specialty mental health services penetration rates, despite no evidence of racial differences in prevalence rates of mental illness.[3] [4] Communities of color are forced to engage with specialty mental health services at disproportionate rates due to not getting the early care (or non-specialty mental health services) they need. These disparities are rooted in structural racism and implicit bias. DHCS should ensure that counties are providing or arranging and paying for Med-Cal reimbursable services that can divert people from inpatient hospitalizations to community-based services that are culturally and linguistically appropriate.

DHCS should ensure equitable access to existing non-specialty mental health services. Serious mental illness and serious emotional disturbances are preventable, manageable, and can be overcome. The Proposed Section 1115 Demonstration is based upon the findings of the California Behavioral Health Landscape: Assessing the Continuum of Care for Behavioral Health Services in California (2022), but our concern with using this assessment is that it fails to mention, let alone assess, the critical role of the non-specialty mental health delivery system in the continuum of care.

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[3] McGuire, T. G., & Miranda, J. (2008). Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications. *Health affairs (Project Hope)*, *27*(2), 393. https://doi.org/10.1377/hlthaff.27.2.393

[4] https://www.chcf.org/wp-content/uploads/2020/11/MentalHealthDisparitiesRaceEthnicityAdultsMediCal.pdf

Disparities in the specialty mental health care system start and end with the non-specialty mental health care system. Since 2014, DHCS has required Medi-Cal managed care plans to provide and/or arrange and pay for non-specialty mental health services. However, CPEHN's review of the data revealed that Black/African American, Latino, and Asian Pacific Islander adults all access non-specialty mental health services at a significantly lower rate than their white counterparts. Access among LGBTQ+ communities is so low that data is not publicly available. DHCS should ensure that Medi-Cal managed care plans provide, arrange, and pay for non-specialty mental health services. Opportunities to improve managed care delivery of non-specialty mental health services include implementing mandatory member and primary care provider outreach (SB 1019, Chaptered 2022), expanding the suite of available services, improving mental health provider networks and diversity, and implementing a required minimum primary care spend for MCPs that take a whole person approach.

DHCS should require community-based services as a statewide requirement, not just an *option* for counties to opt into. We appreciate DHCS's inclusion of community-based services to reduce the need for institutional care and improve outcomes. However, any true expansion of community-based options (ACT, FACT, etc.) should be equitable and *required* for each county. Making community-based services *optional* at the county level deprives those living with serious mental illness and serious emotional disturbance of the opportunity to access enhanced community-based services regardless of where they live. Making community-based services an optional benefit at the county level can have negative implications for continuity of care when a Medi-Cal member moves to a county that does not offer enhanced community-based services, and would no longer have access to the care they need. This would heavily disadvantage adults who may benefit from these services, but do not live in a county that has opted into the services.

DHCS should modify community-based services (ACT, FACT, CSC for FEP) to reduce racial disparities. There is not enough research to show the effectiveness of ACT, FACT, CSC for FEP services in historically discriminated populations. For this reason, while we do believe there is potential for these to be effective methods to improve care for adults living with serious mental illness, we have the following concerns about them:

- *Assertive Community Treat (ACT):* While research has shown that ACT can reduce psychiatric hospitalization, more research is needed regarding its effectiveness on communities of color in reducing racial and ethnic disparities. Therefore, DHCS should adapt all services offered through ACT to meet Californians' culturally and linguistically diverse needs.
- *Forensic Assertive Community Treatment (FACT):* Given that the treatment team through FACT will be a partnership with the criminal injustice system and involve law enforcement in some capacity, we have concerns about FACT being used as a method of allocating additional funding and resources to law enforcement entities. DHCS should limit the involvement of law enforcement in any FACT team and ensure that those involved in the criminal injustice system are not subjected to further trauma.
- *Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP):* CSC focuses on family engagement, as studies have linked family engagement to positive outcomes in care. For this reason, the needs of racial and ethnic minority communities should not be overlooked when conducting outreach to involve families in the treatment plan. Providers should also be trained to work and effectively communicate with family members and patients who experience racism, and campaigns and referrals in CSC should be adapted for those who are involved in the criminal injustice system.
- *Rent/Temporary Housing:* We support rent and housing as a critical part of treatment for those suffering from serious behavioral health conditions. Rent and housing models have been shown

to offer stability and a reduction of ER/inpatient mental health services; however, we urge DHCS to consider more permanent housing solutions, like Housing First, rather than temporary ones.

DHCS should seek Medicaid reimbursement for Community-Defined Evidence Practices (CDEPs). It is evident through the research and data that the vast majority of evidence-based practices were not designed for or appropriately standardized on communities of color. There are opportunities to best support communities most in need, such as BIPOC and LGBTQ+, by approving Medi-Cal reforms that are flexible and culturally responsive with the addition of community-defined evidence practices to the current available outpatient behavioral health services. DHCS should seek federal approval for behavioral health services based on Community-Defined Evidence Practices (CDEPs) through a State Plan Amendment as an additional service under the Medi-Cal preventive services benefit. Such a move would be more powerful and effective than just increasing access to the existing medical model, which historically has not been effective for diverse communities. CDEPs should be billable under specialty mental health care services as well. For instance, residential treatment centers serving the American Indian and Alaskan Native populations currently integrate traditional healing services in combination with their residential treatment services provided by healers and other qualified mental health professionals.

DHCS should categorize CHW/Ps as a required state benefit under County Mental Health Plans. As currently written, DHCS proposes to cover Community Health Worker and Promotores Services (CHW/Ps) as an *optional* benefit that counties can opt-in to cover. CPEHN urges DHCS to make CHW/P services a required benefit under the Medi-Cal specialty mental health services system rather than an optional one. CHW/Ps are critical, culturally responsive community-based service providers that support some of the most vulnerable community members by providing additional linkages to care. CHW/Ps are crucial for engaging racial and ethnic groups who are traditionally underserved or inappropriately served by county behavioral health. Integrating the CHW/P workforce within the specialty behavioral health delivery systems in California has the potential to meaningfully assist counties in reducing disparities.

DHCS should expand access to include Psychiatric Advance Directives (PADs) as part of the demonstration. Psychiatric Advance Directives (PADs) should be a standard part of mental health care, as outlined by CMS in 2006.[5] PADs allow peers and other qualified professionals to create a self-directed legal document that clearly and effectively communicates an individual's treatment preferences if they cannot make decisions about their care due to a mental health crisis. PADs provide related service providers (law enforcement, justice system, medical staff) and family members and caregivers with explicit instructions on how to engage with and support a person during times of crisis. PADs have been shown to actively increase trust and access to services, reduce coercive treatment interventions for individuals experiencing a crisis, improve treatment satisfaction, and reduce recidivism in jail and hospitalization. Jurisdictions implementing PADs have shared experiences in which the creation of PADs has built trust between the mental health care system and community members, prompting them to seek more preventative levels of mental health care voluntarily. Consumers who have executed PADs express feelings of self-determination, autonomy, and empowerment.[6] Expanding access to PADs can significantly increase trust between the state, counties, and mental health consumers.

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[5] https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf

[6] SAMHSA. (n.d.). SAMHSA.GOV. Retrieved from https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf

Precedents to expand access to Psychiatric Advance Directives exist. Texas, Georgia, West Virginia, Washington, New York, Virginia, and Colorado have entered the arena of PADs. The 2018 CMS guidance DHCS is proposing to leverage to draw down federal funds to expand IMDs also emphasizes the importance of Psychiatric Advance Directives as an example of person-centered planning, services, and supports that address the cultural needs and values of individuals with SMI or SED.[7] In California alone, five counties are currently using innovation funds to develop the infrastructure for sustainable PADs usage in their communities.

DHCS should work with stakeholders, consumers, peers, and counties to determine how the state's mental health system should be involved. With the new CalAIM 2022 mandate for interoperability, many counties are seeking new systems to work in conjunction with the medical community. DHCS could work with stakeholders to develop a PADs template, train stakeholders, and adopt a standard PADs Platform that can download into an EHR a completed PAD, as clients can offer consent to have their PAD included in their mental health or physical health client records.

DHCS should remove law enforcement from behavioral health crisis response. Many counties currently operate a co-responder mobile crisis response team that involves law enforcement, although research and community experience clearly demonstrate that law enforcement should rarely be a part of a response to behavioral health issues. In order to make the significant cultural shift that is needed in this area, DHCS should set and enforce a specific statewide standard. We continue to urge DHCS to issue specific guidance to counties to minimize the involvement of local law enforcement in mobile crisis response by narrowly and specifically defining situations in which law enforcement may provide backup. According to DHCS's publicly available data, in 2021, racial disparities were most prominent for crisis intervention services where Black/African American adults were subjected to crisis intervention services far more often than other races– at 15.98% per beneficiary, and had the highest specialty mental health services penetration rate. According to a recent CPEHN publication, communities of color avoid seeking emergency help for behavioral health conditions largely due to fear of interaction with law enforcement. Involving law enforcement in behavioral health issues is neither safe nor equitable. Without decisive action from the state to minimize law enforcement involvement, mobile crisis response may become a benefit that is, in practice, only available to some Californians, not all.

Thank you for your consideration of our recommendations. For more information or any questions, please contact Carolina Valle [redacted] and Ruqayya Ahmad [redacted].

Sincerely,

Carolina Valle, California Pan-Ethnic Health Network

Rayshell Chambers, Painted Brain

Meron Agonafer, California Black Health Network

Sonya Aadam, California Black Women's Health Project

Theresa Zamora, Mi Familia Vota

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

Hina Ahmad, South Asian Network

Lee Lo, Asian American Liberation Network

Paige Medina, Multi-Ethnic Collaborative of Community Agencies

Jimina Afuola, Empowering Pacific Islander Communities

Vanessa Terán, Mixteco Indigena Community Organizing Project

Seng S. Yang, Hmong Cultural Center of Butte County

Mandy Diec, Southeast Asia Resource Action Center

Xochitl Lopez-Ayala, Access Reproductive Justice

Kim Lewis, National Health Law Program

Rosaicela Estrada, El Sol Neighborhood Education Center

Vattana Peong, The Cambodian Family

Pysay Phinith, Korean Community Center of the East Bay

Shanti Huynh, Mid-City Community Advocacy Network

Deb Roth, Disability Rights California

Peter Phillips, Vision y Compromiso

Amina Sheik Mohamed, San Diego Refugee Communities Coalition

Gerson Perdomo

Mar Velez, Latino Coalition for a Health California

Stacie Hiramoto, Racial & Ethnic Mental Health Disparities Coalition

Felica Jones, Healthy African American Families

Yanet Martínez

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration - IEHP Feedback
Date: Thursday, August 31, 2023 4:16:20 PM
Attachments: [redacted]

[redacted]

Good afternoon,

Please find below the comment table with IEHP's feedback on the BH-CONNECT Waiver. Please let us know if you have any questions.

Section	Page of Draft Proposal	Current Language	IEHP Feedback
Key Components	37	Inclusion of a management-level Foster Care Liaison within MCPs to enable effective oversight and delivery of ECM, attend Child and Family Team meetings, ensure managed care services are coordinated with other services, and serve as a point of escalation for care managers if they face operational obstacles. Initial child welfare/specialty mental health behavioral health assessment at entry point into child welfare.	Guidance is requested as to how the role of the foster care liaison will differ from the existing managed care plan role and responsibilities for services provided to the Katie A class and other foster care beneficiaries.

Compliance Regulatory Affairs

10801 Sixth St.
Rancho Cucamonga, CA 91730
[redacted]

IEHP

We heal and inspire the human spirit.

From: [redacted]
To: DHCS BH-CONNECT; [redacted]
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 4:22:46 PM
Attachments: [redacted]

[redacted]

Jaycee and Tyler,

Thank you for the opportunity to provide comments on the Department's Proposed BH-CONNECT Section 1115 Application. Please find comments attached to this email from the California Hospital Association (CHA).

Please do not hesitate to contact me with any questions. We look forward to working with you on this important effort and would be happy to support DHCS' efforts in any way that would be helpful.

Thanks,

Kirsten

Kirsten Barlow, MSW
Vice President, Policy
California Hospital Association
[redacted]

August 31, 2023

Department of Health Care Services
Director's Office
Attn: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

SUBJECT: Comments on Department of Health Care Services Draft "California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration"

Dear Ms. Cooper and Mr. Sadwith:

Every day, California's hospitals care for a significant and growing number of people in a mental health crisis. Given the vast need for behavioral health support in California, the California Hospital Association (CHA) supports all efforts to build a robust continuum of community-based care for Californians living with a serious mental illness or emotional disturbance. For these reasons, CHA strongly supports the Department of Health Care Services' (DHCS) intent to apply for the federal Section 1115(a) Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) demonstration opportunity. We appreciate the opportunity to share the following comments on the DHCS BH-CONNECT Section 1115 Demonstration Application.

(1) DHCS Should Add Strategies to Address *All of CMS' Goals* for this Demonstration

CHA notes the importance CMS places on properly documenting the state's strategies for achieving its demonstration program goals and they "strongly encourage states to articulate in their demonstration applications how their proposals will apply evidence-based programs to meet the needs of people with SMI or SED…." (SMDL #18-011, page 17). By providing specific goals and strategies in the application at the outset, DHCS will receive more targeted and informed input during the upcoming federal comment period and diminish delays to the effective date of the demonstration. Further, more detail in the application at this stage would help inform development of required reinvestments, which are mentioned only in passing within the current draft application. CHA strongly supports reinvestments that focus on enhanced capacity across the entire behavioral health continuum, inclusive of inpatient settings. As you know, the DHCS report, "Assessing the Continuum of Care for Behavioral Health Services in California"

and the RAND Corporation found significant county and regional gaps in the continuum of behavioral health care in California:

- *Statewide, California has a shortfall of approximately 1,971 psychiatric beds at the acute level, 2,796 beds at the subacute level, and 2,963 community residential beds.*
- *There are 24 counties whose residents have no in-county access to inpatient psychiatric hospital services, regardless of whether a person's health coverage is Medi-Cal or commercially insurance.*
- *Of the 34 counties that do have inpatient psychiatric bed capacity, 41% of counties need between one-third to double the capacity to meet projected local needs.*

For these reasons, CHA urges DHCS to add strategies to the Demonstration Application that address the following top two CMS goals:

1. Reduced utilization and lengths of stay in emergency departments (EDs) among Medicaid members with SMI or SED while awaiting mental health treatment in specialized settings.
2. Reduced preventable readmissions to acute care hospitals and residential settings.

The DHCS draft Demonstration Application states:

> *"Under the BH-CONNECT demonstration, county mental health plans can 'opt in' to receive WFP for care provided during short-term stays in IMDs if they meet a robust set of requirements consistent with applicable Centers for Medicare and Medicaid Services (CMS) guidance, including providing a full array of enhanced community-based services and Beeps available through the BH-CONNECT demonstration, meeting key CMS requirements related to accreditation and emergency department (ED) strategies, and meeting robust accountability requirements to ensure care provided in residential and inpatient settings is short-term and high-quality."* (Pages 6-7)

However, it is unclear which of the "Key Features" of the Demonstration Application are designed to directly address these goals. Is the hypothesis that if a county provides transitional rent and certain "enhanced community services" (i.e., [forensic] assertive community treatment, first episode psychosis, Individual Placement and Supported Employment, community health worker services, and clubhouse services) it will lead to lower use, shorter stays, and fewer readmissions to hospitals and residential settings? What are the "robust accountability" requirements that will be used to ensure care is "high quality?"

The Demonstration Application also states that, using existing authorities, one component will include:

> *"Implementation of county and mental health facility 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."* (Page 8)

In addition to this brief description, CHA recommends the Demonstration Application specify which of its features are supported by research evidence that is associated with reducing the utilization and lengths of stay in EDs and preventable readmissions to acute care hospitals and residential settings. The Demonstration Application should also acknowledge that addressing these care transitions must include coordination between hospital EDs, managed care plans, and county behavioral health plans. Additional strategies should be added to the Application and to the corresponding objectives proposed within the Expenditure Authorities section. To this end, CHA offers several options below to assist DHCS in this effort.

CMS Strategies: As suggested in our comments on the January 2023 Concept Paper, CHA urges DHCS to consider at a minimum including these strategies offered by CMS:

- Use accountability measures and payment incentives which could model the Medicare Hospital Readmission Reduction Program for plans and providers.
- Include the cost for hospital/residential treatment program staff to provide follow-up contacts to Medicaid beneficiaries following hospitalization and emergency room services in reimbursement rates.
- Use peer support providers to help make connections with inpatient facilities, emergency departments, and outpatient treatment providers.

Journal of the American Medication Association Strategies: According to a 2020 study published in the Journal of the American Medical Association, the following strategies are suggested for youth after psychiatric hospitalization with a risk of death by suicide:

- Assertive discharge planning
- Patient and family psychoeducation
- Work to facilitate linkage and connectedness, such as follow-up calls, short-term case management, and bridge visits.

Zero Suicide Initiative Strategies: The Zero Suicide initiative provides a framework constructed around evidence-based practices:

> *"Creating successful bridges in care can be a difficult and confusing process. It is essential that health and behavioral health care systems develop clear protocols and procedures that carefully engage individuals at risk of suicide, so those individuals make and keep the appointments that support their care. Effective care transitions are the responsibility of the provider, not the individual or their family members."*

Approaches recommended by Zero Suicide during care transitions include:

- Organizational policies that provide clear guidance for successful care transitions and specify the contacts and support needed throughout the process to manage the transitions.
- Staff are provided training (initial and ongoing) appropriate for their role, on the importance of transitions and the organizational procedures to support transitioning individuals.

- Care transition activities (e.g., phone calls to the individual or collaborating providers, postcards sent, and responses) are recorded in the organization's health record.
- Data are collected to identify gaps in care or training to continuously improve the processes and procedures regarding transitions of care.
- A Just Culture spirit is maintained, particularly if there is an adverse event, and a systems-improvement focus is kept instead of a culture that faults individual service providers.
- Leaders facilitate memorandums of understanding or other collaborative relationships between their organization and other organizations to improve the processes of inter-organizational transitions.
- Caring contacts are used with appropriate transitions (e.g., inpatient to outpatient, clinic to clinic)
- Brief interventions such as safety planning, caring contacts, and care coordination to reduce subsequent suicide attempts for individuals who presented with suicidal thoughts or behaviors in an ED or other medical environment.
- Strategies such as the use of technology, multidisciplinary team approaches, and co-locating medical and behavioral health providers to help bridge care, particularly for rural populations.

(2) Support Removal of Stigmatizing Language about Inpatient and Residential Treatment

CHA supports the effort DHCS made not to carry over stigmatizing terminology from its January 2023 Concept Paper into this Demonstration Application when describing inpatient and residential treatment. As noted in our comments on the Concept Paper, modern-day community hospitals provide safe, caring, accredited, and highly regulated treatment in a setting that is appropriate for individuals experiencing an acute psychiatric crisis. We are pleased to see fewer instances in which inpatient and residential care are described as "institutional." CHA particularly supports DHCS' commitment "to ensuring that Medi-Cal members have access to a comprehensive continuum of care that allows members who require residential and inpatient services to receive them when necessary." (Page 28)

Thank you for the opportunity to provide comments on this DHCS Section 1115 Demonstration Application. Please contact me at [redacted] or [redacted] with any questions you may have.

Sincerely,

[redacted]

Kirsten Barlow, Vice President, Policy

From: [redacted]
To: DHCS BH-CONNECT; [redacted]
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 5:09:37 PM
Attachments: [redacted]

[redacted]

Dear Director Cooper and Deputy Director Sadwith:

Please find DRC's comments on the draft BH-CONNECT 1115 demonstration waiver application. Thank you for the opportunity to provide feedback and the Department's engagement on this proposal.

Best,
Samuel

Samuel Jain (he/him)
Senior Policy Attorney, Mental Health Practice Group
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August 31, 2023

Director's Office
Department of Health Care Services
BH-CONNECT@dhcs.ca.gov

Jacey Cooper, State Medicaid Director
Department of Health Care Services
[redacted]

Tyler Sadwith, Deputy Director for Behavioral Health
Department of Health Care Services
[redacted]

Re: Submission of Public Comment on California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) 1115 Demonstration Waiver Application

Dear Director Cooper and Deputy Director Sadwith:

We appreciate the opportunity to provide feedback on the Department of Health Care Services' (DHCS) California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Waiver application, as well as the Department's engagement with our team on the concept paper. Disability Rights California (DRC) supports DHCS's ongoing and future efforts to expand community-based behavioral health services for Medi-Cal recipients. However, we cannot support DHCS's plan to seek a limited waiver of the IMD exclusion. As described below, there are many ways that DHCS can promote expansion

of community-based services without accepting Medicaid dollars for IMD care.

I. DRC Opposes Using Federal Medicaid Dollars to Cover Care in IMDs.

Medicaid's long-standing IMD exclusion signifies Congress's intent to incentivize states to shift their resources towards community-based behavioral health services.[1] Disregarding this sound Federal policy, California over-relies on IMD stays to provide care to people diagnosed with serious mental illness and serious emotional disturbance. A limited waiver of Medicaid's IMD exclusion is not necessary for counties to realize cost savings on IMD care. Instead, counties can realize cost savings by reducing their reliance on IMDs in favor of expanding access to less-costly community-based services.

Recent attempts by legislators to expand the number of people who can be detained, and ultimately conserved, under the Lanterman-Petris-Short (LPS) Act signals a desire to move backwards in California's deinstitutionalization of people living with mental health disabilities. As described below, DHCS can promote the use of non-institutional, community-based services that will reduce the need for IMD stays and promote integration of people living with mental health disabilities.

II. DHCS Should Ensure Access to Existing Specialty Mental Health Services that Provide Less-Costly Alternatives to Psychiatric Institutionalization.

The only way to reduce the need for IMDs and shorten the lengths of medically-necessary IMD stays is to ensure the availability of meaningful alternatives to institutionalization. DHCS should ensure that County Mental Health Plans (MHPs) are providing or arranging, and paying for, Medi-Cal reimbursable services that can divert people from inpatient hospitalizations, as well as transition residents of IMDs to community-based settings. By diverting people away from IMDs into Medi-Cal reimbursable services,

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[1] *See, e.g.* Jennifer Mathis, *Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate—Argument to Retain the IMD Rule*, PSYCHIATRIC SERVICES, January 2019 (https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201800413).

counties will realize cost savings that they can use to reinvest in the provision of those services.

DHCS's contract with County MHPs requires them to provide or arrange and pay for a range of Specialty Mental Health Services when they are medically necessary for Medi-Cal beneficiaries. However, a review of DHCS's publicly available data shows that County MHPs are under-utilizing many Specialty Mental Health Services that could prevent or shorten IMD stays. For example, DHCS reports that counties provided the following services to adults in fiscal year 2020:[2]

- **Crisis Stabilization.** 57 of 58 counties covered Crisis Stabilization services for a total of 53,180 statewide beneficiaries. However, DHCS's recent assessment of California's behavioral health system indicates that most counties do not have sufficient Crisis Stabilization Unit capacity. This likely means that the majority of Medi-Cal reimbursable crisis stabilization is provided in hospital emergency departments that are not specifically designed or staffed by people trained to treat psychiatric emergencies. In addition, DRC's work in counties statewide shows that, once a person in psychiatric crisis enters a hospital emergency department, it is significantly more likely that the person will ultimately be admitted to an inpatient psychiatric unit because the hospital emergency department was not equipped to effectively resolve the crisis. Creating more opportunities for Crisis Stabilization to take place outside of hospital emergency departments—and outside of general hospitals writ large—will reduce reliance on IMDs.

- **Crisis Residential.** 48 of 58 counties covered Crisis Residential treatment services for a total of 9,140 adult beneficiaries. 17 of these counties covered this benefit for fewer than 11 beneficiaries in the year. Crisis Residential treatment services can be used to divert people in mental health crisis from psychiatric hospitalization, and instead provide them with short-term, community-based support. In turn, this will reduce the numbers of people placed on LPS holds that

[2] California Health and Human Services Open Data Portal, Adult SMHS Utilization (https://data.chhs.ca.gov/dataset/adult-population-performance-dashboard/resource/cbd12741-5df9-439f-8a3f-fe8cedaa6e45?filters=FISCAL_YEAR%3A2020). Though the figures stated in this letter focus only on adult beneficiaries ages 21+, DRC hypothesizes that there are similar under-utilizations amongst beneficiaries under age 21.

clog emergency departments and subsequently enter the backlog of patients in IMDs. Building out the State's capacity to provide Medi-Cal Crisis Residential services will also be important to the success of the Mobile Crisis benefit, as they will provide alternatives to emergency departments for people whose crisis cannot be resolved at home with the help of a mobile team, yet do not need a hospital level of care.

- **Adult Residential.** 34 of 58 counties covered Adult Residential treatment for a total of 1,438 beneficiaries, with half of them covering it for fewer than 11 beneficiaries. Adult Residential treatment, with its time-limited stays and specific focus on building skills for independent living, could be a meaningful alternative to LPS conservatorship and its associated lengthy stays in IMDs. Adult Residential treatment services should only be used when strictly necessary, when beneficiaries need a level of support that cannot be provided by intensive outpatient services offered while living in independent housing.

- **Day Rehabilitation.** 9 of 58 counties covered Day Rehabilitation Services for a total of 243 beneficiaries in 2020. As with Day Treatment Intensive services, if Day Rehabilitation Services become more available, people who are receiving intensive rehabilitation services in IMDs could be discharged and receive intensive rehabilitation services in the community.

- **Day Treatment Intensive.** 2 of 58 counties covered Day Treatment Intensive Services in 2020, with all but one of the 89 total beneficiaries in a *single* county. Day Treatment Intensive services exist specifically to provide "an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting."[3] If County MHP coverage of this service is expanded, many people who are currently receiving intensive treatment in IMDs could be discharged and receive intensive treatment in the community.

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3 9 Cal. Code Regs. § 1810.213.

III. Independent of an IMD Exclusion Waiver, DHCS Can Cover Assertive Community Treatment, Supported Employment, and Coordinated Specialty Care for First Episode Psychosis as Medi-Cal Reimbursable Services for Eligible Beneficiaries Statewide.

DRC appreciates that DHCS is considering including Assertive Community Treatment (ACT), Supported Employment, and Coordinated Specialty Care (CSC) for First Episode Psychosis as covered Medi-Cal benefits. However, DHCS's coverage of these three important evidence-based practices should not be contingent on a county opting in to a waiver of the IMD exclusion. DHCS should use existing Medicaid authority to cover all three of these services statewide.

As of July 2021, 41 state Medicaid programs covered ACT, and 25 covered Supported Employment.[4] In this regard, California is lagging behind many states. Additionally, the Center for Medicare & Medicaid Services (CMS) has issued guidance for using Medicaid authority to cover CSC for First Episode Psychosis: "[t]he federal Medicaid program may reimburse for services to address first episode psychosis through a variety of authorities."[5]

IV. DHCS Should Focus Upcoming Behavioral Health Community Infrastructure Program (BHCIP) Awards on Community-Based Alternatives to Institutional Settings.

DRC commends DHCS's initiative to build out the continuum of California's behavioral health infrastructure through the BHCIP program and especially appreciates that Round 1 of the funding focused specifically on Mobile Crisis infrastructure. However, at least seven awards in the Round 3 "Launch Ready" grants were made for constructing facilities that provide locked, institutional levels of care.[6]

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[4] Medicaid and CHIP Payment and Access Commission (MACPAC), *State Coverage Policies of Mental Health Services for Adults*, July 2021 (https://www.macpac.gov/publication/state-coverage-policies-of-mental-health-services-for-adults/).

[5] Joint Information Bulletin, *Coverage of Early Intervention Services for First Episode Psychosis* (October 16, 2015) (https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf).

[6] Five awards were made for Acute Psychiatric Hospitals, and two awards were made for Mental Health Rehabilitation Centers. *See* BHCIP Round 3 Awardee Map

For the remaining three rounds of BHCIP funding, DRC urges DHCS to focus on awarding funds for non-institutional, community-based infrastructure that will help facilitate the goal of reducing the need for IMD stays. In particular, DHCS should focus awards on facilities that provide outpatient treatment, Peer Respite, mental health urgent care, and other alternatives to institutionalization discussed in this letter. In particular, DHCS could devote Round 6, the parameters of which have not yet been announced, solely to non-institutional infrastructure settings, with a specific emphasis on making awards to peer-run organizations and community-based organizations that provide culturally-responsive services.

V. DRC Supports DHCS's Plans to Provide Counties with More Support and Exercise Stricter Oversight Over County Mental Health Plans.

As detailed in Section II, above, DRC has concerns that County MHPs are not fulfilling their obligations to provide or arrange Specialty Mental Health Services that can divert Medi-Cal beneficiaries from IMDs and can shorten lengths of stay. DRC welcomes DHCS's proposals to provide more support and training to counties, in combination with stricter oversight and accountability measures.

VI. DHCS Should Collaborate with Other State Agencies and Departments to Increase the State's Supply of Permanent Supportive Housing.

Reducing the State's reliance on IMDs necessarily requires having available housing options for the people who would otherwise be institutionalized. In many instances, IMD stays are purely custodial because there is nowhere else for a person to go. DRC recognizes that DHCS is currently involved in at least three initiatives that will provide shelter to people living with mental health disabilities: Behavioral Health Bridge Housing, Community Care Expansion, and the CalAIM Transitional Rent Services Amendment. However, none of these programs provide permanent, long-term, integrated solutions for deinstitutionalization.[7]

(https://public.tableau.com/app/profile/ahpnet/viz/BHCIPRound3AwardeeMap/BHCIPRound3AwardMap?publish=yes).

[7] For example, Board and Care Homes, in which the state is heavily investing through the Community Care Expansion, meet the United States Department of Justice's standards for "segregated settings" that

Permanent Supportive Housing, especially when combined with Assertive Community Treatment, is evidence-based and proven to provide long-term, integrated housing for people living with mental health disabilities who may otherwise be institutionalized.

VII. DRC Urges DHCS to Support Counties in Offering Community-Defined Evidence Practices and Other Treatment Modalities that Complement Medi-Cal Reimbursable Services.

As California is diverse, so are the behavioral health needs of Medi-Cal beneficiaries. Accordingly, DHCS should do more to ensure the availability of services supported by Community-Defined Evidence Practices (CDEPs) and alternative treatment modalities that complement the current menu of Medi-Cal reimbursable behavioral health services. In 2021, the CDEP Integration Advisory Group published a paper that contains several recommendations for DHCS, including adopting new behavioral health outcomes measures that include culturally significant measures and seeking a State Plan Amendment or Section 1115 waiver that allows for reimbursement of CDEPs and traditional healing practices.[8] DRC supports and amplifies the advocacy of organizations led by Black, Indigenous, and People of Color (BIPOC) that seek to transform the behavioral health system for all Californians to ensure that culturally-responsive, community-based services are available statewide.

VIII. DHCS Should Not Seek CMS Authority for an Exemption from Length-of-Stay Limitations on Residential Treatment in Short Term Residential Treatment Programs (STRTPs).

The BH-CONNECT Waiver Application states DHCS will seek an exemption from length-of-stay limitations on stays in STRTPs that are IMDs

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may violate the State's integration obligations under *Olmstead*. *See* United States Department of Justice, *Statement of the Department of Justice on the Integration Mandate of Title II of the Americans with Disabilities Act and* Olmstead v. L.C.*, Questions and Answers on the ADA's Integration Mandate and* Olmstead *Enforcement* (June 22, 2011) (https://www.ada.gov/olmstead/q&a_olmstead.htm).

[8] CDEP Integration Advisory Group, *Concept Paper: Policy Options for Community-Defined Evidence Practices (CDEPs)*, April 2021 (https://cpehn.org/assets/uploads/2021/04/CDEPs-Concept-Paper-April-2021.pdf). In addition, the California Pan-Ethnic Health Network and partners' report, *A Right to Heal: Mental Health in Diverse Communities* (September 2022) is a resource that outlines a vision for strategies and approaches to ensure culturally-responsive service delivery (https://cpehn.org/assets/uploads/2021/09/A-Right-To-Heal-Report_final.pdf).

for beneficiaries under 21. Given that the Legislature has provided the State with authority to create a licensing category for Psychiatric Residential Treatment Facilities (PRTFs) for beneficiaries under 21,[9] a waiver of terms relating to STRTPs is not necessary. PRTFs are specifically exempted from CMS's IMD exclusion.[10] As such, DHCS should not create more opportunities for Federal reimbursement of IMD stays for beneficiaries under 21 by seeking a waiver of length-of-stay provisions for STRTPs that qualify as IMDs.

IX. DHCS Should Include Strong Performance Incentives for Improvements in Quality of Life for Patients in IMDs.

Length of stay is not the only issue that DHCS must address in regard to quality of care in IMDs. If DHCS proceeds with the BH-CONNECT Waiver Application and CMS approves, it should include incentives for other performance benchmarks that increase quality of life for patients receiving care in them. DRC's suggestions include, but are not limited to, incentives tied to: (1) measurable reduction in seclusion and restraint; (2) measurable reduction in denials of rights guaranteed under Welfare and Institutions Code § 5325; (3) measurable reduction in administration of emergency medications, especially by injection; and (4) provision of robust recovery-oriented programming inside of IMDs.

X. DRC Has Concerns About DHCS Placing Additional Obligations on Counties if the BH-CONNECT Waiver Moves Forward and is Approved by CMS.

If DHCS proceeds with the BH-CONNECT Waiver Application and CMS approves, counties that opt in to the limited waiver of the IMD exclusion will have to commit to reducing stays in covered IMDs to a statewide average of 30 days, with a hard stop at 60 days for Federal reimbursement. Though

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[9] *See* Assembly Bill 2317 (Ramos), Chapter 589, Statutes of 2022 (https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2317).

[10] *See* Centers for Medicare and Medicaid Services, *Qualified Residential Treatment Programs (QRTP) and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers*, September 20, 2019 at 3 ("[i]npatient psychiatric hospital services for individuals under 21 furnished by…an accredited psychiatric facility, commonly referred to as a 'Psychiatric Residential Treatment Facility' (PRTF), that meets certain requirements, can also be reimbursed.") (https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf).

DRC supports a goal of reducing IMD stays, we have concerns about this framework for doing so.

First, we have concerns that counties will attempt to meet this goal by discharging patients from IMDs without adequate discharge planning. Though we appreciate DHCS's stated commitment to ensuring robust discharge planning, we have observed that there is a statewide shortage of places for people to go when they are discharged from IMDs, and that a lack of housing options results in prolonged IMD stays. Discharge planning is meaningless without sufficient housing options for people exiting institutions.

In addition, we have concerns about whether counties will be able to meet this goal, given the current severe workforce shortage and other obligations that the State has already committed them to within the same timeframe of the Demonstration. For example, many County MHPs are needing to bring Mobile Crisis services on-line for the first time due to their inclusion as a required Medi-Cal benefit. DRC supports the inclusion of Mobile Crisis as a Medi-Cal benefit, but recognizes that implementing it will be a stretch for many counties that do not already have mobile teams that meet CMS requirements. In addition, CARE Court will be required in all counties by the end of 2024, and will drain significant resources away from voluntary services that could divert a large number of Medi-Cal beneficiaries away from IMDs.

The State Medicaid Director letter on the SMI/SED Demonstration states that CMS expects States to meet the Demonstration milestones by the end of the first two years of the waiver period. While we recognize that the State is currently making efforts to address the workforce shortage and infrastructure deficits, the results of these efforts have yet to be seen. DRC is concerned that trying to do too much all at once will set the counties up for failure, in turn not improving the availability and quality of services for Medi-Cal beneficiaries.

Conclusion

We appreciate this opportunity to provide feedback on the BH-CONNECT Waiver Application. For the reasons outlines above, DRC does not support DHCS's proposal to seek CMS's approval for a limited waiver of the IMD exclusion. There are numerous other ways that DHCS can reduce reliance

on IMD stays, thus generating cost savings that counties can use to reinvest in intensive community-based services. In addition, DRC disagrees with DHCS's proposal to condition beneficiary access to evidence-based, intensive community-based services—coverable under existing Medicaid authority—on a county's willingness to accept Federal reimbursement for IMD care. This sets up inequalities in access to services across county lines. Availability of Medi-Cal behavioral health services should be uniform across the state, and not dependent on a beneficiary's county of residence.

We look forward to further engagement as DHCS refines its proposals for further enhancing the behavioral health system of care for Medi-Cal beneficiaries.

Sincerely,

Andrew J. Imparato
Executive Director

Samuel Jain
Senior Policy Attorney

cc: Michelle Baass, Director
Department of Health Care Services

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 5:13:53 PM
Attachments: [redacted]

[redacted]

Dear DHCS,

On behalf of the California Alliance of Child and Family Services (the California Alliance), we respectfully submit the attached recommendations regarding the proposed BH-CONNECT Waiver Demonstration and the CalAIM Section 1115 Transitional Rent Amendment. The California Alliance represents over 160 nonprofit community-based organizations serving children, youth and families through behavioral health, education, foster care, prevention, and juvenile justice programs throughout the state.

Thank you,

Adrienne Shilton (she/her/hers)
Director of Public Policy and Strategy
[redacted]
Catalyst Center Learning Hub
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www.catalyst-center.org

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August 31, 2023

Department of Health Care Services
Attn: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Sent via email to: BH-CONNECT@dhcs.ca.gov

Re: BH-CONECT Demonstration and CalAIM Transitional Rent Amendment

Dear DHCS:

On behalf of the California Alliance of Child and Family Services (the California Alliance), we respectfully submit the following recommendations regarding the proposed BH-CONNECT Waiver Demonstration and the CalAIM Section 1115 Transitional Rent Amendment. The California Alliance represents over 160 nonprofit community-based organizations serving children, youth and families through behavioral health, education, foster care, prevention, and juvenile justice programs throughout the state.

Our members support many aspects of the proposed waiver. We are extremely pleased, for example, that the waiver will include activity stipends for foster youth. We agree that funding extracurricular activities for young people can significantly bolster their mental health, strengthen their relationships with peers, and help them build the life skills they will need to thrive as independent adults.

Our members also support the much-needed workforce initiative, as well as the cross-sector incentive program, which will strengthen the coordination of child welfare services and Specialty Mental Health Services (SMHS). In addition, we enthusiastically support the requirement that, if counties choose to participate in the statewide incentive program, they must reinvest the FFP they earn into Medi-Cal behavioral health programs. We also are pleased to see the initial child welfare and SMHS assessment at the entry point into child welfare. However, we would like to acknowledge the need to consider change management and phased implementation at the county and provider level with CalAIM, CARE Court, proposed MHSA reforms, BHCIP, and CYBHI all occurring simultaneously.

While are supportive of expansion of peer services, we urge the state to explore existing background check processes, particularly in children and youth serving organizations licensed by Community Care Licensing, that prevent the true incorporation of peers into practice.

<u>Potential Diversion of Funds from Already Strained Behavioral Health and Child Welfare Budgets</u>

In general, our members are deeply concerned that the proposed waiver will divert resources away from the very programs that are most needed to help young people remain in family-based settings in the community. Intensive community-based programs for youth with the most complex needs are currently facing a myriad of challenges, including those summarized below.

- **CalAIM Payment Reform**. Many community-based organizations (CBOs) that contract with Mental Health Plans (MHPs) to provide community-based Specialty Mental Health Services are

struggling with new "one-size-fits-all" rates that fail to cover their actual travel costs for field-based services. Many MHPs, moreover, have chosen to withhold from their contracting providers substantial percentages of the SMHS rates they receive from the state – compounding the financial impact of the one-size-fits-all provider rates. Without negotiated rates that cover actual costs, the CBO provider network will shrink rather than expand to meet the goals of CalAIM.

- **Underfunded Child Welfare Programs**. Many child welfare programs and services remain severely underfunded or simply unavailable. Many California counties, for example, fail to offer any Therapeutic Foster Care (TFC) services. In addition, although the state legislature recently passed a long overdue rate increase for Foster Family Agencies (FFAs), which provide home-based placements for child-welfare involved youth, the legislature has not passed similar rate increases for Intensive Services Foster Care (ISFC) placements, which serve youth with the most intensive needs. Also, some youth wraparound programs, which are dually funded by both MHPs and child welfare, have been instructed to draw down additional child welfare funding to compensate for their lower SMHS rates under Payment Reform – adding additional strains to already overburdened child welfare budgets. Ensuring that there is sufficient state and local funding that will support the development of more family and community-based services through BH-CONNECT will be critical to its success.

- **Proposed Mental Health Services Act (MHSA) Reforms**. The proposed MSHA reforms are also undermining efforts to build more intensive community-based programs for youth. One county, for example, recently chose to withdraw from its plan to build a children's crisis care continuum program because the county feared it would not receive the MHSA funds it had planned to use to complete financing for the project.

Intensive community-based programs youth are already struggling with an array of funding restrictions, therefore we urge DHCS to ensure that the proposed waiver does not divert additional funds away from these programs. We are concerned, for example, that counties will need to pay the local matching funds for new waiver programs, such as the new Evidence Based Practices (EBPs) and Transitional Housing Services provided by MHPs, by diverting Realignment and MHSA funds that counties currently use to provide intensive services for youth, such as High Intensity Wraparound with Intensive Care Coordination (ICC), TFC, Intensive Home Based Services (IHBS), ICC, and Therapeutic Behavioral Services (TBS).

In order to ensure the new waiver will not undermine access to existing community-based services for youth with the most complex needs, we recommend that the waiver include the protections below.

- The waiver should clarify how counties will be able to pay the local match for the new waiver programs and services while also ensuring full access to existing intensive community-based services for youth, including Wraparound, TFC, IHBS, and TBS.
- The state should pass rate increases for ISFC placements that align with the recently enacted 8.8% rate increase for FFA Level of Care Rates.
- DHCS should require MHPs to offer contracting CBOs a minimum "passthrough" SMHS rate of at least 85% of the MHP's rate from the state.

Measures for the Statewide Incentive Program

We encourage DHCS to include, in the measures for the statewide incentive program, factors that reflect not only service utilization, but also more meaningful behavioral health outcomes. We recommend, for example, that the measures for youth include:

- Permanency outcomes, such as the number of placement changes for each youth and whether youth receive a long-term home-based placement; and
- School performance, such as high school graduation rates; school stability; absenteeism rates; and rates of disciplinary measures such as suspensions and expulsions.

We also strongly recommend that DHCS require counties to engage their contractor providers in the development of the Integrated Leadership Teams locally, to support efforts to partner on incentive programs.

Activity Stipends

We are very supportive of how critical activity stipends will be for current and former foster youth. We have several key recommendations on how these funds can be best utilized and operationalized:

- We urge DHCS to create a streamlined process for how community-based providers can access these activity stipends to ensure they are readily available when requested, and require that counties allow access for these for youth placed in CBO programs such as Foster Family Agencies.
- We recommend that there be no age minimum for activity stipends - i.e. removing the three year old minimum. Our members find that there are specific sensory activities that benefit young kids - particularly those that have been substance exposed. These include early swimming lessons / parent and child water lessons, climbing and tumbling classes, early gym classes offered through community centers, and art/ hand painting classes.
- We recommend that in addition to the activities that activity stipends be able to cover the costs of certain equipment and clothing costs. For example, a youth may need running shoes, sports clothes, a basketball, etc. to fully participate in the activity they are interested in.
- For transition-aged youth we recommend that there be flexibility in the stipends to cover mindfulness activities including yoga, the ability to pay for gym memberships/ rock climbing gyms, and community sports (e.g. adult kickball leagues).

Short Term Stays in IMDs

We continue to be concerned that the Institutions of Mental Disease (IMD) component of the waiver is an opt-in by county. This will not address the lack of available residential treatment beds available in the system, particularly as STRTPs have had to reduce their capacity to avoid IMD designation. California has lost over 1,000 STRTP beds in the last year and each month additional beds continue to close. Only two STRTPs in the state are currently designated as IMDs, and they take youth from many different counties. Approaching this issue as a county of residence vs. county of service issue, there will be little incentive to expand services to youth. Additionally, CMS guidance specifies that the state must develop a plan with milestones and timeframes to transition *all* youth out of STRTPs that are designated as IMDs within two

years. While at an individual level, lengths of stay are far shorter than two-years, a waiver with these parameters will not assist in expanding high quality residential interventions for youth with significant behavioral health needs. There needs to be statewide support and rate relief for STRTPs to prevent the hemorrhaging of programs. As written, this will leave many youth in shelters and on the street, with their behavioral health needs unmet. The Alliance urges the state to support at the federal level a more comprehensive fix to exempt Qualified Residential Treatment Programs from the IMD exclusion.

Enhanced Quality of Care in Psychiatric Hospitals and Residential Settings

We request additional detail on what enhanced quality of care in residential settings will mean. While we do not disagree on improvement of quality of care, we request that DHCS consider existing oversight of organizations, namely STRTPs. STRTPs are nationally accredited, and must follow regulations developed by both CDSS and DHCS. The level of scrutiny of these programs is already very high, and frequently new requirements and regulations are imposed without additional funding to support them or to effectuate the changes desired.

Waiver Evaluation Measures

We are pleased to see that the waiver evaluation plan will include several measures for children and youth involved in the child welfare system, including utilization of Activity Stipends, and EBPs including "intensive in-home services, MST, FFT, [and] PCIT" services. (BH Connect Summary, p. 16.) This may be implied in the waiver summary, but we would recommend that the evaluation also assess the extent to which child welfare involved youth have accessed the full range of SMHS, including TBS, IHBS, ICC, and TFC. As recommended above regarding the Statewide Incentive Program, the waiver should also evaluate behavioral health outcome measures for foster youth, such as permanency outcomes and school performance measures. Given possible redirection of Mental Health Services Act funds away from children and youth, payment reform, and other changes impacting the continuum of children and youth behavioral health services, there is a concern that while initiatives such as BH-CONNECT will be working to strengthen the continuum of behavioral health services for children and youth, there may be an overall reduction in availability or quality of services. BH-CONNECT provides a key opportunity to identify early and be able to ameliorate any reductions in access or quality of behavioral health services for children and youth so long as there is regular data reporting disaggregated for special populations.

We thank you for considering these recommendations. Please feel free to reach out to us at [redacted] if you have any questions.

Sincerely,

[redacted]

Adrienne Shilton
Director of Public Policy and Strategy

From: [redacted]
To: DHCS BH-CONNECT; [redacted]
Cc: [redacted]
Subject: [External]CBHDA Comments - BH-CONNECT Section 1115 Demonstration Application
Date: Thursday, August 31, 2023 5:39:13 PM
Attachments: [redacted]

[redacted]

Good Evening DHCS Colleagues,

CBHDA appreciates the opportunity to provide feedback on the state's BH-CONNECT Section 1115 Demonstration Application. We appreciate the department's efforts to expand the continuum of community-based services including the addition of Community Health Workers and Transitional Rent, as well as developing a graduated implementation timeframe to better support county behavioral health departments who opt into this opportunity.

Attached you will find CBHDA's comments on the BH-CONNECT Section 1115 Demonstration Application. Please do not hesitate to reach out if we can provide any further clarification on our comments.

In Partnership,
Tracy

Tracy Lacey
She/Her/Hers
Director of Policy & Regulatory Affairs
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COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

August 31, 2023

Michelle Baass, Director
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95899-7413

Jacey Cooper, Chief Deputy Director, Health Care Programs, and State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95899-7413

Submitted via email at: BH-CONNECT@dhcs.ca.gov

Subject: CBHDA Comments - BH-CONNECT Section 1115 Demonstration Application

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Dear Ms. Baass and Ms. Cooper:

The County Behavioral Health Directors Association (CBHDA), representing county behavioral health executives, appreciates the opportunity to provide comment and feedback on the state's BH-CONNECT Section 1115 Demonstration Application to support adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). The Department of Health Care Services (DHCS) has proposed a bold vision to expand the continuum of community-based services for which we commend. We are appreciative of the Department's early engagement with county behavioral health entities to identify additional considerations including the addition of Community Health Workers and Transitional Rent, as well as developing a graduated implementation timeframe to better support county behavioral health departments who opt into this opportunity.

Reimbursement for Newly Defined Statewide Medi-Cal Benefits

As a part of this overall Demonstration, DHCS proposes to implement various new statewide initiatives. While participation in some of the statewide initiatives is optional (e.g., the Cross-Sector Incentive Pool and the Statewide Incentive program), other components will not be optional. Specifically, DHCS proposes to establish certain evidence-based practices (EBPs) for children and youth as new required Medi-Cal benefits under EPSDT along with a new requirement for county behavioral health to conduct an initial child welfare/specialty mental health assessment at entry point into child welfare.

- **Financing necessary to support implementation of EBPs:** CBHDA is appreciative of the Department's goals to improve program quality and ensure better outcomes for California's children and youth, and in particular foster youth, however, the benefits of

these efforts will not be realized without the associated investment of funding that will be required to implement these changes on a statewide basis.

The Department has included a proposal in the Demonstration for the Centers of Excellence (COE) which is intended to support the implementation of the BH-CONNECT proposal, including implementation of the various EBPs. CBHDA is appreciative of the concept of supporting COEs to support counties and their providers, however, counties will incur substantial costs to implement EBPs and new requirements beyond the trainings and fidelity monitoring supported through the COEs. All of the EBPs identified in the proposal, including Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT), require significant start-up and ongoing costs including, but not limited to staff training, equipment and even capital infrastructure investments. For example, the cost to train one MST team consisting of one supervisor and four clinicians is $136,750 for the initial training and $10,000-$13,000 for retraining. Counties have reported that the retention rate for an MST trained clinician is 2-5 years. As another example, PCIT requires investments in capital and equipment (estimated at approximately $50,000 for a retrofit) to support the one-way mirror required of this intervention in addition to the $3,000-$5,000 cost per trainee with a staff retention rate of 2-5 years.

These proposals would trigger Proposition 30 protections because they impose new programs or higher levels of service on counties for 2011 Realignment responsibilities related to specialty mental health and EPSDT. Proposition 30 prohibits California from requesting any federal approvals that will increase the costs of a 2011 realignment program without committing State General Funds. Moreover, Proposition 30 expressly prohibits the State from submitting a Medicaid waiver request that would increase county costs for 2011 Realignment programs unless the State provides annual funding for the cost increase.

- **Rural Considerations:** In addition, CBHDA wants to emphasize how challenging it will be for rural and small counties to adopt and sustain EPBs given the unique challenges these counties have with fewer or no contract providers as well as workforce shortages. In addition, the relatively smaller population requiring such services, and the capital that will be needed to implement many of these new EBPs will make the concept of including certain EBPs as required services in every county difficult even with adequate funding to support implementation. For example, in a low population county with only a handful of clinicians, in theory each clinician would need to be trained in all the required EBPs, which would present its own challenge. CBHDA strongly recommends that, in addition to waivers for smaller rural counties, DHCS consider establishment of a rural behavioral health-focused COE.

- **Clinical Appropriateness:** Regardless of the scope of new EBP requirements, CBHDA would like to highlight the importance of prioritizing clinical judgment when determining which interventions will be most effective for a particular beneficiary or their family. While we appreciate the importance of improving quality and expanding the clinical tools

available to beneficiaries covered under Medi-Cal, we must ensure that clinicians retain the discretion to determine which interventions will be the most appropriate on an individual basis.

- **Equity Considerations:** In line with the need to ensure clinicians retain their clinical decision making, is also important to recognize that the majority of EPBs are specific to, or have only been tested on individuals who identify as white, and have not been tested for applicability or effectiveness within the types of ethnically and racially diverse populations overrepresented in Medi-Cal. As such, CBHDA encourages DHCS to work with counties to assess how EBPs may need to be adapted or changed to address the needs of Medi-Cal's diverse beneficiaries.

  Additionally, CBHDA would like to take the opportunity to provide feedback regarding community defined evidence practices (CDEPs) that are also referenced in the BH-CONNECT Section 1115 Demonstration Application. CBHDA is appreciative of the department's emphasis on equity and reducing healthcare disparities and the inclusion of CDEPs in the application. Counties have been champions of CDEPs for decades and have funded the establishment and sustainability of CDEPs in California through the Mental Health Services Act (MHSA), primarily through prevention and early intervention (PEI) and Innovation projects. As such, counties have an understanding that CDEPs are unique to each community and are not necessarily geared for statewide implementation. CDEPs are anchored in culturally responsive interventions and practices that have been proven to work but which often have not undergone the more formal external review and analysis necessary to qualify as an EBP. CBHDA recommends that the state engage counties, peers, and local consumers in the exploration and development of which CDEPs can become Medi-Cal benefits and to ensure proper implementation on a larger scale.

❖ **Recommendation: Allocate State General Funds to support county behavioral health implementation of EBPs and new child welfare related requirements, consistent with Proposition 30.**

❖ **Recommendation: Provide an opportunity for smaller, rural counties to request an exemption from the requirement to provide EBPs.**

❖ **Recommendation: Establish a rural behavioral health focused COE.**

❖ **Recommendation: Retain clinical decision making in the application of EBPs.**

❖ **Recommendation: Ensure that EBPs are assessed for appropriateness across Medi-Cal's diverse populations.**

❖ **Recommendation: Work with counties, peers, and local stakeholders to review and analyze CDEPs for statewide applicability.**

State Reliance on local IGTs Places Additional Burdens and Risks on Counties

CBHDA appreciates the state's proposal to create new opportunities for counties to generate additional FFP through the expansion of new or restructured Medi-Cal benefits, however, the BH-CONNECT proposal includes several areas of significant new Medi-Cal spending obligations where the non-federal share is not specified, and which would rely on the availability of county intergovernmental transfers (IGTs). A significant expansion of county IGTs for county behavioral health programs will require counties to develop new fiscal and financial arrangements to manage cash flow, as the required IGTs necessary to implement BH-CONNECT may exceed available local funding for behavioral health purposes. Moreover, all counties would be subject to heightened risks related to their certification of their IGTs in accordance with unclear federal requirements.

In addition to any federal requirements, counties may also face challenges meeting state obligations to ensure that IGT-funded Medi-Cal payments associated with the behavioral health delivery systems are used "for the support of behavioral health related services and activities that benefit patients served by the Medi-Cal behavioral health system." (Cal. Welf. & Inst. Code 14184.403(c)). Absent amendment or clarification, this law could require counties to demonstrate enormous new spending and investments in behavioral health that go well beyond the new federal dollars.

It is critical that DHCS work closely with counties and CBHDA to mitigate these risks and reduce the burdens associated with increased local funding of Medi-Cal payments. In particular, counties need at least the following recommended assurances as part of the waiver process:

- **Recommendation: Provide counties with clear timelines for processing IGTs and making the related payments to county behavioral health delivery systems.**

- **Recommendation: Provide counties with affirmative protection for the ability to use Medicaid revenue, including incentive payment revenue, as a source non-federal share, as long as it has not been specifically committed to be returned to the state as a condition of the Medicaid payment.**

- **Recommendation: Remove any requirements for counties to "retain" Medicaid payments they receive that go beyond a prohibition of earmarking Medicaid payments to be returned to the state. Or, in the alternative, express clarification that funding arrangements that are internal to a county will not be considered a violation of any such retention requirement.**

- **Recommendation: No requirement to trace the use of Medicaid funds a behavioral health system has earned and received. Any requirements to "reinvest" an amount equal to the federal portion of Medicaid funding should be reported at the aggregate level without this kind of tracing.**

Workforce Investment Opportunities

CBHDA appreciates the state's support and ongoing investment in developing and retaining a robust and diverse behavioral health workforce to support Medi-Cal members living with serious mental health conditions, substance use conditions, or both. It will be imperative for the state to be a partner with counties to address the ongoing behavioral health workforce crisis as it will undoubtedly pose challenges to the implementation of the various components of the BH-CONNECT demonstration.

The county safety net workforce includes county employees, as well as employees of contracted community based organizations (CBOs) delivering services to individuals with Medi-Cal. The increased demand for services, along with workforce burnout and the expansion of new telehealth modalities spurred by the pandemic put more pressure on an already strained county behavioral health safety net workforce. In addition to the impacts of the pandemic, new California statewide initiatives focused on behavioral health, including those outlined in the BH-CONNECT Section 1115 Demonstration Application, will create additional demands on the same workforce pool.

As referenced in the BH-CONNECT Section 1115 Demonstration Application, CBHDA commissioned the University of California San Francisco (UCSF) to conduct a comprehensive workforce assessment *Building the Future Behavioral Health Workforce: Needs Assessment*, in order to develop a 10-year strategic plan for strengthening the county behavioral health safety net workforce. While this needs assessment analyzed the most recent available data on the county behavioral health workforce at the time, the gaps identified in the report do not reflect the significant growth in demand in the behavioral health sector driven in part through new state-led initiatives such as the Child and Youth Behavioral Health Initiative (CYBHI) and parity enforcement among others. It is with recognition of these significant gaps and the need to expand our behavioral health workforce that DHCS proposes to make a significant new investment in the behavioral health workforce through the BH-CONNECT Demonstration.

As proposed within the state's Behavioral Health Modernization proposal and outlined in SB 326 (Eggman), the initial $36 million needed as the 15% state match for the BH-CONNECT workforce initiative is intended to be funded through a diversion of local MHSA dollars to the state. Historically, counties have used portions of the MHSA to fund workforce training, recruitment and retention, among other initiatives through the workforce education and training (WET) MHSA funding option. For example, counties have been able to fund workforce pipelines through local community colleges and universities with intern programs, and in some cases have developed partnerships with local high schools to build out a workforce pipeline through MHSA WET funding. Additionally, counties today fund hiring and retention bonuses, loan repayment and training and certification costs for peer support specialists and for clinical staff to be trained in EBPs, among other workforce strategies.

Based on CBHDA's analysis of the overall fiscal impacts of SB 326 on local county behavioral health, counties are not likely to have sufficient MHSA funding to sustain existing, let alone new

WET contributions and investments. In fact, the Legislative Analysts Office (LAO) also expressed concerns that the proposed Behavioral Health Services Act (BHSA) Behavioral Health Services and Supports funding bucket was overprescribed.[1] As such, the workforce funding available through BH-CONNECT will be essential to supporting the implementation of the various new BH-CONNECT initiatives county behavioral health will be responsible for implementing.

As such, CBHDA recommends that the state prioritize county behavioral health BH-CONNECT and other county behavioral health safety net workforce needs with the funding that is being redirected to fund the BH-CONNECT Behavioral Health Workforce Initiative, with an emphasis on supporting the related BH-CONNECT initiatives. For example, given the state's investment and emphasis on the implementation of EBPs, it will be important to ensure the sustainability of these EBP models which will require recruitment of new staff as well as training, retention and retraining. In addition, efforts should be made to fund train-the-trainer cohorts for EBP models within each county and/or CBO agency to ensure that organizations can provide training when there is staff turnover.

CBHDA also appreciates the recognition of the importance of the peer workforce and SUD counselors as well as the need to include Community Health Workers (CHWs) in the county behavioral health safety net, as demonstrated in the suggestion that investments could build upon efforts to support our Peer Support Specialist, CHW, and substance use disorder (SUD) counselor workforce.

CBHDA encourages the department to specifically focus these funds on supporting and building our SUD workforce given the significant disparities in the education, training, and compensation of our SUD workforce. According to the workforce assessment conducted by UCSF, 51% of SUD counselors in the county behavioral health workforce are under age 35 years and the number of graduates from SUD counseling programs decreased by 21%, from 2016 (1,284) to 2020 (1,020), raising concerns about the availability of trained SUD counselors available in the workforce to meet the demand for SUD counseling.[2] Given the desired expansion of SUD services overall and under the proposed BHSA reforms, it is imperative for the state and counties to make strategic investments in the SUD counselor workforce to support sustainable career paths for professionals with training in, and experience in treating individuals with substance use disorders.

CBHDA also strongly supports the application of workforce investments under BH-CONNECT to fund ongoing certification costs for CHWs and peers in the county behavioral health workforce, particularly given the direct link to new BH-CONNECT Medi-Cal benefits for CHWs in specialty behavioral health and forensic peer support specialists. In addition, CBHDA encourages the department to work with CBHDA and peer representatives to improve career ladders for peer

[1] Legislative Analyst's Office. "Mental Health Services Act: Proposed Restructuring of the MHSA Funding Categories and Impacts on County Spending". (2023, August 29) Retrieved from: https://lao.ca.gov/Publications/Report/4782

[2] Healthforce Center at UCSF, "Building the Future Behavioral Health Workforce: Needs Assessment," February 2023. Available at CBHDA_Needs_Assessment_FINAL_Report_2-23.pdf. (squarespace.com)

support specialists and ensure that peers are distinguished in their role as leaders within the specialty behavioral health service delivery system.

- **Recommendation: Prioritize the county behavioral health safety net workforce when developing and funding the workforce strategies outlined in the BH-CONNECT Behavioral Health Workforce Initiative.**

- **Recommendation: Develop a focus on building out the SUD workforce, with an emphasis on closing the gap for SUD counselors and professionals within the BH-CONNECT Behavioral Health Workforce Initiative.**

- **Recommendation: Expand investments in the training and certification of Peer Support Specialists and county behavioral health Community Health Workers through the BH-CONNECT Behavioral Health Workforce Initiative.**

Activity Stipends

CBHDA strongly supports the inclusion of activity stipends to support social and emotional development, promote enhanced long-term mental health, and prevent substance use among children and youth involved in the child welfare system. We applaud the prioritization of these activities under BH-CONNECT as CBHDA and our members view these as essential building blocks for healthy youth development and as a means to mitigate the trauma experienced by child welfare involved children and youth.

Healing from trauma is an individualized process that does not contain a one size fits all solution. Therefore, we are recommending the revision of the language in the proposal from "extracurricular activities" to "wellness activities" or "enrichment activities." This recommendation is aligned with the voices of youth advocates that highlight the need for alternative holistic methods to healing outside of the traditional movement-based models, including massage therapy, aromatherapy, deep breathing classes, and energy healing. By opening the definition to allow the young person flexibility in defining their wellness, youth can also explore more creatively focused activities such as travel, creating a YouTube channel, or taking a coding class. These creative outlets are essential in mitigating trauma and rewiring the brain during periods of neuroplasticity, ultimately improving overall health outcomes.

Regarding the identified age groups of eligible recipients, we appreciate the broad range of young people that would be eligible for this benefit. We urge you to expand that age range further and include children ages 0-2 years old. It's worth noting that as of April 2023, a staggering 9,978 children under the age of 2 years old were in foster care in California.[3] This statistic underlines the critical importance of including this age range in the scope of eligibility.

[3] Webster, D., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Wiegmann, W., Sa ka, G., Courtney, M., Eastman, A. L., Hammond, I., Gomez, A., Sunaryo, E., Guo, S., Agarwal, A., Berwick, H., Hoerl, C., Yee, H., Gonzalez, A., Ensele, P., Nevin, J., & Guinan, B. (2023). California Child Welfare Indicators Project Data. Retrieved from: https://ccwip.berkeley.edu/childwelfare/reports/PIT/MTSG/r/ab636/s

During this crucial period of rapid brain growth and cognitive development, exposing children to diverse sensory experiences, interactive play, and stimulating environments lays the foundation for healthy attachments, lifelong learning, and emotional resilience. It is crucial that California focuses on offering resources that reinforce healthy attachment for young children and their caregivers. Activities such as infant massage, family music classes, and infant swimming lessons help promote positive bonding.

As we consistently work towards implementation of initiatives that facilitate the healing process, CBHDA aims to maintain an ongoing collaborative effort with DHCS and the Department of Social Services. This collaboration seeks to determine the appropriate utilization of these stipends and to establish methods to ensure its alignment with an individualized approach.

- **Recommendation: Change the language in the proposal from "extracurricular activities" to "wellness activities" or "enrichment activities."**

- **Recommendation: Broaden the age range in the activity stipend to include children ages 0-2 years old to use towards enrichment activities that include the foster parent(s) and/or biological family.**

- **Recommendation: Partner with CBHDA to expand the current scope of services, develop secondary guidance, and improve implementation.**

<u>Community Health Worker Benefit</u>

CBHDA is appreciative of the effort the state is making to include the Community Health Worker (CHW) benefit for county behavioral health for both the SMHS and DMC delivery systems. Several counties currently utilize CHWs as part of ECM teams and in these cases the CHWs are working closely with members to address their physical health needs. In addition to utilizing CHWs for ECM, counties have a long history of utilizing MHSA PEI and Innovation funding to offer preventative and outreach services through providers who were identified as cultural brokers, Promotores, or other qualified providers. Services include community trainings in health literacy and stigma reduction, culturally responsive outreach and navigation whereby these providers develop trust with members from diverse communities to educate community members about behavioral health services and expand access to traditionally underserved populations. CBHDA is pleased that counties will have an opportunity to be reimbursed for the important work being done through community health workers working in county behavioral health. While we understand that the CHW benefit is defined by CMS per 42, CFR 440.130 (c), as a preventative service requiring pre-approval by a physician or licensed provider, CBHDA would like to highlight that the role of CHWs may be structured differently within county behavioral health and these differences need to be considered in the benefit design. For example, navigator services provided by CHWs are currently funded primarily through the MHSA are key to expanding access to care and addressing health care disparities.

In addition to the concerns outlined above, counties have shared that the cost of the training and certification for CHWs is often cost prohibitive for individuals who would be ideal candidates for the CHW role. CBHDA is appreciative that the BH-CONNECT Section 1115 Demonstration Application suggesting that the certification costs for CHWs may be covered, as there is a real

need to provide financial assistance to this segment of the workforce when possible. CBHDA requests that DHCS also consider coverage for the cost of any trainings needed outside of the certification process as well.

- **Recommendation: Partner with counties to define a unique scope of benefits and eligibility criteria for the specialty behavioral health CHW benefit.**

- **Recommendation: Support and fund the training and certification for CHWs.**

Transitional Rent Services

CBHDA appreciates the state's recognition that stable housing is an important aspect of wellness and impacts outcomes for Medi-Cal members, particularly those living with serious mental health conditions, substance use conditions, or both. Counties share this philosophy as evidenced by their investment in housing consumers through MHSA as well as other grants and funding sources as available and appropriate. As such, counties and CBHDA supports the inclusion of the transitional rent Medi-Cal Managed Care benefit in the BH-CONNECT Section 1115 Demonstration Application. CBHDA also recognizes the department's interest in ensuring the coordination of this benefit across delivery systems to ensure services are not duplicated.

The transitional rent service as outlined in the application will be available for up to 6 months for eligible Medi-Cal members who are homeless or at risk of homelessness and who meet other specified criteria. CBHDA appreciates the department's modifications of the 24 CFR part 91.5 definition of homelessness or at risk of homelessness to include individuals transitioning from institutional care, congregant settings or correctional facilities, and for adjusting the timeframe for individuals and families at risk of losing housing. Additionally, CBHDA appreciates the inclusion of consumers receiving full-service partnership (FSP) level services in the eligibility criteria for transitional rent.

Under the proposed BH-CONNECT criteria: "transitional rent will be available for a period of no more than six months and will be provided only if it is determined to be medically appropriate." CBHDA is concerned with how state and federal regulators will determine what is considered "medically appropriate," for the purposes of providing temporary rental assistance given the more significant needs of county behavioral health beneficiaries as well as the fact that any experience of homelessness can be inherently traumatic and result in further avoidable physical and psychological distress and harm. If such a determination is required, CBHDA recommends that the department collaborate with stakeholders, including CBHDA, to broadly define the concept of "medically appropriate" to ensure housing benefits are not inappropriately denied or disallowed in compliance reviews.

In addition, DHCS proposes to phase this benefit in across populations and geographic areas, however, little information is provided regarding how these determinations would be made. CBHDA encourages the department to partner with counties and managed care plans (MCPs) to ensure county behavioral health input is considered in developing those policies.

- **Recommendation: Clarify what constitutes "medically appropriate" in relation to a member being eligible for the transitional rent benefit.**

- **Recommendation: Partner with counties and MCPs to determine the process related to a phased-in approach for different populations and geographic areas.**

* * *

The BH-CONNECT provides a unique opportunity to further transform our specialty behavioral health system of care, increasing access to high-quality care for Medi-Cal beneficiaries through the expansion of available benefits, and increased focus on quality improvement. This proposal further bolsters the system transformations under CalAIM and will have a significant impact for all Medi-Cal beneficiaries. We appreciate the Department's engagement with counties in the design of this demonstration and look forward to continuing to provide input as this proposal is further defined.

Thank you for your consideration of our comments and recommendations. Please contact our team directly at [redacted] if we can answer any questions or provide any additional information to clarify our comments in this letter.

Sincerely,

[redacted]

Michelle Cabrera
Executive Director

cc: Tyler Sadwith, DHCS
Paula Wilhelm, DHCS
Erika Cristo, DHCS
Jacob Lam, DHCS
Brian Fitzgerald, DHCS
Stephanie Welch, HHSA
Kimberly Chen, HHSA
Angela Pontes, Office of Governor Newsom
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Scott Ogus, Senate Budget Committee
Joe Parra, Senate Republican Policy Office
Tim Conaghan, Senate Republican Policy Office
Anthony Archie, Senate Republican Fiscal Office
Rosielyn Pulmano, Assembly Speaker Rivas
Andrea Margolis, Assembly Budget Committee
Gino Folchi, Assembly Republican Caucus
Ryan Miller, LAO
Will Owens, LAO
Jolie Onodera, CSAC

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]Seiu comments on BH-Connect
Date: Thursday, August 31, 2023 6:50:50 PM
Attachments: [redacted]
Importance: High

[redacted]

Original Message Attached

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SENT BY EMAIL ONLY

August 31, 2023

Department of Health Care Services
Director's Office
Attn: Jacey Cooper and Tyler Sadwith
P.O. Box 997413, MS 0000
Sacramento, California 95814

Re: Feedback on the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration Proposal

Dear Ms. Cooper and Mr. Sadwith:

On behalf of the Service Employees International Union California (SEIU California) and its 700,000 members and their families, I submit the following comments regarding the Department of Health Care Services (DHCS)' proposal on the BH-CONNECT Section 1115 Demonstration.

There is no such thing health care without timely and complete access to behavioral health care. Heretofore behavioral health has been the gaping hole in our healthcare delivery system. BH-CONNECT will help alleviate some of the current challenges our state faces in this area, in conjunction with other initiatives currently in motion by the Administration and Legislature. While SEIU California believes DHCS is moving in the right direction with the BH-CONNECT proposal, we believe this initiative would be stronger, more effective, and easier to implement with the following changes and considerations:

- **Clarify Non-federal Share of Workforce Investments.** The proposal currently states that the non-federal share of behavioral health workforce investments under the Demonstration will be paid for using either state or local funds. Should counties be made responsible for even part of these investments, they will need to factor this into their budgetary plans. Thus, it is important for the administration to work with local behavioral health departments and leaders well before implementation of the Demonstration to ensure sufficient funding is available for these critical investments.

- **New Investments Must Not Supplant Current County Investments and Should Establish a Broad Pipeline for Future Growth.** On page 20 of the proposal, it states "*will ensure all new investments made through the workforce initiative will build upon, not duplicate, existing behavioral health workforce initiatives in the state and that they will be directed toward the workforce required to provide care to Medi-Cal members living with SMI/SED and/or SUD*." Several

counties currently invest significant funds into behavioral health workforce initiatives; the proposal should ensure that such county investments are also not supplanted by new funding sources. In the state's efforts to train the workforce, it should also ensure that it is not creating additional silos.

Furthermore, the state must establish a pipeline for the behavioral health workforce; this is critical to ensuring that Californians have access to the services they need in the future. This includes making sure that training grants and other investments may be allocated to all eligible organizations, including experienced training funds. Doing so will allow the state to scale up the workforce more quickly and will ensure that the greatest number of future behavioral health workers is trained.

Finally, the state should highlight that investments for training and practices must also include cultural considerations to allow counties to adjust to the diverse needs of our communities.

- **Additional Investments Necessary for Evidence-Based Practices.** Although the proposal highlights evidence-based practices (EBPs) as a focus of future behavioral health initiatives, the Demonstration Proposal does not currently include sufficient funds to implement them. EBPs will require new training, staffing, and other resources that will go beyond what is outlined for the investments in the Centers of Excellence. It would also benefit the state to consider reimbursing for EBP activities that are not currently billable, including provider training and oversight.

- **New Workforce Should Prioritize Community-Based Public Sector Workforce.** As the department is aware, one of the keys to success for the population most in need of behavioral health services is to guarantee continuity of care and services. It can take time to earn the trust of those who are working to care for them. The public sector workforce is ideal to work with this population because they can provide continuous care, including access to essential services and resources. Services that are often contracted out in silos and require patients to move between different providers. While we understand that the current workforce shortage calls for the state to take advantage of all potential opportunities, care will be provided in the most efficient and effective manner if done so through the public sector workforce.

- **Workforce Investments Must Prioritize SUD Field.** As noted by the administration and in the Demonstration proposal, in order to best serve some of California's most vulnerable populations, the state must focus on provision of SUD prevention, early intervention, treatment, and recovery; this is where the highest shortage of providers and services are. While there have been some investments in mental health services, much less has been done and is available regarding SUD. Thus, the state should prioritize the development and expansion of the SUD workforce when considering such investments.

- **Transitional Rent Services: Are There Sufficient Housing Options?** We appreciate the administration for its proposal to include up to 6 months rent

for transitional rent services for qualified individuals. Has the state considered what will happen once the 6 months have expired, and whether there is enough permanent housing to be able to meet demand? Has the state considered what clients may seek, which may be modeled more like therapeutic communities rather than traditional residential treatment? We recently raised concerns with regard to whether there is sufficient housing for those qualifying for housing under the CARE Act and other proposals and are concerned that while funding may be available upon the beginning of implementation of the Demonstration, the long-term housing may not. Furthermore, 6 months may not be sufficient for clients. If the goal is to get people the support and resources they need to eventually be self-sufficient, then the transitional rent service should not be time limited. The time limit will cause additional unnecessary stress.

- **Need for Additional Measures for Evaluation of Demonstration.** Given the significant investments proposed under the Demonstration, it behooves the department to thoroughly evaluate its success and effectiveness. With regard to the hypotheses in Table 2, it is unclear what the source of the claims data used for evaluations will be. The state should ensure claims data from emergency departments, counties, and all other behavioral health providers are included in the evaluation to provide a complete picture of resources being allocated during the Demonstration.

  Furthermore, the state should specifically include outcomes measuring individuals' wellness and health in their evaluation process. Although the proposal currently hypothesizes that "outcomes" for children and youth, justice-involved individuals, and others will improve over the course of the Demonstration, the evaluation methods proposed only include the number and proportion of individuals utilizing services. To truly measure the success of the Demonstration, the behavioral health of the individuals using the services must be determined throughout the process. The figures noting the number of people moving in and out of the emergency departments does not provide insight into the many nuances of treatment and care for individuals with SMI/SED.

  In addition, the state should evaluate the efficacy of the waiver on workforce development and expansion. The state could consider whether this waiver is helping to incentivize employment of behavioral health professionals in shortage areas, such as rural areas and correctional health facilities. We also suggest assessing the efficacy of services delivered by public sector workforce compared to the contracted one.

  Finally, to provide a more complete picture of the success of the Demonstration, evaluation of other factors, including an assessment of the impact SUD treatment and care, and one to ensure that services are reaching and appropriately serving underserved and disproportionately underrepresented clients who may face more barriers (e.g. cultural stigma or lack of linguistically adept providers) in accessing care.

- **Inconsistent References to Children and Youth.** The proposal should clearly identify the inclusion of children and/or youth. The proposal currently

includes inconsistencies in reference to children and youth; some programs include only children (e.g. evidence-based therapies for children and families under Figure 1 of the proposal) while others include children and youth (e.g. the CYBHI referenced in Figure 1). It is unclear whether this is intentional by the department. To reduce confusion during the implementation process by the state and counties, this language should be clarified and/or made consistent throughout the proposal. We recommend using age guidelines from the American Academy of Pediatrics regarding SUD in children.

SEIU California is a strong supporter of the need to expand and change the behavioral health delivery system – with the proviso that the workforce and workforce training, SUD treatment, housing (all of which must be non-discriminatory for medication-assisted treatment) and increased oversight and accountability remain as key components of this transformation.

Thank you for your consideration and time. If you have any questions, please feel free to contact me at [redacted] or at [redacted].

Sincerely,

[redacted]

Robert W Harris
Legislative Advocate

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 7:16:04 PM

[redacted]

Dear DHCS,

I am writing in support of DHCS including Clubhouse model programs in the proposed new Medicaid demonstration project under Section 1115 of the Social Security Act to expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with serious mental illness and serious emotional disturbance.

Accredited Clubhouse programs across the United States and in more than 30 additional countries have consistently demonstrated strong outcomes such as improved quality of life, lower rates of hospitalization and use of crisis services, higher employment rates and improved physical well-being.

In recent years Clubhouse model programs have been recognized by leading mental health and humanitarian organizations including the World Health Organization, The World Federation for Mental Health, the Lancet Commission on Mental Health, The Conrad N. Hilton Humanitarian Prize, The Brain & Behavior Research Foundation as an effective rights-based recovery-oriented service.

Clubhouse model programs with high fidelity to the International Standards for Clubhouse Programs as demonstrated through Clubhouse Accreditation will significantly expand the the continuum at community based services.

Clubhouse International is ready to provide assistance and support to DHCS and developing Clubhouses.

Sincerely,

Joel Corcoran

Executive Director / CEO

Clubhouse International

[redacted]

www.clubhouse-intl.org

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 7:46:48 PM

[redacted]

Dear DHCS,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Best,
Lori Arthur Stroud

Sent from my iPad

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration Application Comments
Date: Thursday, August 31, 2023 8:07:25 PM
Attachments: [redacted]

[redacted]

Good evening,

Please find attached Children Now's comments on the proposed BH-CONNECT Section 1115 Application. Thank you for this opportunity to provide feedback. We look forward to continued discussions and collaboration.

Please feel free to reach out to me with any questions.

All the best,
Amanda

Amanda Miller McKinney, MSW
Senior Associate, Child Welfare Policy
Pronouns: she/her/hers

Children Now

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www.childrennow.org

August 31, 2023

Michelle Baass, Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: Comments on the proposed BH-CONNECT Demonstration Section 1115 Waiver Application.

Dear Director Baass:

Children Now appreciates the opportunity to provide comments on the proposed California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Medicaid Section 1115 Demonstration Application made available on August 1, 2023. Children Now is a non-partisan, whole-child research, policy development and advocacy organization dedicated to promoting children's health, education, and well-being in California. The organization also leads The Children's Movement of California, a network of more than 4,100 direct service, parent, youth, civil rights, faith-based and community groups dedicated to improving children's well-being, as well as the statewide Foster Youth Health Taskforce. Children Now is committed to working with the Department to develop and implement reforms that improve children's mental health, including targeted improvements to meet the unique needs of children and youth involved in the child welfare or juvenile justice systems or experiencing homelessness.

We are pleased to see the Department's ongoing commitment to strengthening the continuum of behavioral health services and support the goal of BH-CONNECT to improve access, equity, and quality of behavioral health services for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED), including recognition of the unique needs of children and youth, and in particular populations experiencing disparities in behavioral health care and outcomes, especially children and youth involved in the child welfare or juvenile justice systems or experiencing homelessness.

Furthermore, we are pleased that the Department was responsive to our previous recommendations to provide further clarity on the components requiring Section 1115 Demonstration Authority, the rules to be waived and their expected impact for children and youth services specifically, whether managed care plan contract changes such as the addition of a foster care liaison will be required, and how the proposal to wave the IMD exclusion relates specifically to children and youth services.

After careful review, Children Now provides the following comments and recommendations on the proposed BH-CONNECT Demonstration Section 1115 application:

General Recommendations

Ensuring coordination of various initiatives and reforms, authentic stakeholder engagement, and strong accountability and oversight structures will be essential to the success of BH-CONNECT. To that end, we recommend the following:

Further development of a robust stakeholder process

As DHCS has acknowledged, this application contains a high-level description of planned activities, but much of the details, mechanisms, and implementation planning, have yet to be developed. In several places the

application mentions plans to engage in a robust stakeholder process. We applaud inclusion of robust stakeholder engagement within the application and strongly believe robust, authentic, and ongoing stakeholder engagement will be critical to success. This robust stakeholder process should include those with lived expertise and representatives from each of the targeted subpopulations, including child welfare stakeholders**. We encourage the Department to develop a plan within each BH-CONNECT domain for identification and recruitment of key stakeholders as well as a calendar of multiple meetings with co-created agendas that are discussion-based in order to ensure expertise of a diverse group of key stakeholders informs the development of the various BH-CONNECT components and provides a mechanism for ongoing stakeholder feedback to continue to refine and improve demonstration components**.

Inclusion of additional services and supports for children and youth

Children Now supports the goal of BH-CONNECT to establish a robust continuum of community-based behavioral health care services and improve access, equity, and quality for Medi-Cal members living with SMI and SED, in particular populations experiencing disparities in behavioral health care and outcomes. While we believe BH-CONNECT will contribute to enhancing the continuum of behavioral health services for children and youth, we have concerns that as currently described, it will not establish a full array of enhanced community-based services and EBPs as intended.

The application states that there are significant gaps in the current continuum of care, particularly among children and youth and especially including children and youth involved in child welfare, yet the application also states that the incentive program for opt-in counties will target most of its resources on "outcomes associated with effective implementation of community-based services such as ACT/FACT, IPS Supported Employment, CSC for FEP, community health worker services, clubhouse services, and transitional rent," the majority of which are primarily designed to support adult populations. We **encourage adaptations for serving transition age youth within services that primarily serve adults as well as inclusion of community-based services designed to serve children and youth, especially those who are child welfare or juvenile justice involved or experiencing homelessness, within the incentive program for opt-in counties.** As identified in the application, of those expected to be served via BH-CONNECT, 20% are children and youth. **We recommend consideration be particularly given to inclusion of services that provide intensive care coordination, mobile response and crisis stabilization services specifically designed for children, therapeutic foster care services, as well as an array of culturally responsive in-home services and supports, which are known to reduce the reliance on residential treatment services and other institutional placements for children and youth**.

Additional goals and strategies to support collaboration across sectors and initiatives

Children Now supports the identified goals and objectives of the BH-CONNECT demonstration. In addition, we believe an additional goal should be added to **identify other initiatives aligned with or positioned to support the goals of BH-CONNECT and to then develop and install mechanisms for coordination with these efforts to ensure enhancement and broadening rather than duplication of services, to capitalize on additional momentum for change within the state, and to foster additional cross-sector collaboration**. For example, the Family Urgent Response System plays an important role in providing mobile crisis stabilization services for children and youth currently or formerly in foster care. Additionally, the Family First Prevention Services program has identified some of the same evidence-based practices as the BH-CONNECT demonstration for inclusion within community continuums of care to strengthen

families and reduce child welfare involvement. Such additional collaboration can also further cross-sector oversight and accountability that BH-CONNECT is also seeking to enhance.

BH-CONNECT Component Recommendations

In addition to our general recommendations, the following details our recommendations related to key components of the BH-CONNECT Demonstration:

Evaluation Plan

Provide Regular Reporting of Disaggregated Data for Special Populations (children and youth in foster care, children and youth with child welfare system involvement, children and youth with juvenile justice involvement, and children and youth experiencing homelessness). Children and youth within special populations have experienced abuse, neglect, family separation, and other traumas, which can lead to behavioral health challenges that may persist into adulthood. Providing timely, high-quality behavioral health services can help them heal, yet barriers, such as multiple placement changes, lack of trauma-informed providers, fragmented and siloed systems, and unavailable or incomplete health histories, often prevent them from getting needed services. In order to understand and meet the behavioral health needs of children and youth in special populations, data reported through BH-CONNECT must be disaggregated and publicly reported for children and youth in foster care, children and youth with child welfare system involvement who are not in foster care, children and youth with juvenile justice involvement, and children and youth experiencing homelessness to better understand and meet their unique needs.

Given possible redirection of Mental Health Services Act (MHSA) funds away from children and youth services, CalAIM payment reform, underfunded child welfare programs, and other changes impacting the continuum of children and youth behavioral health services, there is a concern that while initiatives such as BH-CONNECT will be working to strengthen the continuum of behavioral health services for children and youth, there may be an overall reduction in availability or quality of services. BH-CONNECT provides a key opportunity for early identification and amelioration of any reductions in access to or quality of behavioral health services for children and youth, so long as there is regular data reporting disaggregated for special populations over the course of the demonstration. Additionally, usability testing of certain components of the demonstration would be valuable additions to the evaluation plan to ensure services are accessible and meeting identified needs and efforts are on track to achieve the goals of BH-CONNECT.

Explore opportunities for cross-sector data sharing. Given frequent involvement of children and youth in multiple systems, particularly children and youth who are involved with the child welfare or juvenile justice systems or experiencing homelessness, it is also critical to explore opportunities for cross-sector collaboration, data sharing, and oversight. For example, some behavioral health supports and services may be provided through other mechanisms, such as MHSA, the Family Urgent Response System (FURS) or others. This provides important flexibility within the continuum of services and is important to consider when assessing whether the needs of children and youth, especially those involved in the child welfare or juvenile just systems or experiencing homelessness, are being met. Moreover, these services may not appear in Medicaid claims data. We encourage the Department to explore opportunities to collaborate with other systems and develop data-sharing agreements where possible so as to conduct a thorough assessment of whether there is an effective and robust continuum of community-based behavioral health care services and whether access, equity, and quality of services is being improved, particularly for populations experiencing disparities in behavioral health care and outcomes, such as children and youth involved in the child welfare or juvenile justice systems or experiencing homelessness.

Include additional key data metrics for children and youth. Furthermore, given the goals of BH-CONNECT and some of the proposed changes, we suggest consideration of a few additional data metrics in the evaluation. We recommend collecting data on lengths of stay and number of stays in residential behavioral health treatment services, comparing the identified level of need through CANS or other assessment tools with the level of services being provided, the extent to which child-welfare-involved youth have accessed the full range of specialty mental health services (SMHS) in alignment with the new CalAIM SMHS access criteria, and include child and youth specific outcome metrics (e.g., placement stability, school performance, etc.). These additional metrics will help to ensure the continuum is meeting the needs of children and youth and residential treatment is not overutilized for children in foster care.

Workforce Initiative to Ensure Access to Critical Medi-Cal Behavioral Health Services

Prioritize strengthening the child and youth behavioral health workforce. According to the Youth Truth Student Survey, the availability of supportive adults on campus fell from 46% pre-pandemic to 39% in spring 2021. At the same time, the percentage of students reporting feeling depressed, stressed, or anxious rose from 39% in spring 2020 to 49% in spring 2021. Similarly, the application acknowledges that there is a particularly acute workforce shortage for those who work with children and youth, yet nothing in the workforce initiative describes any prioritization of or incentives intended to address the child and youth behavioral health workforce shortage specifically. We recommend inclusion of specific incentives for strengthening the behavioral health workforce serving children and youth, **including expansion of peer support services for youth, especially child-welfare-involved youth**. Furthermore, we encourage DHCS to consider inclusion of any entity that provides behavioral health services to children and youth to be eligible to access the BH-CONNECT workforce initiative, whether that be community-based organizations, county child welfare agencies, or county departments of behavioral health, so that the workforce may be enhanced across the continuum of children and youth services.

Activity Stipends

Children Now is extremely pleased by the inclusion of activity stipends within this demonstration. We also believe it is important to frame activity stipends as something that supports healing from the trauma child welfare-involved children and youth experience and how it fosters development of social connectedness, a key social determinant of health, and to avoid any language that describes non-child welfare-involved peers as normal. Furthermore, we strongly encourage robust engagement of youth with lived expertise and other child welfare stakeholders in further development of this component of the demonstration.

Clarify inclusion of children under the age of three. It is unclear in the application whether children under the age of three would be able to access activity stipends. As Children Now recommended previously, children under the age of three should be included so that they can attend various early childhood enrichment and other wellness programs. Young children under age 3 can — and do — suffer from mental health conditions. Moreover, these conditions are difficult for providers to identify and address because young children handle emotional experiences and traumatic events differently from adults and older children. During these early years a child's brain is developing more rapidly than at any other point in their life. That makes the early infant and toddler years a critical time for early socialization as a part of childhood development, and there are a variety of early childhood development and wellness activities from which children under the age of three could greatly benefit to reduce the impacts of trauma on early development.

Ensure a rapid and agile mechanism for application and disbursement of activity stipends. A rapid and agile mechanism for approving and disbursing activity stipends will be key for the stipends to be effective. We encourage DHCS to provide guidance to counties on usage of the funds but **allow counties to manage**

application for and distribution of activity stipends to ensure activity stipends can be accessed in a timely and straightforward manner to effectively meet the needs of children and youth.

Ensure flexibility of activity stipends. It is also important for activity stipends to be flexible to pay for all costs associated with an activity, such as any equipment, fees, transportation, or other costs associated with engaging in any supported activity. This is particularly important as children and youth in child welfare often do not have any means for paying for these additional requirements to engage in sports or other activities, which often becomes a barrier to them engaging in these activities.

Cross-Sector Incentive Program for Children Involved in Child Welfare

Clarify how this program will be responsive to the mobility of this population and to children and youth served outside of managed care plans. Children Now appreciates the Department's recognition of the critical need for cross-sector collaboration to meet the needs of children and youth involved in child welfare. However, we have a number of questions as to how this is to be implemented effectively considering that children and youth in child welfare are an extremely mobile population. In addition, 46% of children and youth in child welfare will continue to remain outside of a managed care plan after the upcoming county managed care plan transitions. To address the complexity of this component of the demonstration, we encourage the Department to engage in more robust stakeholder engagement in the development of mechanisms and metrics for the cross-sector incentive pool.

Incorporate strategies to support cross-sector collaboration. As it is described in the application, there does not seem to be any planned efforts to foster and support development of cross-sector collaboration beyond the establishment of monetary incentives. We believe requiring participation in activities that support cross-sector collaboration, such as regular cross-sector learning collaboratives, would be an important requirement for participation in the cross-sector incentive program in order to effectively address identified concerns regarding cross-sector accountability. This could be incorporated into the work of the centers for excellence component of the demonstration.

Consider early inclusion of other sectors. Children and youth involved in child welfare are frequently involved with multiple systems and cross-sector coordination and collaboration is key to meeting their needs. This includes the additional identified sectors in the application of education, developmental disabilities, and juvenile justice, and we encourage the Department to consider including them in the cross-sector incentive program. The application also states that juvenile justice-involved children and youth will be considered as a population for expansion of the cross-sector incentive pool. Given this, it would be helpful to **clarify whether probation youth in foster care will be included initially**.

Statewide Incentive Program

Incorporate strategies to support developing strategies and building collaboration. Children Now appreciates the Departments recognition of a need for greater accountability and use of quality metrics and benchmarks. However, as it is described in the application, there does not seem to be any planned efforts to foster and support development of strategies and building collaborations to meet the selected benchmarks for the selected quality performance measures. beyond the establishment of monetary incentives. We believe requiring participation in activities that support development of strategies and building collaboration, such as regular learning collaboratives, would be an important requirement for participation in the statewide incentive program in order to achieve the benchmarks for the identified quality performance metrics. This could be incorporated into the work of the centers for excellence.

Disaggregate data by special populations. We recommend that data reporting on all quality metrics be disaggregated by special populations, including children and youth in foster care, children and youth with child welfare system involvement who are not in foster care, children and youth with juvenile justice involvement, and children and youth experiencing homelessness. This will help to ensure BH-CONNECT makes progress towards its goal to reduce disparities in access, quality, and outcomes, and provides a mechanism for accountability regarding any such disparities.

Option to Cover Enhanced Community-Based Services & Incentive Program for Opt-In Counties

Include additional EBPs and alternative therapeutic modalities. While we appreciate inclusion of the clarification of coverage requirements for evidence-based practices (EBPs) for children and youth under EPSDT, the three EBPs selected are limited in their ability to ensure a robust continuum of community-based services for children and youth. MST, FFT, and PCIT, like most EBPs, have specific, relatively narrow, target populations, and are only appropriate for a subset of behavioral health treatment needs. We strongly encourage the Department to include additional therapeutic modalities to ensure a diversity of services to meet a wide-range of behavioral health treatment needs, as well as to ensure inclusion of culturally responsive practices and other alternative therapeutic modalities that are often the services with which children and youth in child welfare are more comfortable and therefore most likely to engage.

Provide EBP implementation support beyond training and technical assistance. While training and technical assistance from the centers for excellence is an important component to installation of the identified EBPs, without ongoing coaching, learning collaboratives, mentoring, and close fidelity monitoring and continuous quality improvement efforts, EBPs will not necessarily be effective or have substantial long-term impact on practice. For EBPs to be effectively maintained and achieve the intended outcomes, there must be ongoing implementation support coupled with fidelity monitoring over time. The Department may be able to collaborate with other sectors and initiatives implementing the same or similar practices in order to provide enhanced implementation support. For example, MST, FFT, and PCIT have also been selected as EBPs as part of California's Five-Year State Prevention Plan under the Family First Prevention Services Act.

Transitional Rent Services

Provide supportive services in conjunction with transitional rent services. We greatly appreciate the recognition of housing as critical to individual health and wellbeing. We recommend that transitional rent be provided in conjunction with key support services to help individuals maintain housing at the conclusion of transitional rent services. This is best practice within housing services, and the Department should consider modeling transitional rent services after an evidence-based practice, such as Rapid Re-Housing. This could be more easily done in collaboration with local Continuums of Care or other housing service providers who are familiar with the model. Without coupling transitional rent services with services that support individuals in being able to maintain their housing independently, we are concerned that transitional rent services may only delay housing instability by six months, at which point individuals may be less connected to needed supports.

Increase the flexibility of transitional rent services to meet individual need. Financial needs to maintain housing vary among individuals, and we believe it would increase the effectiveness of the transitional rent services to allow for responsiveness to the variation in need. To this end, we recommend increasing flexibility of the transitional rent services to be able to provide security deposits and to extend beyond six months if there is a demonstrated need. This aligns with housing best practices and the Rapid Re-Housing model, and is particularly critical for transition age youth, who often require a longer period of housing supportive services and financial support to maintain housing independently after these supports end.

Consider ways to provide transitional rent services to youth currently in the child welfare system as well as those transitioning out of the juvenile justice system. We encourage the Department to explore ways in which the transitional rent services may also be extended to youth currently in child welfare, particularly youth in extended foster care. The recent CalYouth study on the extended foster care program has shown numerous benefits for participating youth, including improvements in education, employment, housing, and social support, as well as reductions in pregnancy and justice system involvement. However, it also revealed that over 35% of youth experienced homelessness while enrolled in extended foster care.

Ensure easy, equitable access to transitional rent services. The application specifies that eligible individuals must meet a determination that transitional rent services are medically appropriate but does not further detail what the process for that determination might entail or under what circumstances transitional rent services would be considered medically appropriate. We are concerned that this could create an undue barrier to access that may vary based on the individual assessments of various medical personnel, who may have various levels of understanding of the importance of housing for greater health and wellbeing. We believe that the specified eligibility criteria should be sufficient to demonstrate a need for transitional rent services.

Short-Term Residential and Inpatient Psychiatric Stays in IMDs

Create stringent safeguards and oversight to protect against unnecessary and lengthy stays in STRTPs. Children Now appreciates the clarification of the expected impact of the wavier of the IMD exclusion for children and youth. As detailed in the application, we are concerned that a waiver of the IMD exclusion specifically for STRTPs in conjunction with a request to waive length-of-stay requirements, without proper safeguards in place, may result in unnecessary and lengthy stays in STRTPS for children and youth in foster care. We strongly encourage establishment of a **clear and robust assessment process to ensure not only that placement at an STRTP would meet a clinical need, but additionally that it is also the least restrictive environment appropriate to meet the clinical need in accordance with requirements under the Americans with Disabilities Act**. Additionally, we strongly encourage there be **extremely robust oversight and accountability mechanisms for any residential treatment for children and youth, including a clear and robust approval process for any lengths of stay that would extend beyond typical length of stay requirements; establishment of individualized, youth-driven, and strengths-based transition plans with intensive transition support; and more robust expansion of community-based services specifically to support step down from residential treatment services and to reduce need for residential treatment for children and youth**.

Initial child welfare/specialty mental health behavioral health assessment

Clarify when and for whom the assessment will occur and how the joint assessment can provide the foundation for continuity of behavioral health care. The application does not discuss in detail the establishment of a joint initial child welfare and specialty mental health assessment at the entry point into child welfare, however it is critical to identify what DHCS is considering the entry point into child welfare. Will this be for every child for whom there is an allegation of abuse or neglect? What about those in family maintenance or other segments of the child welfare system outside of foster care? We encourage assessment as early as possible to ensure timely access to needed services. Additionally, we recommend that the Department consider how those providing the behavioral health assessment can provide support in linking to services, conducting closed loop referrals, and continuing to support access to and provision of behavioral health services throughout the life of the case to ensure improved access and greater continuity of care. This may also provide an opportunity to connect children, youth, and families with supports via the

community pathways counties are developing as part of their Family First Prevention Services Comprehensive Prevention Plans.

Foster Care Liaison

Address how the foster care liaison will achieve its purpose and how similar support could be provided to children and youth not in a managed care plan. While the application does not discuss in detail the inclusion of the foster care liaison within managed care plans, within the description provided, there seems to be an outsized responsibility of the foster care liaison to ensure effective coordination of managed care services for children and youth in foster care. The multiplicity of tasks and responsibilities listed seem larger than what one position could effectively manage. Seventy-two members of the Foster Youth Health Taskforce provided similar and specific feedback on the foster care liaison role as part of their feedback on the draft managed care plan template memorandum of understanding with county child welfare agencies, which may provide additional feedback to inform the construction of this role. Furthermore, this continues to neglect the large number of children and youth in foster care who are served outside of managed care plans. Even after the upcoming county managed care plan transitions, it is expected that 46% of children and youth in foster care will remain in fee-for-service Medi-Cal.

Tools to connect members to appropriate care

Clarify identification and usage of tools to connect members to appropriate care. The implementation timeline included in the application mentions evidence-based tools to connect members living with SMI/SED to appropriate care, but no further detail is provided. We appreciate that the Department identified that such tools should be evidence-based and request further details on how these tools will be identified and deployed.

Thank you again for this opportunity to comment and for the Department's consideration of our recommendations. We appreciate the Department's commitment to these issues and look forward to future conversations and ongoing collaboration to realize our shared goal of a stronger continuum of behavioral health supports for children and youth, particularly those who are involved in child welfare or justice systems or are experiencing homelessness. Please contact me at [redacted] with any questions.

Sincerely,

[redacted]

Amanda Miller McKinney, MSW
Senior Associate, Child Welfare Policy

Cc: Jacey Cooper, Medicaid Director
Tyler Sadwith, Deputy Director, Behavioral Health
Kim Johnson, Director, CDSS
Jennifer Troia, Chief Deputy Director, CDSS
Angie Schwartz, Deputy Director, Children and Family Services Division, CDSS

From: [redacted]
To: DHCS BH-CONNECT
Cc: [redacted]
Subject: [External]BH-Connect Demonstration
Date: Thursday, August 31, 2023 8:16:52 PM

[redacted]

To whom it may concern:

As a volunteer with Clubhouse El Dorado, I would like to complement the State for including the clubhouse model in its application for Federal demonstration funding. We who believe in this unique service delivery concept are in full support of this effort.

A clubhouse is not just a place to come and hang out. On the contrary, it is a place where people dealing with mental illness can go to acquire social, educational and vocational skills. Although membership is voluntary, members are expected to actively participate in the operation of the clubhouse. In doing so, they perform meaningful work in areas such as building maintenance, food service and office work. Through group meetings associated with a work ordered day, they develop the interpersonal and social skills to complete all the necessary functions to keep the clubhouse operating on a daily basis.

A clubhouse offers a positive, constructive and supportive environment that provides a bridge between treatment or therapy visits. It affords a pathway for people living in relative isolation to reintegrate into the broader community. At relatively low cost, the clubhouse model has been shown to be an effective means by which people dealing with mental illness can progress toward building meaningful relationships, acquiring vocational education and training, and ultimately gainful employment.

Those of us associated with the clubhouse movement truly hope the State will continue to direct resources toward the development of additional clubhouses in communities throughout the state. Including clubhouses in the application for Federal demonstration funds represents a significant step in this direction. We urge the State to continue its efforts to identify ways in which to expand the clubhouse model as an integral component of the statewide behavioral health system.

Respectfully,

Scott Richmond

From: [redacted]
To: DHCS BH-CONNECT; [redacted]
Cc: [redacted]
Subject: [External]BH-CONNECT Demonstration: CWDA Comments
Date: Thursday, August 31, 2023 9:46:07 PM
Attachments: [redacted]

[redacted]

Please find attached the CWDA comments on the BH-CONNECT Demonstration Proposal. Thank you for this opportunity to comment and we look forward to continuing to work with your Department to realize the goals of this important initiative.

Diana Boyer | Director of Policy for Child Welfare and Older Adult Services
office: [redacted]
Cell: [redacted]
[redacted] | cwda.org
@CWDA_CA

CWDA
Advancing Human Services
for the Welfare of *All* Californians

CWDA
Advancing Human Services for the Welfare of *All* Californians

August 31, 2023

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Submitted via email: BH-CONNECT@dhcs.ca.gov

RE: CWDA RESPONSE TO THE PROPOSED CALIFORNIA BEHAVIORAL HEALTH COMMUNITY-BASED ORGANIZED NETWORKS OF EQUITABLE CARE AND TREATMENT (BH-CONNECT) DEMONSTRATION PROPOSAL

The County Welfare Directors Association (CWDA) appreciates the opportunity to review and provide additional feedback on the California Behavioral Health Community-Based Organized Networks of Equitable Care (BH-CONNECT) Section 1115 Demonstration Proposal. We continue to support the goals of the proposal to strengthen California's behavioral health system for children and youth across California, and specifically for child welfare system-involved youth, through cross-system coordinated services to ultimately improve health outcomes. CalAIM and BH-CONNECT are pivotal initiatives that will improve services and outcomes for children, youth and their families served by the child welfare services system.

CWDA is supportive of several components of the proposal and accompanying new investments, including specifically the proposal for joint visitation and assessments by a Specialty Mental Health Service (SMHS) provider and child welfare worker prior to the child's entry into the foster care system, foster care liaisons within managed care plans (MCPs), and activity stipends for foster children. We look forward to working with the Administration to further develop the implementation policies and refinements to budget estimates in areas impacting county child welfare programs in the near future.

Generally, we appreciate that this proposal clearly distinguishes between the elements that warrant Section 1115 Waiver authority, those that require a State Plan Amendment (SPA), and those that simply require state-level guidance. We also appreciate the distinction made

between those activities that are statewide versus those that are county optional and specifying the level of new State investments for the proposed elements of the demonstration.

CWDA RECOMMENDATIONS

Demonstration Goals and Measures: CWDA appreciates the goals of the Demonstration (pages 4-5) including expanding the continuum of community-based services, strengthening family-based services and supports and incentivizing outcome and performance improvements for children and youth involved in child welfare who receive care from multiple systems. We also support the goals (listed on page 13) of "improved outcomes for members living with SMI/SED and/or SUD, particularly for those who historically have experienced healthcare disparities, including individuals who are involved in child welfare, justice-involved, and homeless or at-risk of homeless." DHCS plans to contract with an independent evaluator to develop a comprehensive evaluation design and has proposed initial hypotheses, measurements and data. CWDA has the following comments and recommendations in this area:

- We request the inclusion of a robust stakeholder engagement process to work with the independent evaluator in finalizing the evaluation method and data collection, to include county child welfare agencies, county behavioral health agencies and others.
- There is typically a time lag of several months or longer when using claims data because claims can only be submitted after expenditures are made and must go through a validation and auditing process. This is likely to result in delays in data to inform the evaluation, and it may miss other qualitative indicators and outcomes. CWDA encourages use of other existing data (such as the Child and Adolescent Strengths and Needs Assessment aka CANS) or development of other data tools to measure outcomes on a more timely basis.
- Existing child welfare outcome data should be utilized whenever feasible, in addition to other identified sources of information, to measure outcomes related to child welfare-involved youth and families.
- We request the addition of specific measures related to addressing healthcare disparities in the chart, since this desired outcome is included in the overarching goals.
- We recommend an additional goal of promoting cross-system coordination of programs and initiatives. For example, mobile crisis units should be coordinated with the existing Family Urgent Response System (FURS), and there are opportunities to coordinate and leverage services through the Child and Youth Behavioral Health Initiative.
- We recommend the addition of milestones and interim check-points in the course of the five-year demonstration, including a preliminary evaluation in years three and four, so that DHCS and stakeholders can assess the progress and impact prior to the conclusion of the demonstration and can determine if changes are warranted, and to inform future iterations of this demonstration upon the demonstration's conclusion in year five (since these may warrant legislative changes and/or new funding

investments). The procurement of an independent evaluator should include provisions to allow for interim reporting.

- With respect to measuring use of Short-Term Residential Treatment Programs (STRTPs) referenced on page 17, we note that due to several factors, including implementation of the Institutions of Mental Disease (IMD) federal directive, counties have lost significant capacity of STRTP beds. This has resulted in foster youth (who have been deemed by Qualified Individuals to need residential care) not having access to residential treatment in an STRTP, and many foster youth as a result are temporarily in unlicensed settings. County child welfare agencies remain committed to reducing the number of foster youth in congregate care settings and building family-based intensive supports and services. However, and as noted in the proposal, STRTPs continue to be needed for some youth with more intensive needs for short periods. Therefore, in determining outcome measures related to STRTPs, we recommend broadening this measure to assess the adequacy of services in the continuum to support youth who require such level of care – to prevent congregate-level care, to provide family-based alternatives to congregate care, to provide high quality services when crisis or congregate care is necessary, and to support aftercare services.

Workforce Initiative: CWDA supports efforts to bolster the behavioral health workforce to address the workforce shortages and appreciates the Demonstration Proposal references other existing initiatives underway in this area. We support the proposed short and longer-term strategies noted in the proposal and encourage targeted efforts in alignment with the proposal, including building a diverse workforce reflecting the populations served, and incentives to work with populations served through BH-CONNECT, particularly foster youth. We note that masters' level social work degrees are the first step before licensure, and county child welfare agencies have lost staff once they have obtained their licensure to other systems (behavioral health, education and health care). To align with BH-CONNECT goals, we recommend the scope of program investments be further targeted to individuals who will ultimately work with children, youth and families served by county child welfare and county mental health plans, given the significant trauma and special mental health care needs of this population. We also recommend the scope of program utilize strategies to diversity in the workforce. We would also like to underscore the need for specialists to serve individuals struggling with alcohol and drug addiction who can work with youth populations.

Activity Stipends: CWDA continues to support this proposal, which would be administered through the California Department of Social Services (CDSS) and county child welfare agencies. We have the following comments and questions:

- Eligibility Criteria: This proposal would provide activity stipends for child welfare-involved under aged 21. However, we are unclear if this would also include the 0-3 population and request clarity. CWDA continues to advocate for inclusion of the 0-3 population, given research on early brain development which clearly shows that abuse or neglect that occurs during this important time of brain development can have profound and lifelong behavioral impacts on a child, and given that therapeutic

interventions coupled with sensory stimulation can likewise improve the trajectory of growth and development, ameliorating the negative impacts of trauma.

- We have questions on other proposed eligible populations. Specifically, for former foster youth up to age 26, county child welfare agencies do not track these youth after they exit age 21. Activity stipend payments for youth who were in foster care in another state in the prior 12 months and who now reside in California presents similar challenges.
- Administration and Automation Issues: We understand that further discussion on the implementation of this proposal will occur with your Department and CDSS, and we look forward to determining how to address these issues in the near future. We note that child welfare does not currently have an automated mechanism to issue payments for activity stipends, and this could result in a significant amount of new administrative manual workload that county child welfare agencies may not be able to absorb. The funding to administer the activity stipends is proposed at $47.6 million annually once fully established. Given pending discussions on the implementation of the activity stipends, we look forward to working with the Administration to ensure sufficient funding to county child welfare agencies to administer the activity stipends. We also note that automation changes to issue activity stipend payments through our payment system, CalSAWS, would similarly require funding and due to the timing of migration and other changes already in the queue for CalSAWS, counties would be unable to issue payments through the automated system, which is likely to occur sometime after July 1, 2025.

Cross Sector Incentive Program for Children Involved in Child Welfare: The proposal would include $250 million over four years to establish a program to provide fiscal incentives for MCPs, county behavioral health delivery systems, and county child welfare systems to work together and share responsibility for improvement in behavioral health outcomes among children and youth involved in child welfare. We have the following feedback on this component:

- We generally support opportunities to build cross-system collaboration and we see the value of building such collaboration with MCPs given CalAIM implementation. However, this component is lacking detail. The proposal notes DHCS "is working closely with stakeholders on this framework and measure set" however, we are not involved in such discussions currently. We respectfully request robust engagement with stakeholders, including CWDA and our county mental health partners, to flesh out the specifics of this proposal, including: outcome measures, outcome data sources, and distribution of incentive funds. These consensus areas should be developed prior to submittal of the proposal to federal agencies for approval.
- Outcome measures alone will not be sufficient to create incentives for collaboration. Structures must be in place to support collaboration. As such, we would like to continue to encourage DHCS to leverage the AB 2083 System of Care efforts to promote cross-sector support for children at risk of or involved in the child welfare program. MCPs are not required members of the AB 2083 local interagency teams

yet such collaboration across agencies may help facilitate the type of collaboration envisioned by BH-CONNECT.

- We are supportive of the proposal's intent to fold in children involved with juvenile justice, regional centers and educational agencies and we would like to see a stronger commitment in this proposal to add these populations prior to the conclusion of the demonstration.

Option to Cover Enhanced Community-Based Services – Transitional Rent: We appreciate the inclusion of young persons transitioning out of the child welfare system in the eligible population. CWDA recommends broadening the allowable uses of this category to also include any ancillary supports needed for an individual who is homeless or at risk of homelessness, such as first and last months rent, security deposits, etc. We also recommend allowing for an extension of up to another six months, on a case-by-case basis, if an alternative housing support is not yet available and the extension would allow the individual to access such supports.

Short-Term Residential and Inpatient Psychiatric Stays in IMDs: CWDA does not have comments on this section.

Foster Care Liaison: The demonstration would establish, effective January 1, 2024, a management-level Foster Care Liaison within MCPs "to enable effective oversight and delivery of ECM (Enhanced Care Management), attend Child and Family Team meetings, ensure managed care services are coordinated with other services, and serve as a point of escalation for care managers if they face operational obstacles." CWDA continues to support this proposal. However, inclusion of the Liaisons at the CFT meetings we believe is not the best use of their time and may result in delays in CFT meetings due to the need to schedule these meetings with, at times, many other participants. We would instead welcome and encourage the liaisons to attend local Interagency Placement Committee meetings and local AB 2083 interagency team meetings, upon request of the county child welfare agency and other interagency members. We also request county child welfare and stakeholder engagement, and collaboration with CDSS, in the development of the liaison qualifications, roles, responsibilities, and process for engagement with county child welfare agencies.

Centers of Excellence and Clarification of Coverage Requirements for Evidence-Based Programs: CWDA is supportive of this proposal and has the following additional recommendations to enhance the desired outcomes of this approach:

- The Demonstration Proposal identifies three specific programs for clarification of coverage requirements (MST, FFT and PCIT) but notes that additional therapeutic modalities may be added. As CWDA noted previously, those programs serve limited populations (either justice-involved youth or families with young children). We would like to re-iterate our prior recommendation that the Centers for Excellence provide clarification for additional therapies, including promising practices as well as culturally-relevant interventions for black, Latino and tribal families. We highly encourage that the clarifications align with the programs identified in county child welfare Family First Prevention Services Plans and recommend collaboration with

CDSS to prioritize the interventions that would benefit from technical assistance from the Centers for Excellence.

- We further request the Centers for Excellence provide technical support and guidance to counties to implement other trauma-based healing interventions, in conjunction with traditional therapies, that can help improve regulatory balance for children who have experienced trauma and are dysregulated. Research indicates that trauma can result in behaviors in children that can overwhelm their caregivers, causing instability in care which can require intervention from the child welfare and mental health systems. Trauma-based healing interventions can include activities such as animal therapy, art therapy, yoga, dance, acupuncture, therapeutic massage, etc.

Statewide Incentive Program: The proposal would invest $1.5 billion to county managed health plans (MHPs) and DMC-ODS counties to equip them to provide a robust array of community-based services as described by BH-CONNECT, as an incentive to improve performance on quality measures and reduce disparities in behavioral health access and outcomes. CWDA is supportive of such investments and the measured goals as identified in the proposed scope. We have the following comments:

- We appreciate that the measures would be further developed through a robust stakeholder input process and CWDA would appreciate inclusion in this process, to ensure measures also capture the outcomes for children and youth involved in child welfare, given the trauma-based needs of foster youth often leading to high utilization and costs in the behavioral health system.
- We would like to see a commitment in this proposal to a process of engagement between county child welfare and MHPs and DMC-ODS in the development of priorities for local spending of these funds, to facilitate cross-agency collaboration in serving youth with serious mental illness (SMI)/serious emotional disturbances (SED). County child welfare agencies are the safety net program for serving youth with SMI/SED when their needs exceed their family's ability to provide care. By working together, county child welfare and behavioral health agencies can help prevent entry into foster care and promote family reunification or other optimal permanency outcomes.

Initial joint child welfare and specialty mental health assessment at point of entry into child welfare: CWDA continues to support joint efforts between child welfare and specialty mental health service providers to assess and serve children and youth in or at risk of foster care, beginning in 2025. A similar version of this proposal was initially put forth by our organization and the County Behavioral Health Directors Association (CBHDA). This Demonstration Proposal however does not elaborate on the details of this proposal. Our recommendations and comments are as follows:

- "Entry" is not defined in the proposal. CWDA requests elaboration in this proposal. It is our understanding pursuant to prior conversations that this is intended to address cases with substantiations for abuse/neglect.
- In alignment with the CWDA/CBHDA proposal and the Integrated Core Practice Model (ICPM), we continue to urge that such partnership between county child

welfare and SMHS occur throughout the life of the child's case, to not only assess for services, but to also ensure appropriate engagement through child and family teams, service planning, monitoring/adapting services, and transition planning. Additionally, such collaboration would help ensure universal access to SMHS as envisioned and required through CalAIM and BHIN 21-073.

- We would like to further discuss how this work will be supported through joint training of staff and what tools will be used by staff to support such assessments.
- We encourage exploration of an expansion to this proposal, to enable such visits to occur prior to substantiation, to divert and prevent entry into foster care.

Child and Family Tams for Family Maintenance Cases: This proposal was put forth in a previous draft of the Demonstration Proposal and it was included in the latest Governor's January Budget and May Revise proposals. Implementation was proposed for January 1, 2025 and the 2023-24 Budget Act provides funding for pre-implementation activities. CWDA continues to support this proposal and questions why this is not included in the current iteration.

CWDA appreciates this opportunity to submit comments and looks forward to a robust stakeholder engagement process to implement the many components of this proposal.

Sincerely,

Eileen Cubanski, Interim Executive Director
County Welfare Directors Association (CWDA)

cc: Jacey Cooper, Chief Deputy Director Health Care Programs & State Medicaid Director, DHCS
Kim Johnson, Director, California Department of Social Services (CDSS)
Jennifer Troia, Chief Deputy Director, CDSS
Angie Schwartz, Deputy Director, Children and Family Services Division, CDSS

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Thursday, August 31, 2023 9:56:46 PM

[redacted]

Dear DHCS,

I STRONGLY support the decision to include availability of Clubhouse services in the state's application to the federal government. Please. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago and continues to spread because it truly changes the game for those with severe mental illness.

Thank you
Paula Kravitz

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-Connect Demonstration
Date: Thursday, August 31, 2023 11:06:14 PM

[redacted]

Dear CHHS people,

As a family member of a seriously mentally ill person who has been homeless and in jail, my interest in the BH-Connect program is that it promised to do away with the IMD exclusion for serious mental illness, and let Medi-Cal pay for stays in mental hospitals and large supportive residences that provide psychiatric services. It's a very damaging, discriminatory exclusion that prevents counties from getting paid for what they spend treating illness, just because it is mental illness.

Doing away with the IMD exclusion for SMI is what family members were hoping for when we heard that California would finally apply for the waiver. We all know someone who has died or gotten into great medical or legal trouble because beds were not available when needed—acute beds, subacute beds like MHRCs, beds in dual-diagnosis residential facilities, and in board-and-cares with services onsite. Beds of these types have extended my own family member's life.

These beds aren't available to most of those who need them, because even if they are built the money isn't available to pay for stays there.

You can't rely on the January 2022 Manatt report regarding the need for these beds, because it focuses on crisis management (SMI is usually lifelong, not just a crisis) and because it ignores the thousands of people incompetent to stand trial being forced out of the prison and state hospital system—they need beds too. Rely instead on the RAND report of 2023 that says we need 4764 acute and subacute beds.

And why would the demonstration have to reduce admissions to acute care hospitals and residential settings? No one should be in these settings unnecessarily, but we have been talking for many decades about trying to reduce such admissions, while people die for lack of beds. It may be that to save lives we need to increase such admissions, at least temporarily. In the long run, we may need to hospitalize people less if we don't keep dischargng them to drug-ridden streets over and over, but again, people should be hospitalized and should be in special residences for SMI or SUD if that's what they need. And there is a shortage of such beds.

As far as I can tell from this bulky document, counties can only get a waiver of the

exclusion if they participate in a program that hopes to demonstrate that hospitalization and stays in psychiatric residences can be reduced! Our own county is saying the waiver is too much trouble to apply for.

And if a county should get the waiver, it is limited to 60 days at the very most. Let Medi-Cal pay for stays that are medically necessary. Do what it takes to keep people alive and well and with a chance of recovery.

I am greatly disappointed in this proposal. I refer you to Douglas Dunn's comments well-informed comments also.

It would be simpler and more effective for the state to take a position that the IMD exclusion be abolished at the federal level.

Thank you for this opportunity to comment.

Alison Monroe
[redacted]

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]Comments for the BH-CONNECT submission
Date: Thursday, August 31, 2023 11:22:12 PM
Attachments: [redacted]

[redacted]

Dear Ms. Cooper and Mr. Sadwith,

First and foremost, ***congratulations and thank you*** for leading California's monumental movement toward equitable access and whole person care for Medi-Cal members. On behalf of those with SMI/SED or SUD and their families, (in which I proudly count myself thanks to treatment I've been privileged to receive after years of trauma and abuse), what you're undertaking offers hope for so many languishing in our overly fragmented specialty behavioral health systems.

As a pediatrician and intergenerational trauma researcher who partners with diverse providers, payers and families in low-income and marginalized communities, I can't stress enough the ***imperative of getting continuity of care and care coordination right, once and for all,*** across our exceedingly complex and siloed systems.

The youth mental health crisis that overwhelms our ER's and primary care practices is a poignant example where a true continuum could help avoid preventable tragedies that today deprive families of sons and daughters, fathers and mothers.

I have been blessed to lead trauma-informed care innovation and integration to scale in community-based settings across California, from reproductive health to early childhood integrated behavioral health in primary care to community mental health centers. I advise DHCS on universalizing ACEs/trauma identification in community networks of care and have helped Los Angeles and California grow life-saving 988, mobile crisis, urgent care, and crisis residential services. All of it is so desperately needed, as you know, and so interdependent if we are to ensure the least restrictive care empowers kids and families with more severe behavioral health needs to heal, while driving down total costs and improving county accountability.

With humility, few physicians turned behavioral health executives in California share my breadth of experience across the continuum of services and payers found in BH-CONNECT and CalAIM - from primary care to Community Health Workers, Community Schools to Enhanced Care Management to Psychiatric Health Facilities. I hope this perspective proves useful as you consider this demonstration to build upon CalAIM.

Below are opportunities for BH-CONNECT to further care and financing integration that would improve access, quality and outcomes for traumatized, severely ill populations experiencing disparities in our communities and streets:

1) Children with SED don't start out on county MHP access lines. They're illness risk and often early symptoms are usually first identified in primary care. ACEs screening to ECM 'pipelines' we're building in communities statewide therefore need to be rock solid so that **all of California's children with a high trauma burden and toxic stress have access to needed treatment and supports,** regardless of whether delivered via county or managed care payment.

Suicide is by far the highest risk ACE-associated health condition from the brain toxicity of extreme stress, with a 37-fold increased odds of an attempt in those with 4 or more ACEs. (By comparison, most other leading causes of death in California have only double to triple the odds from exposure to 4+ ACEs.) In order to prevent and address the complex traumas that lead California's children to suicidal despair and overdose (and we're seeing it in kids as young as age 8 texting and calling 988), ***it is vital that BH-CONNECT address how the PEARLS/ACEs tools Medi-Cal managed care plans (MCP's) pay for can be reconciled with the CANS tools county MH plans (MHP's) and child welfare systems require***.

Addressing this seemingly innocuous incongruity would improve clinical quality and outcomes across all BH-CONNECT services as well as drive ECM enrollment rates beyond today's low mid-teen %'s, increasing mental healthcare access and follow-up after ED visits and hospitalizations for those with SMI/SED.

As you seek to get MHP's and child welfare agencies using the same CANS version, ***how might that work include ACEs screening primary care professionals and incentivize alignment of DHCS' reimbursable PEARLS tool and ECM and ACEs Aware initiatives,*** in line with the stated goal for SMI/SED demonstrations outlined in State Medicaid Director Letter (SMDL) #18-011 of "increased integration of primary and behavioral health care"?

Attached is a schematic of these primary and behavioral health care tools' misalignment to help explain. Note how the CANS doesn't fully measure the 10 ACEs shown in the literature to drive SMI/SED development and illness severity. It therefore limits the likelihood DHCS, BH-CONNECT and CMS investments in the CANS could fully identify let alone support all kids who are at risk of developing significant behavioral health conditions. Only 7 of the CANS' 12 "potentially traumatic/adverse childhood experiences" would count toward SMHS and thereby ECM eligibility per BHIN 21-073, limiting the number of kids who would be measured as high-risk and referred to these benefits, including BH-CONNECT's robust requested service array.

2) It's important BH-CONNECT's Cross-sector Incentive Program ***include ACEs and trauma symptoms as measures of individual and population-level progress*** given the diagnosis we see most frequently in specialty mental health services for kids is *Reaction to Severe Stress, unspecified (F43.9).* Unlike academic arguments, this is not about choosing between measuring risk-defining experiences and ongoing symptoms. Parents want both and clinicians agree - both matter to prevent and mitigate severe illness, including crises, *as well as* prove overall trauma burden reduction across high-risk, high-cost populations, including those with SMI/SED, from initiatives like BH-CONNECT and CalAIM.

The unnavigable nature of California's systems today can be traumatizing, so conversely, the trauma reduction of continuity could be measured. ACEs not only predict disease development and explain levels of severity, they can explain medication nonadherence and resistance to

treatment that have confounded providers and plans in California for far too long. Including ACEs and trauma symptom measurement in shared MCP, MHP, and child welfare measure sets for the Cross-sector Incentive Program would therefore enable primary care providers, specialty behavioral health providers, county MH plans, managed care plans, and child welfare systems to collaborate, integrate, and improve the health and wellbeing of our most at-risk children and families.

Even the courses of those already homeless or involved with child welfare and justice systems can be altered for the better with this data. A biased narrative propagating stigma says 'they're already in the system", when we know these measures of lifelong risk to physical and mental health remain clinically invaluable when serving kids and teens.

3) To make the importance of primary care and behavioral health alignment and integration more visible, consider including ACEs Aware under Prevention and Wellness Services or Outpatient Services in ***Figure 1. Building Out the Continuum of Care for Individuals Living with SMI/SED and/or a SUD***. Many of us have experience with ACEs screening building a strong therapeutic alliance with clients in outpatient services. ACEs Aware could also be included among our State's incredible system transformations in Appendix 1.

4) Coordinate the BH-CONNECT demonstration evaluation with that of ACEs Aware in addition to CalAIM. That way you can show that ACEs screening and ECM together lead to the appropriate levels of intensive, peer and recovery, crisis and inpatient and residential treatment services requested for kids. Same for the synergistic reduction of ED use and readmission rates - ACEs are associated with increased ED utilization and recurring psychiatric inpatient stays, in addition to influencing community-based behavioral healthcare utilization.

5) Ensure the workforce initiative includes training and competency in ACEs-informed care in addition to the more traditional "trauma-informed care" lens of specialty behavioral health providers in California serving SMI/SED populations. These are not the same skills and knowledge, though champions tend to align and overlap! Ask any SMHS provider of the specific physical health risks of childhood trauma to their clients by age and you're unlikely to get a sufficiently informed answer for true integrated care.

6) Consider adding more trauma-focused treatments to the list of EBP's in BH-CONNECT, such as Parent-Child Psychotherapy; Attachment, Self-regulation, and Competency (ARC), and Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

Thank you again for leading Medi-Cal forward and receiving public comment on this important care continuity initiative for our communities. It may not seem so in your day to day, but those of us who've been advising and cheering DHCS on for years feel *we're in a hopeful 'last leg' of this epic journey to break down silos between physical and behavioral healthcare.* Including and especially their respectively separate and unequal financing today.

Your ability to integrate care across BH-CONNECT, CalAIM and other incredible Medi-Cal investments like ACEs Aware can make this bending of our history toward justice one that finally lands and stays solidly grounded in health equity for generations. Godspeed with the demonstration!

Ever yours in the pursuit of just, whole care,

Jonathan Goldfinger, MD, MPH, FAAP
CEO, Principal
Goldfinger Health

PEARLS (MCP) – CANS (County MHP, Child Welfare) Alignment and PHM

Many specialty BH providers for kids, like Children's Institute, are ECM contracted for expertise spanning Priority Provider Types *and* POF's

Children/Youth ECM Population of Focus (POF)	Example Priority Provider Types
Children with Serious Mental Health and/or SUD Needs (includes children with high ACEs scores)	» *School-based clinics/BH providers (italics highlight multiple areas of expertise that exist within a single provider organization)* » *Public Health & Social Service Programs* » *CBOs serving children and families with social needs* » *County behavioral health services*
Children and Youth Enrolled in California Children's Services (CCS)	» CCS paneled providers, including specialty care centers, and pediatric acute care hospitals
Children and Youth At Risk for Avoidable Hospitalization or ED Use	» *School-based clinics* » Medical providers depending on underlying reasons for ED utilization
Children and Youth Involved in Child Welfare	» *CBOs, Public Health & Social Service* Programs: First5, Help Me Grow, WIC, Black Infant Health Program, etc.

Aligning kids' trauma/ACE-identification incentives across BH-CONNECT, CalAIM, and ACEs Aware would boost ECM and specialty BH enrollment, and thereby the PHM and health equity of marginalized families

- Managed Care Plans (MCP's) pay a rapidly growing number of PCP's to screen millions of kids in low-income households for ACEs using the PEARLS tool, which includes discrimination, child welfare involvement, juvenile justice involvement, and housing insecurity (among other known toxic adversities) – all highly valuable PHM data currently stored in EHR's
- High-risk on the PEARLS (4+ or any positive score plus an ACE-associated health condition) is an eligibility criteria for ECM through the specialty mental health benefit (BHIN 21-073) being "a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the ***high-risk range under a trauma screening tool approved by the department***, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness"
- As of BHIN 21-073's release (December 2021), DHCS was meant to "explore the approval process and standards for trauma screening tools for beneficiaries under 21 years of age through continued stakeholder engagement." County MH Plans (MHP's) were "not required to implement the (PEARLS) tool until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria."
- BH-CONNECT's proposed Cross-Sector Incentive Program seeks to reward MCP's, MHP's, and Child Welfare Systems for meeting specified measures related to coordinated care for children and youth in the child welfare system
- DHCS is seeking stakeholder input on how this coordination will be measured/monitored but the 3 payers use different ACEs measurement tools for criteria for care coordination services
- In parallel, DHCS is working to align the Child and Adolescent Needs and Strengths (CANS) tool to ensure both child welfare and BH provider are using the same CANS tool – only 2 of 3 payer types represented

How this impacts Medi-Cal members/patients at the point of care

- Exponentially more kids are being screened for ACEs every day by PCP's using the PEARLS, than by county directly operated and contracted behavioral health providers using the CANS
- These PCP's want to refer to and share clinical ACEs information (scoring, associated conditions, treatment plans) with kid-specialized ECM providers and specialty BH providers using the PEARLS but specialty BH providers are being trained in the CANS only (and most ECM providers are as yet unaware of this issue)
- The CANS does *not* include all original 10 ACEs in its "Potentially Traumatic/Adverse Childhood Experiences" section (see next slide) – parental mental illness and substance misuse are in another section; 2 types of neglect are lumped together; and 5 of 12 listed "ACEs" aren't per the original literature
- The PEARLS measures exposure to discrimination, food insecurity, and romantic partner violence not found on the CANS
- The CANS has a severity score not found on the PEARLS, specific to individual caregivers' involvement, MH, & substance use needs
- Depending on the context – primary care vs. dyadic psychoeducational services (H2027) vs. the family therapy benefit vs. specialty BH services – there may be strengths of using one tool vs. the other…and there may be things providers in one context wish they had from the other tool/setting (e.g. discrimination data for family therapy/specialty BH)

Comparing CANS (DMH) ACEs to PEARLS (MCP) ACEs (Part 1)

x = not an original 'ACE' (no arrow to PEARLS Part 1), nor an ECM enrollment criteria

y = an original ACE in a different CANS section

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERS. NO = no evidence YES = interferes with functioning; action needed	NO	YES
T1. Sexual Abuse	☐	☐
T2. Physical Abuse	☐	☐
T3. Emotional Abuse	☐	☐
T4. Neglect	☐	☐
T5. Medical Trauma X	☐	☐
T6. Witness to Family Violence	☐	☐

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERS. NO=no evidence YES=interferes with functioning; action needed	NO	YES
T7. Witness to Community/School Violence X	☐	☐
T8. Natural or Manmade Disaster X	☐	☐
T9. War/Terrorism Affected X	☐	☐
T10. Victim/Witness to Criminal Activity X	☐	☐
T11. Disruption in Caregiving/Attachment Losses	☐	☐
T12. Parental Criminal Behaviors	☐	☐

CAREGIVER RESOURCES AND NEEDS

A. Caregiver Name: _____
Relationship: ** _____

0=no evidence; this could be a strength
1=history or suspicion; monitor; may be an opportunity to build
2=interferes with functioning; action needed
3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
41a. Supervision	☐	☐	☐	☐
42a. Involvement with Care y	☐	☐	☐	☐
43a. Knowledge	☐	☐	☐	☐
44a. Social Resources	☐	☐	☐	☐
45a. Residential Stability	☐	☐	☐	☐
46a. Medical/Physical	☐	☐	☐	☐
47a. Mental Health y	☐	☐	☐	☐
48a. Substance Use y	☐	☐	☐	☐
49a. Developmental	☐	☐	☐	☐
50a. Safety	☐	☐	☐	☐

PART 1: Please check "Yes" where apply. ☑

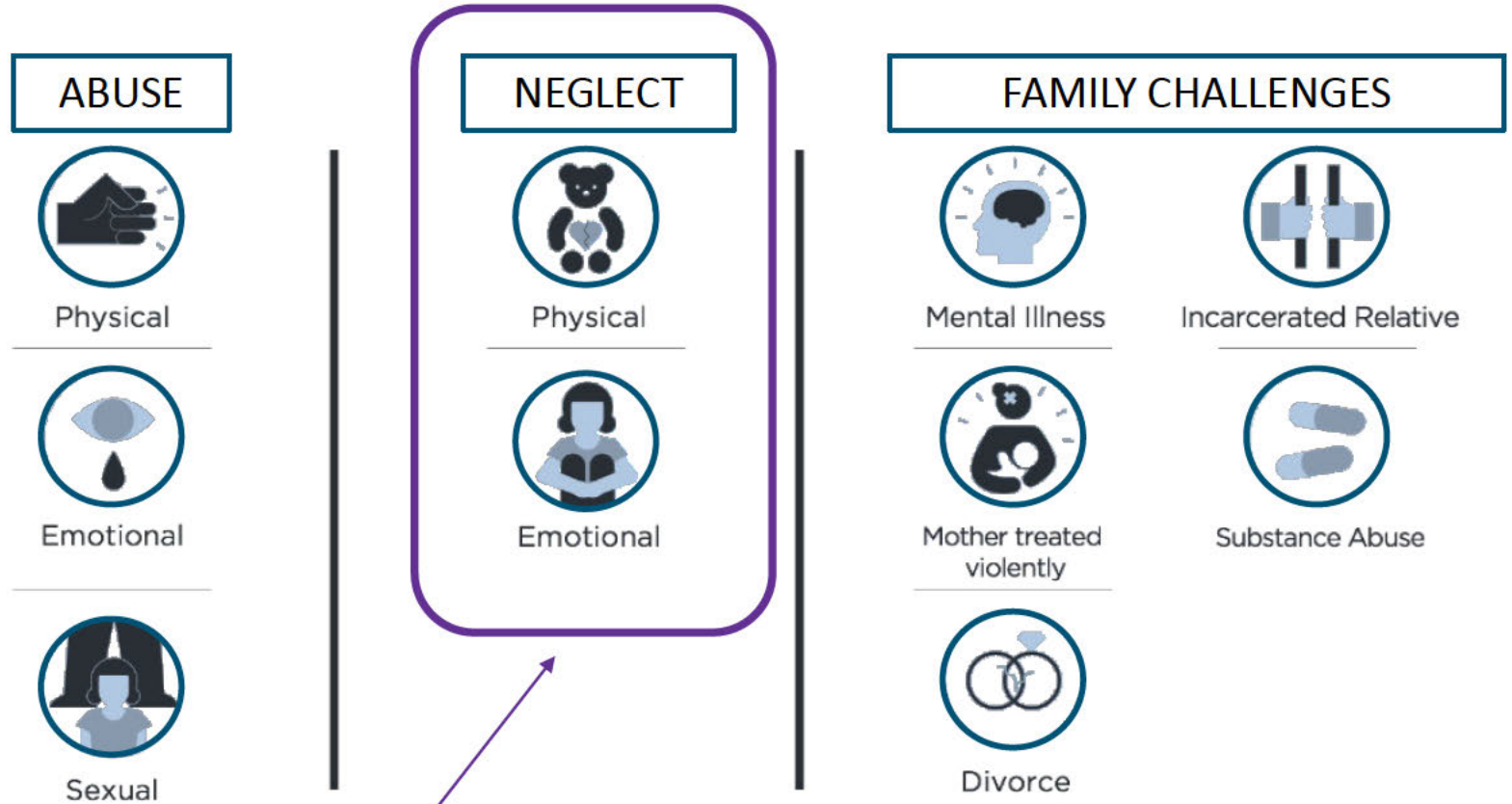
1. Have you ever lived with a parent/caregiver who went to jail/prison? ☐
2. Have you ever felt unsupported, unloved and/or unprotected? ☐*
3. Have you ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)* ☐
4. Has a parent/caregiver ever insulted, humiliated, or put you down? ☐
5. Has your biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use? ☐*
6. Have you ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not being cared for when sick or injured even when the resources were available)* ☐*
7. Have you ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?

   Or have you ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon? ☐
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at you? ☐*

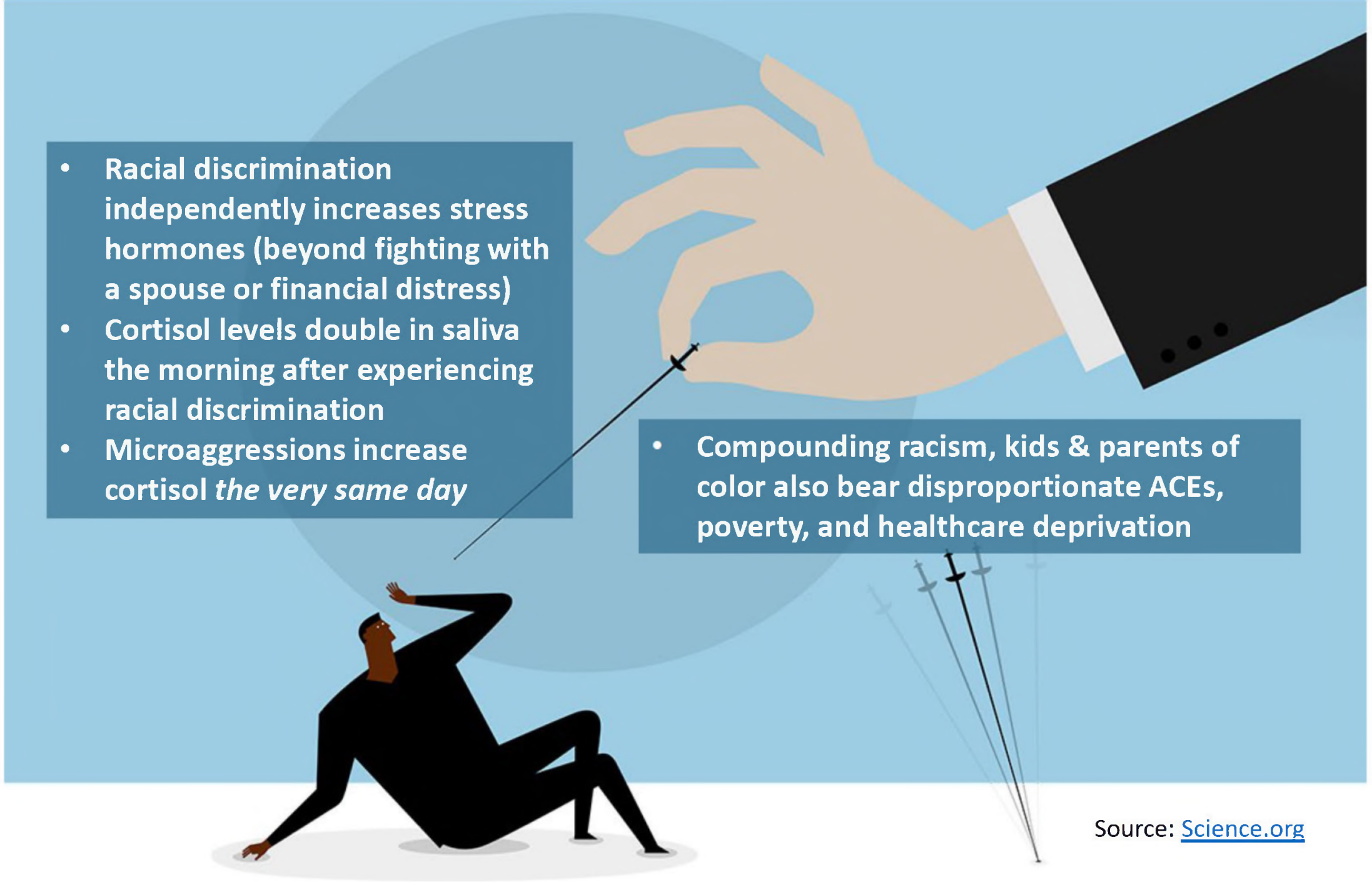
   Or has any adult in the household ever hit you so hard that you had marks or were injured?

   Or has any adult in the household ever threatened you or acted in a way that made you afraid that you might be hurt?
9. Have you ever experienced sexual abuse? *(for example, has anyone touched you or asked you to touch that person in a way that was unwanted, or made you feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with you)* ☐
10. Have there ever been significant changes in the relationship status of your caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)* ☐

10 Traditional Adverse Childhood Experiences (ACEs) drive poor health *(in white, middle-income KP pop.)*



The PEARLS follows original and ongoing ACE research separating neglect into 2 types, with likely different biological mechanisms of toxic stress and thereby different clinical phenotypes and treatments. The CANS lumps these 2 types into one.



Source: Science.org

Comparing CANS' and PEARLS' additional adversities (Part 2)…and DHCS' new universal Youth Screening Tool for MH Services

PART 2:	Please check "Yes" where apply.	
1. Have you ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	☐	
2. Have you experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	☐	
3. Have you ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	☐	*
4. Have you ever worried that you did not have enough food to eat or that food would run out before you or your parent/caregiver could buy more?	☐	*
5. Have you ever been separated from your parent or caregiver due to foster care, or immigration?	☐	
6. Have you ever lived with a parent/caregiver who had a serious physical illness or disability?	☐	
7. Have you ever lived with a parent or caregiver who died?	☐	
8. Have you ever been detained, arrested or incarcerated?	☐	
9. Have you ever experienced verbal or physical abuse or threats from a romantic partners? *(for example, a boyfriend or girlfriend)*	☐	

How many "Yes" did you answer in Part 2?: ☐

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERS. NO=no evidence YES=interferes with functioning; action needed		
T5. Medical Trauma	☐	☐
T7. Witness to Community/School Violence	☐	☐
T8. Natural or Manmade Disaster X	☐	☐
T9. War/Terrorism Affected	☐	☐
T10. Victim/Witness to Criminal Activity	☐	☐
T11. Disruption in Caregiving/Attachment Losses	☐	☐

CAREGIVER RESOURCES AND NEEDS

A. Caregiver Name: _____
Relationship: ** _____

0=no evidence; this could be a strength
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	0	1	2	3
41a. Supervision	☐	☐	☐	☐
42a. Involvement with Care	☐	☐	☐	☐
43a. Knowledge	☐	☐	☐	☐
44a. Social Resources	☐	☐	☐	☐
45a. Residential Stability	☐	☐	☐	☐

State of California – Health and Human Services Agency — Department of Health Care Services

Youth Screening Tool for Medi-Cal Mental Health Services

Youth Respondent

9. Are you currently without housing or a safe place to sleep?[1]

NOTE: *If yes, stop the screening and refer to the MHP for clinical assessment.*

10. Have you ever been without housing or a safe place to sleep?

Comparing CANS' and PEARLS' (Part 2) additional adversities…and DHCS' new universal Youth Screening Tool for MH Services

a = not represented on the CANS

PART 2:	Please check "Yes" where apply. ☑
1. Have you ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	☐
2. Have you experienced discrimination? **a** *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	☐
3. Have you ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	☐
4. Have you ever worried that you did not have enough food to eat or that food would run out before you or your parent/caregiver could buy more? **a**	☐
5. Have you ever been separated from your parent or caregiver due to foster care, or immigration?	☐
6. Have you ever lived with a parent/caregiver who had a serious physical illness or disability?	☐
7. Have you ever lived with a parent or caregiver who died?	☐
8. Have you ever been detained, arrested or incarcerated? **a**	☐
9. Have you ever experienced verbal or physical abuse or threats from a romantic partners? *(for example, a boyfriend or girlfriend)* **a**	☐

How many "Yes" did you answer in Part 2?: ☐

z = not represented on the PEARLS

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERS.

NO=no evidence
YES=interferes with functioning; action needed

T5. Medical Trauma	☐	☐
T7. Witness to Community/School Violence	☐	☐
T8. Natural or Manmade Disaster **z**	☐	☐
T9. War/Terrorism Affected	☐	☐
T10. Victim/Witness to Criminal Activity **z**	☐	☐
T11. Disruption in Caregiving/Attachment Losses	☐	☐

CAREGIVER RESOURCES AND NEEDS

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44a. Social Resources	☐	☐	☐	☐
45a. Residential Stability	☐	☐	☐	☐

****CAREGIVER RELATIONSHIP VALUES**

County Social Worker	Mother	Father
Foster Mother	Foster Father	Grandmother

State of California – Health and Human Services Agency — Department of Health Care Services

Youth Screening Tool for Medi-Cal Mental Health Services

Youth Respondent

9. Are you currently without housing or a safe place to sleep?[1]

NOTE: *If yes, stop the screening and refer to the MHP for clinical assessment.*

DHCS can solve this measurement problem…

- Because MCPs may not impose additional requirements to authorize ECM services, such as use of the CANS' additional measures, DHCS' PHM Division could clarify with BH-CONNECT leadership (Tyler Sadwith?) whether the proposed *Cross-Sector Incentive Program* and/or *MHP/child welfare CANS alignment* is at risk of forcing MCP hands
- ACEs being one specialty BH/ECM criteria that will not go away upon reassessment – once it happened it happened – DHCS can clarify for MCP's and MHP's whether/that these kids are eligible for ECM lifelong even if they no longer meet other specialty BH criteria at reassessment
- DHCS could update BHIN 21-073 with findings from its exploration of "the approval process and standards for trauma screening tools for beneficiaries under 21 years of age through continued stakeholder engagement", or use this issue as an opportunity to launch an exploration in partnership with SME's, plans and providers contracted across plans
- DHCS could encourage MCP's, MHP's and child welfare to implement trauma/ACE-identification and data sharing workgroups as part of CalAIM IPP, PATH CITED, and/or BH-CONNECT incentives, and issue additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria and ECM
- DHCS could leverage the PHM Program for demonstration of ACEs' value to population health
    - For example, LA County's Local Health Department (LHD, Dept. of Public Health) community health improvement plan (CHIP) process will focus on violence (ACE) prevention and center on equity, starting Fall 2023…aligning MCP's Population Needs Assessments (PNA) with LHD CHIPS via the PHM Program means recognizing *both* will need to measure exposure to violence/ACEs … which could be aligned with BH-CONNECT's need to align tools between a 3rd and 4th system (MHP and Child Welfare/DCFS)

On the ground we seek to support solutions…

- …without adding more work or double screening across programs, confusing or retraumatizing participants.
- …enabling internal collection/use of PEARLS ACEs data for specialty BH, ECM and CHW eligibility and new partnerships with primary care.
- …considering the value of risk factors only found in one tool (e.g. PEARLS' discrimination question or CANS' caregiver MH/SUD severity scores).
- …reflecting on tool, workflow, automation adaptations *all* as options or ingredients to help solve this puzzle.
- …in partnership with allies at MCP's, MHP's, child welfare, and DHCS. Not having to choose between them as we all seek to provide trauma-informed care and equitable access to kids and families!

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Friday, September 1, 2023 1:34:09 PM

[redacted]

Dear DHCS,
I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It doesn't focus on temporary treatment, but instead it offers an ongoing recovery process. It creates a community that supports members and reduces isolation. The first Clubhouse was opened 75 years ago.

Thanks for listening,
Rob O

From: [redacted]
To: DHCS BH-CONNECT
Subject: [External]BH-CONNECT Demonstration
Date: Saturday, September 2, 2023 11:26:19 PM

[redacted]

Dear DHCS ,

I strongly support the decision to include availability of Clubhouse services in the state's application to the federal government. The mission of Clubhouses in California is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. As a social and vocational rehabilitation program that is free, voluntary, and for life, Clubhouse meets the goal of extending a continuum of services to Californians in need. It does not focus on temporary treatment, instead it offers an on going recovery process. It creates a community that supports members and reduces isolation.

Thanks so much for your consideration!

Tamara Hunter
Executive Director
Mental Health Connections
[redacted]
www.mentalhealthconnectionsca.org