Systems and Medicaid Committee Agenda

Thursday, October 19, 2023
Embassy Suites by Hilton San Francisco Airport Waterfront
150 Anza Boulevard Burlingame, CA 94010
Ambassador A
Zoom link
Meeting ID: 844 4358 1426 Passcode: SMC2023
Join by phone: 1-669-900-6833 Passcode: 4568239
8:30 a.m. to 12:00 p.m.

8:30 am	**Welcome and Introductions** *Karen Baylor, Chairperson and All Members*	
8:35 am	**Approve June 2023 Draft Meeting Minutes** **Approve August 2023 Interim Meeting Minutes** *Karen Baylor, Chairperson and All Members*	**Tab 1**
8:40 am	**Review and Update SMC Work Plan & Discussion of CBHPC Year-End Report** *Karen Baylor, Chairperson and All Members*	**Tab 2**
9:25 am	**Public Comment**	
9:30 am	**Overview of CalAIM Documentation Redesign Initiative** *Alexandria Simpson, Medi-Cal Behavioral Health Division, California Department of Health Care Services (DHCS)*	**Tab 3**
10:15 am	**Public Comment**	
10:20 am	**Break**	
10:35 am	**Overview of Physical and Digital Behavioral Health Platforms for Children and Youth** *Steve Adelsheim, MD, Clinical Professor & Associate Chair for Community Engagement, Stanford Department of Psychiatry* *Jill Huckels, Manager, Sutter Health Design & Innovation* *Karan Malhotra, Project Coordinator, Sutter Health Design & Innovation*	**Tab 4**
11:20 am	**Public Comment**	
11:25 am	**CBHPC Workgroups Update** *Karen Baylor, Chairperson and All Members*	**Tab 5**
11:35 am	**Behavioral Health Policy Updates** *Ashneek Nanua, Council Analyst and All Members*	**Tab 6**

11:45 am	**Public Comment**	
11:50 am	**Nominate 2024 SMC Chair-Elect** *Uma Zykofsky, Chair-Elect and All Members*	**Tab 7**
11:55 am	**Wrap Up/Next Steps** *Karen Baylor, Chairperson and All Members*	
12:00 pm	**Adjourn**	

The scheduled times on the agenda are estimates and subject to change.

Systems and Medicaid Committee Members

Karen Baylor, Chairperson Uma Zykofsky, Chair-Elect

Erin Franco	Dale Mueller	Walter Shwe
Jessica Grove	Noel O'Neill	Marina Rangel
Veronica Kelley	Liz Oseguera	Cindy Wang
Steve Leoni	Vandana Pant	Susan Wilson
Catherine Moore	Deborah Pitts	Tony Vartan
Javier Moreno	Daphne Shaw	Joanna Rodriguez (on leave)

Committee Staff: Ashneek Nanua, Health Program Specialist II

TAB 1

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 19, 2023

Agenda Item: Approve June 2023 Draft Meeting Minutes
Approve August 2023 Draft Meeting Minutes

Enclosures: June 2023 Draft Meeting Minutes
August 2023 Draft Meeting Minutes

Background/Description:

Committee members will review and approve the draft meeting minutes for the June 2023 Quarterly Meeting, as well as the SMC August 2023 Interim Meeting.

Systems and Medicaid Committee

Meeting Minutes (DRAFT)
Quarterly Meeting – June 15, 2023

Members Present:

Karen Baylor, Chairperson	Uma Zykofsky, Chair-Elect	Catherine Moore
Walter Shwe	Marina Rangel	Cindy Wang
Jessica Grove	Susan Wilson	Daphne Shaw
Deborah Pitts	Tony Vartan	Steve Leoni
Dale Mueller	Liz Oseguera	Javier Moreno
Veronica Kelley	Vandana Pant	

Staff Present:
Ashneek Nanua, Jenny Bayardo

Presenters: Jacob Lam, Michelle Doty Cabrera, Azahar Lopez, Anthony Le, John Drebinger, Tim Ryder

Meeting Commenced at 8:30 a.m.

Item #1 Approve April 2023 Draft Meeting Minutes

The Systems and Medicaid Committee (SMC) reviewed and approved the SMC April 2023 draft meeting minutes.

Action/Resolution
The April 2023 SMC Meeting Minutes will be posted to the CBHPC webpage.

Responsible for Action-Due Date
Ashneek Nanua – June 2023

Item #2 CBHPC Workgroups Update

The SMC received updates on CBHPC's Workgroups. Javier Moreno provided an update on the substance use disorder (SUD) Workgroup from the April 2023 Meeting. He stated that this first workgroup meeting focused on defining the framework for upcoming workgroup meetings. The SUD workgroup is aiming to educate the CBHPC on SUD issues, therefore, the workgroup invited Captain Emily of District 9 from the Substance Abuse Mental Health Services Administration (SAMHSA) to present on SAMHSA's efforts during the General Session meeting in June 2023.

Vandana Pant provided an update on the Children and Youth Workgroup June 2023 Meeting. The workgroup identified 3 key goals: 1) identify youth working in policy and advocacy organizations throughout California to recruit youth into the workgroup 2) create awareness and knowledge for the workgroup around community programs and interventions being launched by organizations in California and 3) support advocacy and legislation on specific issues important to youth in order and propose these topics to the Legislation Committee. For the October 2023 meeting, the Children and Youth Workgroup will invite a representative from Allcove, a program by Stanford University, to present on a mental health community space for children and youth. The workgroup will also invite a representative from a Sutter Health Program, Scout, which is a digital platform focused on upstream prevention and resilience-building.

Uma Zykofsky provided an update on the Reducing Disparities Workgroup (RDW). Prior meetings focused on narrowing down priorities for the workgroup to focus on. The workgroup would like to embed reducing disparities in the work of all the CBHPC committees and are currently working on developing a series of questions for all presenters to answer when addressing the Council.

Action/Resolution
The workgroup representatives will report the activities of the CBHPC workgroups at subsequent SMC meetings.

Responsible for Action-Due Date
Karen Baylor, Uma Zykofsky, Javier Moreno, Vandana Pant - Ongoing

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Item #3 Overview of CalAIM Payment Reform

Jacob Lam, Assistant Deputy Director of Health Care Financing, California Department of Health Care Services (DHCS), provided an overview of CalAIM payment reform which will begin on July 1, 2023. Jacob reviewed three transitions that will occur in the process of implementing payment reform:

1) Cost-based reimbursement will end and fee-for-service payments will begin in order to simplify payments and reduce administrative burden for counties.
    - Health plans will negotiate payment terms and rates with subcontracted providers. Health plan reimbursement for each service is final.
2) The financing mechanism for Medi-Cal county behavioral health plan payments will shift from Certified Public Expenditures (CPE) to Intergovernmental Transfers (IGT).
    - Reimbursement will be claimed via the fee schedule with the county share transferred from the county to the state.
3) Current Procedural Terminology (CPT) billing will be used in place of HCSPCS II billing codes. This change aims to improve data reporting, support data-driven decision making, increase alignment with other health care systems, and comply

with Centers for Medicare and Medicaid Services (CMS) requirements to adopt CPT codes for all Medicaid programs where appropriate.

- CPT codes are more detailed with nationally standardized definitions for each code.
- Certain HCPCS II codes will be retained for behavioral health providers and services not captured by CPT codes.

DHCS established Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Drug Medi-Cal fee schedules by service type and rates are county-specific and updated annually. DHCS has released coding guidance and updated billing manuals in Behavioral Health Information Notice 22-046 and contracted with the California Mental Health Services Authority (CalMHSA) to offer training and technical assistance materials.

Jacob Lam indicated that provider contracts and reimbursement will continue to be negotiated with counties, as the fee schedules will be for behavioral health plan reimbursement rather than provider reimbursement. Counties will also continue to rely on the same sources of non-federal share, and the coding transition does not change the benefit definitions or covered services. Next steps include providing technical assistance to counties with the County Behavioral Health Directors Association (CBHDA) and CalMHSA, monitoring impacts to counties, providers, and Medi-Cal members, and using learnings to inform potential rate adjustments and next phases.

Q & A:
Karen Baylor asked if there has been analysis for the impact on the county level to ensure counties are not losing money in the new payment process. Jacob worked with CalMHSA to develop a financial modeling tool for counties to use to view the fiscal impact based on their specific rates and levels of utilization. DHCS has not seen a significant increase or decrease level of reimbursement that counties will be receiving.

Deborah Pitts stated that the American Occupational Therapy Association, Speech Therapy Association, and Physical Therapy Association have negotiated with the American Medical Association (AMA) for a specific set of rehabilitation codes which allows for billing across service sectors. She stated that these codes do not show up in the CPT codes, yet Occupational Therapists (OTs) can provide mental health services. She indicated that OTs are listed as “other” rather than core mental health and behavioral health providers and asked if DHCS is open to expanding the CPT code options. Jacob stated that CPT codes will be updated by DHCS as they are updated at the national level and he will discuss this item with DHCS’ behavioral health policy team.

Uma Zykofsky asked if counties determine the amount for Intergovernmental Transfers locally at a fixed point or if it is variable. Jacob stated that DHCS worked with counties to model the average number of claims paid monthly per county and the associated county share of those claims to provide counties with an estimate of how much IGT they will need to send the state monthly in order for the state to pay those claims to the counties. In terms of the volatility of Realignment and Mental Health Services Act (MHSA) revenues, counties will have to address fluctuations and shortfalls on a county-

by-county basis as they do now. Counties will have flexibility on when and how much IGT they send to the state but must send those funds to the state to receive payments.

Javier Moreno asked if there is a contingency plan in place to ensure that counties and providers do not experience cash flow issues with denials of payments during the first quarter or year of implementation to account for the learning curve needed to implement payment reform. Jacob stated that DHCS proposed $375 million of State General Fund to pre-fund the activities during the first quarter to ensure dollars are available for counties and providers to submit claims to the state. This proposed funding is currently being negotiated in the state budget process. Counties also have one year to submit claims to receive reimbursement, and counties are currently in the user testing process in the state which will be maintained through Fall 2023 to address any issues prior to entering the billing system that may deny or require claim adjustments.

Steve Leoni stated that the Mental Health Services Act (MHSA) has a different philosophy than Medi-Cal and there is tension between billing for Medi-Cal services and using the MHSA model. He asked if payment reform will help or hinder using concepts of MHSA and billing Medi-Cal. Jacob Lam stated that payment reform will have more detail on the services provided for Medi-Cal. MHSA reporting requirements would not change under payment reform but would rather have more granularity on the services the dollars were used for and would still need to be reported to the state.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #4 Public Comment

Azahar Lopez asked whether the cost settlement process will continue with counties which is eight years behind. She inquired if DHCS anticipates that it will take eight more years to settle costs for counties or if the process will be expedited. Jacob Lam indicated that DHCS is working with counties to settle costs a few years at a time on an annual basis to move through the settlements more quickly.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #5 Statewide & County Impact of CalAIM Payment Reform

Michelle Doty Cabrera, Executive Director for the County Behavioral Health Directors Association (CBHDA), presented on the statewide and county impact of CalAIM payment reform. She first reviewed the problems with the existing reimbursement methodology of Certified Public Expenditures (CPEs) to pay the non-federal share of Medi-Cal and then discussed the various impacts of the initiative.

Statewide and county impacts of payment reform include the transfer of $7 billion worth of specialty behavioral health services to a new financing and reimbursement methodology. The hope for payment reform is to allow more tracking of services delivered across systems. There are cashflow concerns of CPE to fee-for-service (FFS) under Intergovernmental Transfers (IGTs) which has exacerbated gaps in funding due to the deferment of taxes from April to October. Additionally, the timeline for payment reform is aggressive which poses challenges for implementation such as the inability for counties to model rates in their systems and make determinations on how to do individual rate setting at the provider level. This has caused an inability to provide timely information to providers which poses provider uncertainty and inability to plan. Current Procedural Terminology (CPT) codes are new which requires time for staff to adjust to and the timing with the pandemic has an impact on rate development and staff fatigue.

Additional local impacts include lack of clarity on what plans will receive for services versus what providers will receive and rates will need to reflect different service delivery models to consider impact of payment reform on field and home-based services. Also, there will no longer be guaranteed payment for providers regardless of whether services are rendered in the transition to cost-based to FFS so the shift in productivity must reflect more time and quality on client care.

County impacts include a shift in financing mechanism to IGTs which does not allow for matching federal dollars and the IGT Agreement is still not finalized and public but other federal rules do apply which will require education to counties. Counties have different approaches to rate negotiations with providers. CBHDA encouraged their members to look at funding inadequacy issues after the initial implementation. Counties also must determine what can be adjusted via business practices versus rate adjustments. Additionally, there is a large shift in technology via Electronic Health Records (EHRs).

Michelle shared that payment reform aims for administrative simplification and may act as a stepping stone to capitation and options for value-based payments to behavioral health plans and providers, as well as a move to a payment structure that allows for reinvestment into the system. The long-term vision is capitated payments to behavioral health plans to maximize delivery system flexibilities, explore options for alternative payment models for providers, expand value-based payment arrangements to incentivize desired outcomes, and increase services and improve quality of care.

Action/Resolution
N/A

Responsible for Action-Due Date
N/A

Item #6 County Perspective of CalAIM Payment Reform

Veronica Kelley, Behavioral Health Director, Azahar Lopez, Interim Director of Quality Management Services, and Anthony Le, Fiscal Manager, for Orange County Health Care Agency's Mental Health and Recovery Services presented on the implications of CalAIM payment reform at the county level. Anthony Le stated that the biggest impact as a Fiscal Manager is the change in reimbursement structure as it will decrease the administrative work, however, there is risk in a fee-for-service model which may cause discrepancies on what providers are paid throughout the county. Anthony stated that the Intergovernmental Transfer (IGT) process may pose some cash flow issues.

The presenters discussed factors impacting payment reform. DHCS received input from the counties to get an accurate idea of cost but the backlog of cost settlements poses concerns and risks at the county level because the rates they receive may or may not be adequate. Problems with documentation standards may result in ineligible claims as there is no clear definition of fraud, waste, and abuse from the state. The state does not want cost settlement at the end of the year and many county contracts are contracted at actual cost which is a significant change, but the county is communicating with providers to convey that the rate that providers receive is different than the health plan rate. Due to the lag in cost report settlements, counties may owe or be owed funds by the state for the past eight years which is a barrier to establish provider rates. Medi-Cal cost reports are no longer needed for Fiscal Year 2022-23 but counties must still send this data to the state. Orange County sent a memo to providers to outline the process and agreed to continue under the same terms of provider contracts for an additional year to help evaluate costs and set more accurate reimbursement rates.

Azahar Lopez highlighted and reviewed the payment reform timeline. The Quality Management Services team identified the Current Procedural Terminology (CPT) codes that will be needed in March 2023 with communications to providers in April 2023, and provider training on the CPT coding and documentation in May and June 2023. In June, contract services worked with providers to amend contracts to incorporate CalAIM terms and agreement to continue the current reimbursement structure for Fiscal Year 2023-24. The transition in billing codes occurs in July 2023 with an Electronic Health Record (EHR) update by October 2023.

For the first three months of implementation, Orange County will not have the EHR ready to accept claims to submit to DHCS with potential cash flow issues. Claims will need to be held until the system is ready, and there will likely be a high volume of billing and processing work once the system is ready to accept the claims. The counties must also consider the provider learning curve for CPT codes and documentation standards.

The committee engaged in a Q & A session with the presenters around topics of disallowances and fraud, waste, and abuse, Medi-Cal eligibility processes, documentation standards guides being county-specific to their systems, provider contracts staying cost-based for 2023-24, and concerns around provider travel time.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #7 Public Comment

John Drebinger thanked Orange County for their comments around providers on behalf of the California Council of Community Behavioral Health Agencies (CBHA). He agreed that it can be difficult for providers to assess costs associated with services as they focus on delivering services above all else and stated that CBHA members have the right to work with counties to continue navigating rate change.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #8 Provider Perspective of CalAIM Payment Reform

John Drebinger, Senior Advocate of Policy and Legislative Affairs for the California Council of Community Behavioral Health Agencies (CBHA), and Tim Ryder, President and CEO of the San Fernando Valley Community Mental Health Center, presented the provider perspective of CalAIM payment reform. Tim shared that providers are working with county partners to ensure readiness. Tim shared challenges including the tight timeline for implementation as well as the delays in getting rates and Current Procedural Terminology (CPT) codes to providers. These delays trickle down to electronic health record staff to ensure that providers can bill for services. Additionally, travel time is important for SMI/SUD populations who need in-person services, but the rates were in a way that disincentives travel.

LA County recently came out with contracts for payment reform based on amendments for the elimination of cost reimbursement and cost reports. This leaves more risk to providers but there is no floor for cost reimbursement which makes cash flow important. Tim shared that LA County is open to conversations about contract revisions in the future and is willing to look at contingencies of cash flow advances if billing is delayed.

Documentation reform is a parallel to payment reform. LA County worked on simplifying documentation by releasing templates and reducing administrative burden by 40-60%. Tim stated that it would help to have a minimum standard for all counties for documentation to help agencies that struggle going in-between counties that have different documentation requirements.

John Drebinger shared legislative opportunities around payment reform to make it easier for non-profits to contract with the state on things like advanced and timely payments. CBHA is co-sponsoring one of those six bills. Additionally, AB 1470 is a bill aiming to streamline and standardize documentation for providers in the state. The SMC engaged CBHA in a Q & A session upon conclusion of the presentation. Q & A topics included the use of collaborative documentation and AB 1470.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #9 Behavioral Health Policy Updates, Discussion, & Planning

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Ashneek Nanua, SMC staff, provided an update on the Governor's May Budget Revision for 2023-24 as well as policy updates discussed during the CalAIM Behavioral Health Workgroup, Behavioral Health Stakeholder Advisory Committee (BH-SAC), and CalHHS Behavioral Health Taskforce meetings. Staff provided updates on the BH-CONNECT Waiver and CalAIM documentation redesign policy which will be released for public comment in Summer 2023. Staff engaged in Q & A with the SMC.

Action/Resolution
Staff will continue tracking behavioral health initiatives and policies to update the SMC.

Responsible for Action-Due Date
Ashneek Nanua – October 2023

Item #10 Wrap Up/Next Steps

The committee will review and update the SMC Work Plan and monitor ongoing behavioral health activities during the October 2023 Quarterly Meeting. The SMC will hold an interim meeting to respond to the BH-CONNECT Waiver application prior to the October 2023 meeting.

Action/Resolution
The SMC Officers and staff will plan the October 2023 Quarterly Meeting agenda and interim meeting to create recommendations for the BH-CONNECT waiver.

Responsible for Action-Due Date
Ashneek Nanua, Karen Baylor, Uma Zykofsky - October 2023

Meeting Adjourned at 12:00 p.m.

Systems and Medicaid Committee

Meeting Minutes (DRAFT)
Interim Meeting – August 22, 2023

Members Present:

Karen Baylor, Chairperson	Uma Zykofsky, Chair-Elect	Walter Shwe
Vandana Pant	Steve Leoni	Susan Wilson
Javier Moreno	Noel O'Neill	Erin Franco

Staff Present:
Ashneek Nanua, Naomi Ramirez

Meeting Commenced at 3:00 p.m.

Item #1 High-Level Overview of BH-CONNECT 1115 Demonstration Waiver

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Systems and Medicaid Committee (SMC) staff provided a high-level overview of the California Behavioral Health Community-Based Networks of Equitable Care and Treatment (BH-CONNECT) 1115 Demonstration Waiver Application. The Department of Health Care Services (DHCS) initiated a public comment period for stakeholders to provide feedback on the waiver application prior to submitting the application to the Centers for Medicare and Medicaid Services (CMS). The waiver application was built upon the California Behavioral Health Community-Based Continuum (CalBH-CBC) concept paper. The SMC wrote a letter of recommendations to DHCS regarding the concept paper in January 2023. In the overview presentation, SMC staff reviewed the BH-CONNECT demonstration goals, key components, waiver authority, requested expenditures, preliminary evaluation plan, implementation timeline, and next steps.

Action/Resolution
N/A

Responsible for Action-Due Date
N/A

Item #2 Create Recommendations for BH-CONNECT 1115 Demonstration Waiver

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Committee members provided feedback on the BH-CONNECT 1115 Demonstration Waiver Application. The SMC's key comments are provided below:

- Ensure a robust continuum of community-based care to reduce institutionalization and the need for Institutes for Mental Disease (IMD).
- Include the concept of recovery in workforce training similar to the recovery provision in the Mental Health Services Act (MHSA).
- Request clarification on why residential treatment and inpatient treatment are in the same box in Figure 1 on Page 12 of the demonstration application as these are distinct services.
- Seek clarity on how the Centers of Excellence (COE) will operate and how organizations will be determined as a COE. SMC members recommend that technical assistance provided to implement the evidence-based practices (EBPs) would be a statewide effort or the ability for counties to enable regional models as many small, rural counties may not have the resources to participate in the county opt-in community-based EBP services.
- Seek clarification on whether the definition for the COEs is based on a federal definition or state definition. There are also questions on whether there is a sustainability plan for the COEs to operate on a continuous basis.
- Expand workforce funding as it should not be limited to specific groups or direct providers because there are many workforce shortages that exist outside of providers such as administrative staff and Executive Directors. Workforce dollars should be open to anyone who needs them.
- Encourage the state to engage in meaningful stakeholder meetings.
- If the HUD definition for homelessness is a federal definition, recommend that the state have a state definition for more flexibility as the federal definition often leaves out a large group of people.
- Seek clarification on what happens if an individual resides in an IMD past the 60-day Federal Financial Participation (FFP) reimbursement period.
- Ask the state to set aside dollars to invest in people who have been historically marginalized and people of color to give them opportunities to open programs in their communities as they are the best individuals to understand their community's needs. This would be favorable compared to setting up current funding sources that make it difficult for the average person to tap into dollars.
- Seek clarity on the utilization of Assertive Community Treatment (ACT) versus Full Service Partnerships. Committee members noted that the choice of the EBP used in the demonstration along with its fidelity is tied to issues around the workforce shortage.

Action/Resolution
The SMC Officers and staff will assemble and finalize the committee's recommendations for the BH-CONNECT 1115 Demonstration Waiver Application.

Responsible for Action-Due Date
Ashneek Nanua, Karen Baylor, Uma Zykofsky – August 2023

Meeting Adjourned at 3:45 p.m.

TAB 2

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 19, 2023

Agenda Item: Review and Update SMC Work Plan & Discussion of CBHPC Year-End Report

Enclosures: SMC 2022-2023 Work Plan
SMC Activities 2022-2023

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

The Work Plan is an instrument to guide and monitor System and Medicaid Committee activities in its efforts to uphold its duties within the framework of the Planning Council.

Background/Description:

The purpose of the Work Plan is to establish the objectives and goals of the SMC, as well as to map out the necessary tasks to accomplish those goals. The SMC will review activities and accomplishments of the 2022-2023 SMC Work Plan. Committee members will then update the Work Plan for 2024. Committee members will also determine which accomplishments during the 2023 calendar year they would like to see highlighted in the CBHPC Year-End Report.

The Systems and Medicaid Committee have reviewed, addressed, and/or provided recommendations on the topics listed below per the SMC 2022-2023 Work Plan.

January 2022

Overview of CalAIM Changes for the Criteria to Access Specialty Mental Health Services (SMHS)

County Perspective of Criteria to Access SMHS (Orange County, San Joaquin County, San Diego County, CA Primary Care Association)

Overview of Medi-Cal Peer Support Specialist Benefit

Recommendations on Behavioral Health Information Notice (BHIN): Documentation Requirements for all SMHS, Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Providers

Recommendation Letter for BHIN: No Wrong Door Policy

March 2022

Recommendation Letter for DHCS Telehealth Policy Proposal

April 2022

County Perspectives on CalAIM Implementation (Santa Clara County, CBHDA)

Overview of Enhanced Care Management (ECM) and Community Supports

Local Perspectives on ECM and Community Supports (Local Health Plans of CA, CBHDA)

Planning of CalAIM Presentation for General Session

Recommendations on BHIN: Guidance Regarding the Submission of an Opt-In Letter and Claiming Requirements for Peer Support Services in the DMC, DMC-ODS, and SMHS Programs

May 2022

Recommendations on BHIN: Expand and Clarify Network Adequacy Certification Submission Requirements for County MHP and DMC-ODS Plans

Recommendations on Youth Medi-Cal Mental Health Screening Tool

Recommendations on Youth Medi-Cal Serviced Referral or Transition of Care Request Instructions

June 2022

Presentation on 988 Suicide Prevention Hotline and Crisis Continuum (CBHDA)

Local Perspectives on ECM and Community Supports Implementation (Loma Linda University, San Bernardino County, Riverside University Health System)

September 2022

Recommendations on BHIN: Obligations to Indian Health Care Providers in Drug Medi-Cal Organized Delivery System (DMC-ODS) Counties

October 2022

Presentation on Sacramento County Implementation of 988 Suicide Prevention and Crisis Hotline and Crisis Care Continuum (Sacramento County, WellSpace Health)

Presentation on Providing Access and Transforming Health (PATH) Supports

November 2022

Recommendations on BHIN: Medi-Cal Mobile Crisis Services Benefit Implementation

Recommendations on Adult Screening Tool for Medi-Cal Mental Health Services

Recommendations on BHIN: Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services

December 2022

Recommendations for California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration Concept Paper (now entitled BH-CONNECT)

Recommendations on BHIN: Guidance to Counties and Providers on STRTP Placement and Institutes for Mental Disease (IMD) Transitions

Recommendations on BHIN: Parity Requirements for Drug Medi-Cal State Plan Counties

Recommendations for BHIN: Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal

January 2023

Presentation on Institutes for Mental Disease (IMD)

Presentation and Discussion on Local Impacts of SMI/SED IMD Waiver

Presentation on Behavioral Health Continuum Infrastructure Program (BHCIP) Presentation

Recommendation Letter for California Community-Based Continuum (CalBH-CBC) Concept Paper

February 2023

Recommendation Letter for CalAIM Behavioral Health Administrative Integration Concept Paper

March 2023

Recommendations on BHIN: Elimination of Cost Reporting Requirements for Counties and Providers (SMHS, DMC-ODS, and DMC)

April 2023

Overview of DHCS Children and Youth Programs/Initiatives and Short-Term Residential Treatment Programs (STRTPs)

Overview of Children and Youth Behavioral Health Initiative (CYBHI) and CYBHI Progress Reports

Presentation on STRTPs (CA Alliance of Child and Family Services)

Local Implications of School-Based Behavioral Health Services for Children and Youth (CBHDA)

Provider Perspective of Children and Youth Initiatives (CBHA)

May 2023

Recommendations for BHIN: Obligations Related to Indian Health Care Providers for Drug Medi-Cal (DMC) Counties

June 2023

Presentation on Statewide and County Impact of CalAIM Payment Reform (CBHDA)

County Perspective of CalAIM Payment Reform (Orange County)

Provider Perspective of CalAIM Payment Reform (CBHA)

July 2023

Recommendations for Memorandum of Understanding (MOU) Template between Medi-Cal Managed Care Plans (MCPs) and County Mental Health Plans (MHPs)

Recommendations for Memorandum of Understanding (MOU) Template between Medi-Cal Managed Care Plans (MCPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS)

August 2023

Recommendation Letter for California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) 1115 Waiver Application

October 2023 (anticipated)

Recommendations for BHIN: Updates to Documentation Redesign Requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Programs

Presentation on CalAIM Documentation Redesign Initiative

Presentation on Physical and Digital Behavioral Health Platforms for Children and Youth

TAB 3

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 19, 2023

Agenda Item: Overview of CalAIM Documentation Redesign Initiative

Enclosures: DHCS Behavioral Health Documentation Redesign Presentation
Behavioral Health Information Notice (BHIN) 22-019

Additional Resources:
CalAIM Documentation Frequently Asked Questions
CalAIM Behavioral Health Webpage

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to provide the SMC with an overview of the CalAIM documentation redesign initiative. Committee members will utilize this information to evaluate system changes for populations utilizing the Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Drug Medi-Cal (DMC) systems.

Background/Description:
As of July 1, 2022, the Department of Health Care Services (DHCS) streamlined behavioral health documentation requirements for Substance Use Disorders (SUD) and SMHS to align more closely with national standards. DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, except for the continued requirements specifically noted in Attachment 1 of BHIN 22-019. The new behavioral health documentation requirements include the use of an active and ongoing problem list with progress notes reflecting the care given, aligning with the appropriate billing codes.

Alexandria Simpson from the Medi-Cal Behavioral Health Division will provide the SMC with an overview of the CalAIM documentation redesign initiative and how these changes impact County Mental Health Plans, DMC, and DMC-ODS counties. Committee members will have an opportunity to engage DHCS in a question-and-answer session upon conclusion of the presentation.

California Behavioral Health Planning Council Documentation Redesign Updates

October 19, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Welcome and Introduction

- **Alexandria Simpson**, Chief, Program Implementation Section, Legislation and Regulations Branch, Medi-Cal Behavioral Health – Policy Division

Meeting Overview

- Documentation Redesign Background
- Documentation Redesign Updates
- Next Steps: FAQs and Technical Assistance
- Questions and Answers

Documentation Redesign Background

DHCS

CalAIM Vision and Goals

- California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year Department of Health Care Services (DHCS) initiative to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across Medi-Cal.
- Goals of CalAIM Behavioral Health initiatives:

Support whole-person, integrated care	Reduce complexity and increase flexibility to make Medi-Cal behavioral health administration more consistent and seamless	Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation

Background: Documentation Redesign

Background

- Previous documentation requirements varied by service and were burdensome for plans and providers, taking them away from member care.
- A lack of consistency existed across counties/plans, which frustrated providers and sometimes led to duplicative documentation.
- New guidance streamlines and simplifies documentation requirements across mental health and Substance Use Disorder Medi-Cal services.

Statewide implementation of the initiative began on July 1, 2022, and updated guidance will be published in Fall 2023.

Guidance

- DHCS released BHIN 22-019 in 2022
- Forthcoming guidance will supersede (replace) this BHIN, and update documentation requirements for SMHS, DMC services, and DMC-ODS.
- Final guidance will update requirements for:
  - Standardized Assessments;
  - SMHS Assessment Domains;
  - SMHS, DMC, and DMC-ODS Problem Lists;
  - SMHS, DMC and DMC-ODS Progress Notes; and
  - Treatment and Care Planning Requirements;

Documentation Redesign: Key Components

Old Requirements	New Requirements
Static treatment plan	Dynamic problem list
Guidelines for assessment content	Domain-driven assessments
Complex & lengthy narrative notes	Lean and functional notes
Disallowances for variances in documentation	Disallowances for fraud, waste, & abuse: CAPs for variations in quality

Documentation Redesign Updates

DHCS

Forthcoming Documentation Redesign Updates

Policy Updates

Clarify applicability. Does not apply to:

Inpatient settings; Narcotic Treatment Programs

Clarify treatment planning requirements

Identify a single standard for compliance with treatment planning requirements that remain in state and federal law.

Progress notes clean-up

Remove references to ICD-10 and CPT codes, and travel and documentation time. Other revisions, pending stakeholder input.

Align assessment timeframes

Eliminate 30/60 day timeframes for completion of Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS) assessments. Align with Specialty Mental Health (SMH): Complete according to clinical standards of practice.

An updated Documentation Redesign BHIN will be released in Fall 2023 and will go into effect on January 1, 2024.

Policy Topic: Treatment Plan

GOAL: Remove standalone treatment planning requirements to simplify and streamline provider documentation.

SOLUTION:
Treatment planning requirements (from state and federal law) documented flexibly in the clinical record, and shared as needed.

TCM and SABG Treatment Plans

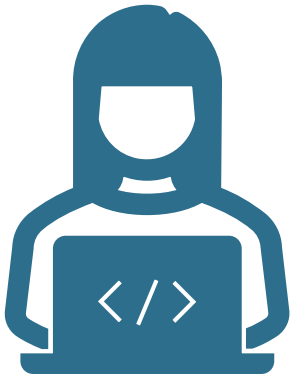
- CMS approved the TCM waiver to clarify that "standalone" care plans are not required for TCM and ICC.
  - Services must be documented consistent with 22 C.C.R. § 51351 and 42 CFR § 440.169(d)(2).
  - The approved 1915(b) waiver can be found on the DHCS 1915(b) Waiver website.
- SAMHSA confirmed that a standalone treatment plan is not required for SABG funded services.
  - Services must be documented consistent with 45 CFR § 96.136(d)(6).

Policy Topic: Assessment Timelines

GOAL: Align Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) assessment timelines with Specialty Mental Health Services.

SOLUTION:

For all Medi-Cal behavioral health delivery systems, to ensure that beneficiaries receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible and in accordance with generally accepted standards of practice.



FAQs and Technical Assistance

DHCS

FAQ Round 1 Topics

FAQ Round 2 topics are in development!

Documentation requirements for crisis intervention services	Problem list vs billing diagnosis	Adding a diagnosis outside the scope of practice
Progress note timeframes	Progress note requirements for bundled services	Progress note requirements for group services
Group participant lists	Treatment plans for SABG-funded programs	NTP exemption
Youth Treatment Guidelines	Perinatal Practice Guidelines	Medication consents

Technical Assistance

- Following the release of the update to BHIN 22-019, DHCS will hold a series of webinars to assist with implementation.
- Documentation trainings on current policies are available on the CalMHSA website.
- Additional information on county and/or provider Technical Assistance (TA) is forthcoming.

Technical Assistance

Based on stakeholder feedback, specific topics that may be addressed via webinar include:

- Assessments
- Auditing
- Crisis Residential Treatment Facilities
- Problem Lists
- Progress Notes
- Treatment Planning
- Z Codes

Questions and Answers

DHCS

Contact Information

- If you have questions, please email DHCS at BHCalAIM@dhcs.ca.gov Subject Line “CBHPC – October 19”

Thank you!

DHCS

TAB 4

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 19, 2023

Agenda Item: Overview of Physical and Digital Behavioral Health Platforms for Children and Youth

Enclosures: Scout by Sutter Health Presentation
Allcove by Stanford Presentation

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to provide the SMC with an overview of physical and digital platforms for children and youth. Committee members will utilize this information to evaluate how to improve access and build a robust care continuum for children with serious emotional disturbances (SED).

Background/Description:
Jill Huckels, Manager of Sutter Health Design & Innovation, and Karan Malhotra, Project Coordinator of Sutter Health Design & Innovation will provide an overview of the Scout Program, a digital behavioral health platform for children and youth. Steven Adelsheim, Director of Stanford Center for Youth Mental Health and Wellbeing, will present to the SMC on the Allcove Program, a physical behavioral health platform for children and youth. Committee members will compare and contrast the digital and physical platforms, payment mechanisms, and other key criteria to build their knowledge base and advocacy efforts for a robust care system to support children with SED.

Presenter Biographies

Steven Adelsheim, MD, Clinical Professor & Associate Chair for Community Engagement, Stanford Department of Psychiatry

Steven Adelsheim, MD, is a Clinical Professor & Associate Chair for Community Engagement at Stanford's Department of Psychiatry, directing the Center for Youth Mental Health and Wellbeing. Steve's work is focused on early detection/intervention programs for young people and he leads the effort to bring allcove to the US, an integrated youth mental health model, which opened in June 2021 in Palo Alto and San Jose, CA, and LA County in November 0f 2022. with plans to open in other California sites over the few years. Dr. Adelsheim also co-leads PEPPNET, the national clinical network for early psychosis programs. Steve also co-directs the Media and Mental Health Initiative in Stanford's Psychiatry Department. Dr. Adelsheim has partnered for many years with Native American and tribal partners on expanding early intervention mental health supports for tribal youth. Steve previously spent many years leading school mental health efforts for the State of New Mexico and served as New Mexico's state Psychiatric Medical Director. Dr. Adelsheim is committed to developing the national public mental health early intervention continuum for young people, from school mental health to allcove community integrated youth mental health programs to early psychosis programs.

Jill Huckels, Manager, Sutter Health Design & Innovation

Jill Huckels is a Manager on Sutter Health's Design & Innovation Team. In her role, she leads the product development of Scout by Sutter Health, overseeing the collaborations between development, design, analytics teams and the clinical and youth advisories. Prior to joining Sutter Health, Jill graduated from Stanford University with a degree in Human Biology and a master's degree in Healthcare Management Science & Engineering.

Karan Malhotra, Project Coordinator, Sutter Health Design & Innovation

Karan Malhotra is a Project Coordinator on Sutter Health's Design & Innovation Team. He primarily supports business growth and customer acquisition for the Scout by Sutter Health product. Karan earned his B.S. in Economics at San José State University in 2022.

TAB 5

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 19, 2023

Agenda Item: CBHPC Workgroups Update

Enclosures: None

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the opportunity for the Systems and Medicaid Committee to coordinate the activities of the CBHPC workgroups in accordance with the SMC Work Plan.

Background/Description:

CBHPC's Executive Committee would like to ensure the Planning Council's workgroups are integrated into the work of all committees. Committee members who attended each workgroup will report on discussions held during each workgroup meeting to identify any points of collaboration with SMC activities and Work Plan items.

CBHPC workgroups:

- **Reducing Disparities Workgroup**
  - Representative: Uma Zykofsky
- **Children and Youth Workgroup**
  - Representative(s): Vandana Pant / Noel O'Neill
- **Substance Use Disorder Workgroup**
  - Representative(s): Javier Moreno / Karen Baylor

TAB 6

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 19, 2023

Agenda Item: Behavioral Health Policy Updates

Enclosures: Behavioral Health Policy Updates Presentation PowerPoint
SMC Recommendation Letter Re: BH-CONNECT 1115 Demonstration Waiver Application
SMC Responses to Memorandum of Understanding (MOU) Template Between Managed Care Plans (MCPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS)
SMC Responses to Memorandum of Understanding (MOU) Template Between MCPs and County Mental Health Plans (MHPs)

Additional Resources:
BH-SAC July 2023 and August 2023 Presentation Slides
CalAIM Behavioral Health Workgroup Presentation Slides
Children and Youth Behavioral Health Initiative September 2023 Update
MHSOAC Update on Governor Newsom's Modernization Proposal (September 2023) Presentation Slides
ECM & Community Supports Year One Report: Executive Summary
Year One Report: Enhanced Care Management Summary
Year One Report: Community Supports Summary
Enhanced Care Management/Community Supports: A Policy "Cheat Sheet"

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides committee members with information about the activities of advocates and stakeholders involved in developing behavioral health policies for California's most vulnerable populations. The SMC will use this information to stay informed of current initiatives and plan future activities to advocate for policies that improve access to high-quality health care in California's public behavioral health system (PBHS).

Background/Description:

Systems and Medicaid Committee staff will provide a high-level update on current activities, initiatives, and efforts towards transforming the public behavioral health system in California to better serve individuals with behavioral health conditions. Additionally, staff will review policy guidance and initiatives that the committee provided recommendations for since June 2023.

Committee members will use this information for the ongoing effort to track various behavioral health policy meetings, engage in advocacy and make recommendations to the state for Medi-Cal beneficiaries with serious mental illness and substance use disorders. SMC staff will provide updates on the following behavioral health policy meetings and topics:

- DHCS Behavioral Health Stakeholder Advisory Committee (BH-SAC) July 2023 and August 2023 Meetings
- CalAIM Behavioral Health Workgroup August 2023 Meeting
- CalHHS Behavioral Health Taskforce October 2023 Meeting
- Children and Youth Behavioral Health Initiative (CYBHI) September 2023 Update

Behavioral Health Policy Updates

Ashneek Nanua, Systems and Medicaid Committee Analyst

Behavioral Health Meetings and Webinars Attended Since June 2023 Quarterly Meeting

- DHCS Behavioral Health Stakeholder Advisory Committee (BH-SAC) July 2023 and August 2023 Meetings
- CalAIM Behavioral Health Workgroup August 2023 Meeting
- Enhanced Care Management & Community Supports Update (2022 Implementation Report)
- Children and Youth Behavioral Health Initiative (CYBHI) September 2023 Monthly Public Webinar
- CalHHS Behavioral Health Taskforce October 2023 Meeting
  (updated PowerPoint slides will distributed at a later date)

DHCS Behavioral Health Stakeholder Advisory Committee (BH-SAC) July 2023 Meeting Updates

- Approved DHCS Budget
- Justice-Involved Waiver
- Behavioral Health Modernization
- Contingency Management
- Behavioral Health Bridge Housing
- Behavioral Health Continuum Infrastructure Program (BHCIP)
- Documentation Redesign

Approved DHCS Budget

- Signed Budget Act includes $156.6 billion ($38.3 State General Fund) for DHCS programs
  - $6.1 billion for BH-CONNECT (1115 Waiver)
    - $2.4 billion ($480 million a year for 5 years) to strengthen pipeline of behavioral health professionals including recruitment and retention
  - $250 million to cover non-federal share of behavioral health services at the start of CalAIM Payment Reform
  - $67.3 million in FY 2023-24 and $151 million ongoing for CARE Act

Justice-Involved Waiver and PATH Funds

Justice Involved Waiver:

- The draft guidance for the Medi-Cal Justice-Involved Reentry Initiative is intended to lay out the policy, design and operational processes that will serve as the foundation to implementing the Initiative.
- DHCS will finalize draft guidance in Summer 2023
- Will be updated on an ongoing basis

Providing Access and Transforming Health (PATH) funding:

- Approved CalAIM 1915(b) Waiver has $410 million available for PATH Justice-Involved Capacity-Building Program to support collaborative planning and IT investments (for 90 days pre-release)
- Round 3 funding was released to support correctional entities with personnel, capacity, and IT system adjustments for pre-release services and behavioral health linkages

Behavioral Health Modernization Updates

The updated proposal is reflected in SB 326 (Eggman) –Behavioral Health Services Act (BHSA) Modernization and AB 531 (Irwin) –Behavioral Health Infrastructure Bond Act of 2023

- New funding bucket allocations:
  - 30% for housing interventions for individuals with SMI/SED and SUD
  - 35% for Full Service Partnerships
  - 35% for Behavioral Health Services and Supports
    - Prevention, Early Intervention, Outreach and Engagement, Workforce Education and Training, Capital Facilities and Technology, Innovation Pilots and Projects, Prudent Reserve
  - 10% New Statewide, state-lead investments
    - 4% of total funding for Prevention
    - 3% of total funding for Workforce
    - 3% of total funding for Statewide Oversight and Monitoring

Recovery Incentives Program (Contingency Management) Updates

- 24 DMC-ODS counties covering 88% of the Medi-Cal population are participating in the Recovery Incentives Program
  - Serving 188 members since June 29, 2023
  - 19 sites approved (Los Angeles, Kern, San Francisco, Fresno, and Riverside)
  - 47 sites in 10 additional counties have completed all training requirements and are working to complete the readiness assessment prior to receiving approval
- DHCS is initially financing the non-federal share of CM services with federal funds received for the DHCS Home and Community-Based Spending Plan. *DHCS must spend the additional federal funds by March 31, 2024.*
  - If counties elect to participate in CM services after the pilot period ends, the counties will be responsible for covering the non-federal share of services, administrative costs, and incentives associated with providing CM services.
- The Budget Act of 2023 includes approved funding for additional positions and support for training and technical assistance, evaluation, and the Incentive Manager vendor through December 2026.

Behavioral Health Bridge Housing Updates

- Focus is to help people experiencing homelessness who have SMI move out of homelessness through supportive services and housing navigation
- $1.5 billion funding for operational and supportive services not covered under Medi-Cal or other funding sources, through DHCS for county behavioral health agencies and tribal entities through June 30, 2027
- Initial round of funding includes $907.6 million to county behavioral health agencies to plan and implement bridge house settings
  - First 39 awards announced in June 2023, totaling $777 million, with remaining awards in process of finalization
  - Funding must be used by June 30, 2027
- $50 million available for tribal entities with applications due in September 2023 and award announcements beginning in November 2023
- The $500 million remaining of the $1.5 billion in funding will be released in competitive rounds of funding.

Behavioral Health Continuum Infrastructure Program (BHCIP) Updates

- $2.2 billion in funding through DHCS to construct, acquire, and expand properties and invest in mobile crisis infrastructure through June 30, 2027 through 6 rounds of funding grants
  - Round 1: Crisis Care Mobile Units (Appx. $163 million awarded)
  - Round 2: Planning Grants (Appx. $7 million awarded)
  - Round 3: Launch Ready ($518 million awarded)
  - Round 4: Children and Youth ($480.5 million awarded)
  - Round 5: Crisis and BH Continuum ($430 million awarded)
  - Round 6: Unmeet Needs (In development)
    - Divided into 2 parts totaling $480 million
    - RFA for Part I anticipated for release in January 2024 with award announcements in July 2024
    - RFA for Part II will follow same process as Part I in 2025

Documentation Redesign Updates

- Updated Guidance (Proposed):
  - Clarify that the policy is not applicable to inpatient settings or Narcotic Treatment Programs
  - Identify a single standard for compliance with treatment planning requirements that remain in state and federal law
    - Treatment planning requirements may be documented flexibly in the clinical record and plan information must be shared as needed to support care coordination
    - This will address confusion on how to document an array of requirements for treatment plans for different programs and services
  - Remove references to ICD-10 and CPT codes, and travel and documentation time in progress notes
  - Eliminate 30-60 day time frame to complete Drug Medi-Cal or DMC-ODS assessments and instead align requirements with Specialty Mental Health Services system
- DHCS will post the updated draft Behavioral Health Information Notice (BHIN 22-019) for stakeholder review in Summer 2023, post the finalized guidance in Fall 2023, and implement the guidance rules in January 2023.

CalAIM Behavioral Health Workgroup Meeting (August 2023)

- Recovery Incentives Program
- BH-CONNECT Waiver
- CalAIM Transitional Rent Services Amendment

BH-CONNECT Demonstration

- **Key Components**
  - Features for which DHCS is requesting Section 1115 demonstration expenditure and waiver authorities

    **activity stipends, incentive programs, FFP for short-term IMDs, etc.*
  - Features for which DHCS will pursue a State Plan Amendment (SPA)

    **county-opt in community-based services (ACT, FACT, CSC for FEP, IPS Supported Employment, CHW services, Clubhouses)*
  - Other features that will be implemented through state-level guidance using existing federal Medicaid authorities

    **Centers of Excellence, clarification of EBPs, foster care liaison, etc.*
- $6.98 billion requested expenditure authority
- Demonstration period: January 1, 2025 - December 31, 2029 with a phased-in approach
- Next Steps: DHCS will submit the waiver application to CMS in late 2023

CalAIM Transitional Rent Services Amendment

- Requesting expenditure authority of approximately $565.7 million
- Cover transitional rent for up to 6 months provided if determined medically appropriate
- Eligibility:
  - Meet access criteria for SMHS, DMC, and/or DMC-ODS services
  - Meet US Dept of Housing and Urban Development (HUD) definition of homeless or at risk of homelessness
  - Must be transitioning out of an institutional care or congregate residential setting, correctional facility, child welfare system, recuperative care facility or short-term post-hospitalization housing, transitional housing, homeless shelter, meet criteria for unsheltered homeless, or meet eligibility for a Full Service Partnership program

Enhanced Care Management (ECM) Update (2022 Implementation Report)

- ECM is a statewide MCP benefit that provides person-centered, community-based care management to the highest need members.
- The Department of Health Care Services (DHCS) and its MCP partners began implementing ECM in phases by Populations of Focus (POFs), with the first three POFs launching statewide in Calendar Year (CY) 2022.
  - 109,004 MCP members across California received ECM in CY 2022. That number increased by 40% from the end of Quarter 1 (Q1) to the end of Q4.
  - There were an estimated 1,158 contracts with providers of ECM in CY 2022. That number increased by 70% from the end of Q1 to the end of Q4.
  - 2022 POFs: Adults Experiencing Homelessness; Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization; Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs; Adults Transitioning from Incarceration (certain former Whole Person Care counties only)

Community Supports Update (2022 Implementation Report)

- Community Supports are services that address members' health-related social needs and help them avoid higher, costlier levels of care. Although it is optional for MCPs to offer these services, every Medi-Cal MCP offered Community Supports in 2022, and at least **two** Community Supports services were offered and available in every county by the end of the year.
  - **36,391** MCP members across California received **80,859** Community Supports services in CY 2022. The number of members served increased by **160%** from the end of Q1 to the end of Q4.
  - There were an estimated **1,563** contracts with providers of Community Supports in CY 2022. That number increased by **112%** from the end of Q1 to the end of Q4.
  - As of Q1 2023, **11** counties offered all **14** Community Supports and at least **6** Community Supports were available in each county.

ECM and Community Supports: Looking Ahead

- DHCS anticipates an acceleration of the ECM & CS work in 2023 and in subsequent years. The major levers of this acceleration will include:
  - **Expanding access to services** by launching ECM for additional POFs and increasing the number of available Community Supports services in each county across the state
  - **Refining program operations and policies** to eliminate barriers to provider contracting and service utilization
  - **Providing grant funding and technical assistance (TA)** to support providers to implement and expand capacity for ECM and Community Supports through Providing Access and Transforming Health (PATH)
  - **Incentivizing MCPs** to further increase utilization of ECM and Community Supports through the Incentive Payment Program (IPP)

Children and Youth Behavioral Health Initiative (CYBHI) September 2023 Update

DHCS Workstream:

- Statewide E-consult (January 2024)
  - DHCS is finalizing contract with UCSF who recently completed a process to identify a tech vendor to launch the service
  - DHCS and UCSF are finalizing the launch milestones and project roadmap
- Evidence-Based Practice (EBP)/Community Evidence Defined Practice (CDEP) Grants
  - Applications are open for Round 3 (Early Childhood Wraparound Services), Round 4 (Youth-Driven Programs – MHSOAC), and Round 5 (Early Intervention Programs/Practices – MHSOAC)
  - Round 6 grant applications (CDEPs) will be released in Fall/Winter 2023
- Mindfulness, Resilience, and Well-Being Grants
  - Memorandums of Understanding (MOUs) are being completed to begin distributing grant funds to County Offices of Education (COEs) to implement Social Emotional Learning (SEL) and mindfulness programs in schools

Information regarding all CYBHI workstreams may be found on the CYBHI Events Webpage under the Public Webinar held on September 14, 2023.

Children and Youth Behavioral Health Initiative (CYBHI) September 2023 Update

DHCS Workstream (Continued):

- Statewide Fee Schedule
  - 3 Phases/Cohorts: Early Adopters of Local Education Agencies (LEAs) with existing infrastructure (January 2024), Expansion to CA Community Colleges and additional LEAs (July 2024), and Rolling Opt-In for all LEAs and public higher education campuses (January 2025)
  - For Phase/Cohort 1, COEs completed a statement of interest indicating a set of LEAs that may be suitable as early adopters. LEAs who were approved must submit a completed application package for DHCS approval.
    - 30 COEs responded with a total of 129 LEAs
    - 26 counties serving 2 million of Tk-12 students served in public schools
- School-linked Grants ($550 million – 400M for TK12; 100M for higher education)
  - Statewide Lead for County Office of Education as Third Party Administrator (TPA) for TK-12 grants is Sacramento COE and Santa Clara COE
  - DHCS will release an RFI to get input for the TPA scope of work

ATTACHMENT 1: MEMORANDUM OF UNDERSTANDING TEMPLATE COVER PAGE

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*DMC-ODS*]

This Memorandum of Understanding ("MOU") is entered into by and between [*name of MCP*] ("MCP**"**) and [*name of party*], a *[description of other party]* ("DMC-ODS"), effective as of [*date*] ("Effective Date"). [*Where the MCP has a delegated Subcontractor arrangement and delegates part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), such Knox-Keene licensed health care service plan(s) shall be added as an express party to this MOU and named in the MOU as having the responsibilities set forth herein that are applicable to such Subcontractor.*] Each of MCP and relevant Subcontractor and DMC-ODS may be referred to herein as a "Party" and collectively as "Parties."

WHEREAS, the Parties are required to enter into this MOU, a binding and enforceable contractual agreement, under Medi-Cal Managed Care Contract ("Model Contract") Exhibit A, Attachment III, to enter into this MOU, All Plan Letter ("APL") 22-005 and subsequent revisions, and all other relevant California Department of Health Care Services ("DHCS") to ensure that Medi-Cal members enrolled, or eligible to enroll, in MCP are able to access and/or receive substance use disorder ("SUD") services in a coordinated manner from MCP and DMC-ODS (referred to herein as "Members"); and

WHEREAS, the Parties desire to ensure that Members receive SUD services in a coordinated manner and provide a process to continuously evaluate the quality of the services provided.

In consideration of mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the DHCS, unless otherwise defined herein.

2. **Term.** This MOU is in effect as of the Effective Date and continues for three (3) years or as amended in accordance with Section 14.f of this MOU.

3. **Services Covered by This MOU.** This MOU governs the coordination between DMC-ODS and MCP for SUD services as described in APL 22-006 and Medi-Cal Managed Care Contract, BHIN 23-001, DMC-ODS Requirements for the Period of 2022-2026, and the DMC-ODS Intergovernmental Agreement as revised or superseded from time to time.

4. **MCP Obligations**.
    a. **Provision of Covered Services**. MCP is responsible for authorizing Medically Necessary Covered Services, ensuring MCP's Network Providers coordinate the provision of care for Members as provided in the applicable Medi-Cal Managed Care Contract, and services provided by MCP and carve-out programs and benefits to Members.

b. **Oversight Responsibility.** The [*insert title*] ("MCP Responsible Person"), listed on Exhibit A, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. meet at least quarterly with DMC-ODS, as required by Section 9;

ii. report on MCP's compliance with the MOU to MCP's Compliance Officer no less frequently than quarterly. The Compliance Officer must include MOU compliance oversight and reports as part of MCP's compliance program and address deficiencies in accordance with the MCP compliance program policies;

iii. ensure there is a sufficient number of staff at MCP who support compliance with and management of this MOU;

iv. ensure an appropriate level of leadership on MOU engagements from both MCP and DMC-ODS;

v. ensure training and education regarding MOU provisions are conducted annually to employees, Subcontractors, Downstream Subcontractors, and Network providers as applicable; and

vi. serve, or may designate a person at MCP to serve, as the day-to-day liaison with DMC-ODS ("MCP-DMC-ODS Liaison"); the MCP-DMC-ODS Liaison must be listed on Exhibit A. MCP must notify the Oversight Team of any changes to the MCP-DMC-ODS Liaison as soon as reasonably practical, but no later than the date of change, and must also notify DHCS within five (5) Working Days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, to comply with any applicable provisions of the MOU.

5. **DMC-ODS Obligations.**

a. **Provision of Covered Services**. DMC-ODS is responsible for providing or arranging covered SUD services.

b. **Oversight Responsibility.** The [*insert title*] ("DMC-ODS Responsible Person") at DMC-ODS must be responsible for overseeing DMC-ODS' compliance with this MOU. The DMC-ODS Responsible Person serves, or may designate a person to serve, as the day-to-day liaison with MCP ("DMC-ODS Liaison"); the DMC-ODS Liaison is listed on Exhibit B. DMC-ODS must notify MCP of changes to the DMC-ODS Liaison as soon as reasonably practical but no later than the date of change. The DMC-ODS Responsible Person must:

i. ensure there is sufficient staff at DMC-ODS who support compliance with and management of this MOU;

ii. develop and implement MOU compliance policies and procedures for DMC-ODS programs, including oversight reports and mechanisms to address barriers to care coordination;

iii. ensure training and education regarding MOU provisions are conducted annually to employees, Subcontractors, Downstream Subcontractors, and Network providers as applicable; and

iv. be responsible for meeting MOU compliance requirements, as determined by policies and procedures established by DMC-ODS, and reporting to the DMC-ODS Responsible Person.

6. **Training and Education.**

a. To ensure compliance with this MOU, MCP must provide training and orientation for its respective employees, Network Providers, as applicable, Subcontractors, and Downstream Subcontractors who carry out responsibilities under this MOU. The training will include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. The training must be provided prior to any such person or entity performing responsibilities under this MOU and at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and DMC-ODS services to its contracted providers. *[The Parties may agree to make this requirement mutual.]*

b. The Parties must provide Members and Providers with educational materials related to accessing Medically Necessary Services, including those provided by DMC-ODS.

c. The Parties each must provide the other Party with training and/or educational material on how MCP Covered Services and DMC-ODS services may be accessed, including during nonbusiness hours.

d. DMC-ODS must provide the DMC-ODS Liaison and DMC-ODS providers with training and educational materials on MCP Covered Services to support DMC-ODS in assisting Members with accessing Covered Services.

[The parties may add requirements such as:

- *The Parties must together develop training and education resources covering the services provided or arranged by the Parties, and each Party must share its training and educational materials with the other Party to ensure the information included in their respective training and education materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and DMC-ODS policies and procedures, and with clinical practice standards.*
- *Parties must develop and share outreach communication materials and initiatives to share resources about MCP and DMC-ODS with individuals who may be eligible for MCP Covered Services and/or DMC-ODS services.]*

7. **Required Policies and Procedures.**

a. **Screening and Assessment.**

i. The Parties must adopt a joint policy and procedure that addresses how Members must be screened and assessed for Covered Services.

ii. MCP must develop policies and procedures for providing Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment ("SABIRT") to Members aged eleven (11) and older in accordance with APL 21-014, as well as to younger children as merited by family history and symptomology. MCP policies and procedures must include, but not be limited to:

1. A process for ensuring Members receive comprehensive substance use, physical, and mental health screenings services, including the use of American Society of Addiction Medicine (ASAM) Level 0.5 SABIRT guidelines;

2. A process for providing or arranging the provision of medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings;

3. A process for facilitating and electronically tracking bidirectional referrals between the MCP and DMC-ODS utilizing the Referral Tracking System.

b. **Referral Process.** The Parties must work collaboratively to develop policies and procedures that ensure that Members are referred to the appropriate DMC-ODS services.

i. The Parties must facilitate referrals to DMC-ODS for Members who meet the criteria of the SUD services and ensure DMC-ODS has procedures for accepting referrals from MCP or responding to referrals where they cannot accept additional Members.

ii. MCP must refer Members using a patient-centered, shared decision-making process.

iii. MCP must develop and implement an organizational approach to the delivery of services and referral pathways to DMC-ODS Covered Services.

iv. DMC-ODS should refer Members to the MCP for Covered Services, as well as any Community Supports services or care management programs for which they may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). If DMC-ODS is an ECM Provider, DMC-ODS provides ECM services pursuant to that separate agreement between MCP and DMC-ODS for ECM services; this MOU does not govern DMC-ODS' provision of ECM.

v. The Parties must adopt a "no wrong door" referral process for Members and work collaboratively to ensure that Members may access services through multiple pathways and are not turned away based on which pathway they rely on pursuant to BHIN 22-011, including ensuring Members receive SUD services when Members have co-occurring SMHS and/or NSMHS and SUD needs.

vi. MCP must have a process by which MCP accepts referrals from DMC-ODS staff, providers, or a self-referred Member for assessment, making a determination of medical necessity for the Member to receive DMC-ODS Covered Services, and providing referrals within the DMC-ODS provider network; and

vii. DMC-ODS must have a process by which DMC-ODS accepts referrals from MCP staff, providers, or a self-referred Member for assessment, and the mechanism for communicating such acceptance to MCP, the provider, or the self-referred Member, respectively.

c. **Closed Loop Referrals.** By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding Closed Loop Referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Policy Guide, APL 22-024, and the 2024 Managed Care Contract, as amended from time to time, and as set forth by DHCS through APL, or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and DMC-ODS comply with the applicable provisions of Closed Loop Referrals guidance within ninety (90) days of issuance. The

Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.

8. **Care Coordination and Collaboration.**
    a. **Care Coordination.**
        i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the specific requirements set forth in this MOU *[and in any exhibits]*.
        ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.
        iii. MCP must have policies and procedures in place to maintain collaboration with DMC-ODS and to identify strategies to monitor and assess the effectiveness of this MOU.
        iv. The Parties must adopt joint policies and procedures for coordinating Members' care that addresses:
            1. The requirement for DMC-ODS to refer Members to MCP to be assessed for Care Coordination and other similar programs and other services for which they may qualify provided by MCP including but not limited to ECM, CCM, or Community Supports;
            2. The specific point of contact from each Party, if someone other than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing Care Coordination for all Members under this MOU;
            3. A process for how MCP and DMC-ODS will engage in collaborative treatment planning to ensure care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships;
            4. A process for coordinating the delivery of Medically Necessary Covered Services with the Member's Primary Care Provider and other Medically Necessary Covered Services for eligible Members;
            5. A process for how MCP and DMC-ODS will help to ensure the Member is engaged and participates in an integrated care program and a process for ensuring the Members, caregivers, and providers are engaged in the development of the Member's care;
            6. A joint process for reviewing and updating a Member's problem list, as clinically indicated. The process must describe circumstances for updating care plans and coordinating with outpatient SUD providers;
            7. Joint processes for how the Parties will engage in collaborative treatment planning and ensure communication among providers, including procedures for exchanges of medical information; and
            8. Joint policies and procedures to ensure that Members and providers can coordinate coverage of Covered Services outlined by this MOU outside of normal business hours, as well as providing or arranging for 24/7 emergency access to Covered Services.
        v. **Transitional Care.**
            1. The Parties must develop a process describing how MCP and DMC-ODS will coordinate transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to

another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home- or community-based settings,[1] level of care transitions that occur within the facility, or transitions from outpatient therapy to intensive outpatient therapy and vice versa. For Members who are admitted for residential SUD treatment, where DMC-ODS is the primary payor, DMC-ODS is primarily responsible for coordination of the Member upon discharge. In collaboration with DMC-ODS, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[2] including, but not limited to:

a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by DMC-ODS;

b. Approving prior authorizations and coordinating services where MCP is the primary payer (e.g., home services, long-term services, and supports for dual-eligible Members);

c. Ensuring the completion of a discharge risk assessment and developing a discharge planning document;

d. Assessing Members for any additional care management programs or services for which they may qualify, such as ECM, CCM, or Community Supports, and enrolling the Member in the program as appropriate; and

e. Notifying existing Care Managers of any admission if the Member is already enrolled in ECM or CCM.

f. Assigning or contracting with a care manager to coordinate with county care coordinators to ensure physical health follow up needs are met for each eligible Member as outlined by the Population Health Management Policy Guide.[3]

2. The Parties must include a process for updating and overseeing the implementation of the discharge planning documents as required for Members transitioning to or from MCP or DMC-ODS services;

3. For inpatient residential SUD treatment provided by DMC-ODS or for inpatient hospital admissions or emergency department visits known to MCP, the process must include the specific method to notify each Party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services.

vi. **Clinical Consultation**. MCP is responsible for coordinating with DMC-ODS and must, together with DMC-ODS, develop a process for ensuring that Members receiving services through DMC-ODS have access to clinical consultation, including consultation on medications, as well as clinical navigation support for patients and caregivers.

vii. **Enhanced Care Management.**

[1] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf

[2] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf; *see also* PHM Roadmap and Strategy: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf

[3] CalAIM Population Health Management Policy Guide available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

1. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM including:

a. That MCP prioritize assigning a Member to a DMC-ODS Provider as the ECM Provider if the Member receives DMC-ODS services from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions; and

b. A process for DMC-ODS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria.

2. A process for avoiding duplication of services for individuals receiving ECM with DMC-ODS Care Coordination. MCP Members receiving DMC-ODS Care Coordination can also be eligible for and receive ECM.

3. MCP must have written processes for ensuring the non-duplication of services for MCP Members receiving ECM and DMC-ODS Care Coordination.

viii. **Community Supports.**

1. Coordination must be established with applicable Community Supports providers under contract with MCP, including:

a. The identified point of contact from each Party to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination as mutually agreed upon in MCP and DMC-ODS protocols;

b. Identification of the Community Supports covered by MCP; and

c. A process specifying how DMC-ODS will make referrals for Members eligible for or receiving Community Supports.

ix. **Prescription Drugs.** The Parties must develop a process for coordination between MCP and DMC-ODS for prescription drug and laboratory, radiological, and radioisotope service procedures, including a process for referring eligible Members for SUD services to a Drug Medi-Cal-certified program or a DMC-ODS program in accordance with C.C.R. Tit. 22, § 51341.1(d)(1-6).

9. **Quarterly Meetings.**

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU but not less frequently than quarterly to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communicating with others within their organizations about such activities. *[Parties may agree to meet more frequently.]*

x. The Parties must each post on its website the date and time of the quarterly meetings and, as applicable, distribute to meeting participants a summary of any follow-up action items or corrective actions that are necessary to fulfill the Parties' obligations under the Model Contract and this MOU.

xi. The Parties each must invite the other Party's executives to participate in quarterly meetings to ensure appropriate committee representation,

including local presence, to discuss and address care coordination and MOU-related issues.

xii. The Parties must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

xiii. Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

b. **Local Representation.** MCP must participate, as appropriate, at meetings or engagements to which MCP is invited by DMC-ODS, such as local county meetings, local community forums, and DMC-ODS engagements, to collaborate with DMC-ODS in equity strategy and wellness and prevention activities.

10. **Quality Improvement.** The Parties must establish policies and procedures for the oversight of the MOU requirements, including, without limitation, requirements related to QI activities, including, but not limited to, any applicable performance measures and QI initiatives as well as reports that track cross-system referrals, Member engagement, and service utilization and to prevent duplication of services rendered.

[The Parties may add requirements such as: The Parties must adopt joint policies and procedures establishing and addressing QI activities for coordinating the care and delivery of services for Members.]

11. **Data Sharing and Confidentiality.** The Parties must adopt joint policies and procedures to ensure data is exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below. The Parties will share protected health information ("PHI") for the purposes of medical and behavioral health Care Coordination pursuant to CAL. CODE REGS. tit. 9, § 1810.370(a)(3) and in compliance with the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 C.F.R. Part 2, as well as other state and federal privacy laws.

a. **Data Exchange.** MCP and DMC-ODS must share information necessary to facilitate referrals and coordinate care under this MOU *[and any Exhibit]*. The Parties must have policies and procedures for timely and frequently exchanging Member information and data, including behavioral health and physical health data; maintaining the confidentiality of exchanged information and data; bidirectional monitoring of data exchange processes; and obtaining Member consent. The data elements to be shared must be agreed upon jointly by the Parties, reviewed annually, and set forth in this MOU. Additional data elements to be shared by the parties are set forth in Exhibit C. To the extent permitted under applicable law, the Parties must share, at a minimum, Member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health and/or welfare. DMC-ODS and MCP must enact policies and procedures to implement the following with regard to information sharing:

i. A process for timely exchanging information about Members eligible for ECM, regardless of whether DMC-ODS Provider is serving as an ECM Provider;

ii. A process for DMC-ODS to send regular real time or batches of referrals to ECM and Community Supports to MCP;

iii. A process for DMC-ODS to send admission, discharge, and transfer data to MCPs when Members are admitted to, discharged from, or transferred from facilities contracted by DMC-ODS (e.g., residential SUD treatment facilities, residential SUD withdrawal management facilities), and for MCP to receive this data;

iv. A process to implement mechanisms to alert MCP of behavioral health crises (e.g., DMC-ODS alerts MCP of uses of SUD crisis intervention); and

v. A process for MCP to send admission, discharge, and transfer data to DMC-ODS when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (e.g., emergency department, inpatient hospitals, nursing facilities), and for DMC-ODS to receive this data.

[The parties may add requirements such as:

- *MCP and DMC-ODS must enter into the state's Data Exchange Framework Data Sharing Agreement ("DSA") (Exhibit C) for the safe sharing of information.*
- *If Member authorization is required, the Parties must agree to a standard consent form to obtain a Member's authorization to share and use information for the purposes of treatment, payment, and care coordination protected under 42 C.F.R. Part 2.]*

c. **Behavioral Health Quality Improvement Program**. If DMC-ODS is participating in the Behavioral Health Quality Improvement Program ("BHQIP"), then MCP and DMC-ODS are encouraged to execute a DSA. If DMC-ODS and MCP have not executed a DSA, DMC-ODS must sign a Participation Agreement (Exhibit E) to onboard with a Health Information Exchange that has signed the California Data Use and Reciprocal Support Agreement ("CalDURSA") and joined the California Trusted Exchange Network ("CTEN").

d. **Interoperability.** MCP must exchange data in compliance with the payer-to-payer data exchange requirements pursuant to 45 C.F.R. Part 170. MCP must make available to Members their electronic health information held by the Parties and make available an application program interface ("API") that makes complete and accurate network provider directory information available through a public-facing digital endpoint on MCP's and DMC-ODS' respective websites pursuant to 42 C.F.R. 438.242(b) and 42 C.F.R. 438.10(h). The Parties must comply with DHCS interoperability APL 22-026, BHIN 22-068, as applicable, within ninety (90) days of issuance.

12. **Disaster and Emergency Preparedness.** The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of DMC-ODS services and MCP Covered Services for impacted Members.

13. **Dispute Resolution.**

a. In the event of any dispute arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between

themselves. Pending resolution of any such dispute, DMC-ODS must continue without delay to carry out all its responsibilities under this MOU unless the MOU is terminated. MCP must not be required to make payments for any services that are the subject of the dispute resolution process until such dispute has been resolved by the Parties. If the dispute cannot be resolved within fifteen (15) calendar days of initiating such negotiations or such other time period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law.

b. Unless otherwise determined by the Parties, the DMC-ODS Liaison must be the designated responsible individual to receive notice of actions, denials, or deferrals from MCP, and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination.

c. MCP must monitor and track the number of disputes with DMC-ODS where the Parties cannot agree on an appropriate place of care and, upon request, must report all such disputes to DHCS.

d. Until the dispute is resolved, the following must apply:

i. The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or

ii. When the dispute concerns MCP's contention that DMC-ODS is required to deliver SUD services to a member and DMC-ODS has incorrectly determined the Member's diagnosis to be a diagnosis not covered by DMC-ODS, MCP must manage the care of the Member under the terms of its contract with the state until the dispute is resolved.

iii. When the dispute concerns DMC-ODS' contention that MCP is required to deliver physical health care-based treatment, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose, DMC-ODS must be responsible for providing or arranging and paying for those services until the dispute is resolved.

14. **General**.

a. **MOU Posting.** MCP must post this MOU on its website.

b. **Documentation Requirements.** MCP must retain all documents demonstrating compliance with this MOU for at least ten (10) years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP must submit the requested MOU within ten (10) Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by personal delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail are deemed given on the date of delivery indicated on the return receipt. Each Party may

change its address for purposes of receiving notice hereunder by giving notice of such change to the other Party in the manner provided for herein.

d. **No Delegation.** The Parties cannot delegate this MOU; provided, however, MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Model Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a party to this MOU. Further, the Parties may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU.

e. **Annual Review.** MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified in a writing executed by the Parties, provided, however, that this MOU is deemed automatically amended or modified to incorporate any provisions required by applicable law or any applicable guidance issued by a state or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the state of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between DMC-ODS and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither DMC-ODS nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitutes one and the same instrument.

j. **Superseding MOU.** This MOU and all exhibits constitute the final and entire agreement between the Parties and supersede any and all prior oral or written agreements, negotiations, or understandings between the Parties pertaining to the subject matter herein. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP

Signature:
Name:
Title:
Notice Address:

DMC-ODS

Signature:
Name:
Title:
Notice Address:

[Subcontractor]

Signature:
Name:
Title:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A and B

[Placeholder for exhibits to contain MCP-DMC-ODS and DMC-ODS Liaisons as referenced in Sections 4.b. and 5.b]

Exhibit C

Data Elements

[The Parties may add data elements to incorporate and/or any Data Sharing Agreement between the Parties]

ATTACHMENT 1: MEMORANDUM OF UNDERSTANDING TEMPLATE COVER PAGE

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*Mental Health Plan*]

This Memorandum of Understanding ("MOU") is entered into by and between [*name of MCP*] ("**MCP"**) and [*name of party*], *[*a *description of other party] ("MHP"),* effective as of [*date*] ("Effective Date"). [*Where the MCP has a delegated Subcontractor arrangement and delegates part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), such Knox-Keene licensed health care service plan(s) shall be added as an express party to this MOU and named in the MOU as having the responsibilities set forth herein that are applicable to such Subcontractor.*] Each of MCP and relevant Subcontractor and MHP may be referred to herein as a "Party" and collectively as "Parties."

WHEREAS, the Parties are required to enter into this MOU, a binding and enforceable contractual agreement under the Medi-Cal Managed Care Contract ("Model Contract") Exhibit A, Attachment III, All Plan Letters ("APL*")* 18-015, 22-005, 22-006, 22-028, Behavioral Health Information Notice ("BHIN") *[insert #]* and subsequent revisions, and all other relevant California Department of Health Care Services ("DHCS") guidance as referenced herein to ensure that Medi-Cal members enrolled in MCP are able to access and/or receive mental health services in a coordinated manner from MCP and MHP (referred to herein as "Members"); and

WHEREAS, the Parties desire to ensure that Members receive MHP services in a coordinated manner and provide a process to continuously evaluate the quality of the services provided.

In consideration of mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the DHCS, unless otherwise defined herein.

2. **Term.** This MOU is in effect as of the Effective Date and continues for three (3) years or as amended in accordance with Section 14.f of this MOU.

3. **Services Covered by This MOU.** This MOU governs the coordination between MCP and MHP for Non-specialty Mental Health Services ("NSMHS") covered by MCP and further described in APL 22-006, as revised or superseded from time to time, and Specialty Mental Health Services ("SMHS") covered by MHP and further described in APL 22-003, APL 22-005, BHIN 21-073, as revised or superseded from time to time. The population eligible for NSMHS and SMHS set forth in APL 22-006 and BHIN 21-073 is the population served under this MOU.

4. **MCP Obligations.**

a. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services, including NSMHS, ensuring MCP's Network Providers coordinate the provision of care for Members as provided in the applicable Medi-Cal Managed Care Contract, and services provided by MCP and carve-out programs and benefits to Members.

b. **Compliance and Oversight Responsibility.** The [*insert title*] ("MCP Responsible Person") listed on Exhibit A, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. meet at least quarterly with MHP, as required by Section 9;

ii. report on MCP's compliance with the MOU to MCP's Compliance Officer no less frequently than quarterly. The Compliance Officer must include MOU compliance oversight and reports as part of MCP's compliance program and address deficiencies in accordance with the MCP compliance program policies;

iii. ensure there are a sufficient number of staff at MCP who support compliance with and management of this MOU;

iv. ensure an appropriate level of leadership on MOU engagements from both MCP and MHP;

v. ensure training and education regarding MOU provisions are conducted annually to employees, Subcontractors, Downstream Subcontractors, and Network Providers as applicable; and

vi. serve, or may designate a person at MCP to serve, as the day-to-day liaison with MHP ("MCP-MHP Liaison"); the MCP-MHP Liaison must be listed on Exhibit A. MCP must notify MHP of any changes to the MCP-MHP Liaison as soon as reasonably practical, but no later than the date of change and must notify DHCS within five (5) Working Days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, to comply with any applicable provisions of the MOU.

5. **MHP Obligations.**

a. **Provision of Covered Services.** MHP is responsible for providing or arranging for the provision of SMHS.

b. **Oversight Responsibility.** The [*insert title*] ("MHP Responsible Person"), listed on Exhibit B, at MHP must be responsible for overseeing MHP's compliance with this MOU. The MHP Responsible Person serves, or may designate a person to serve, as the day-to-day liaison with MCP ("MHP Liaison"); the MHP Liaison is listed on Exhibit B. MHP must notify MCP of changes to the MHP Liaison as soon as reasonably practical but no later than the date of change. The MHP Responsible Person must:

i. ensure there is sufficient staff at MHP who support compliance with and management of this MOU;

ii. develop and implement MOU compliance policies and procedures for MHP, including oversight reports and mechanisms to address barriers to care coordination;

iii. ensure training and education regarding MOU provisions are conducted annually to employees, Subcontractors, Downstream Subcontractors, and Network providers as applicable; and

iv. be responsible for meeting MOU compliance requirements, as determined by policies and procedures established by MHP, and reporting to the MHP Responsible Person.

6. **Training and Education.**

a. To ensure compliance with this MOU, the Parties must provide training and orientation for their respective employees; Network Providers, as applicable; Subcontractors; and Downstream Subcontractors who carry out responsibilities under this MOU. The training will include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. The training must be provided prior to any such person or entity performing responsibilities under this MOU and at least annually thereafter. The Parties must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and MHP services to its contracted providers. [*The Parties may agree to make this requirement mutual.*]

b. The Parties must provide Members and Providers with educational materials related to accessing Medically Necessary Services, including those provided by MHP.

c. The Parties each must provide the other Party with training and/or educational materials on how MCP Covered Services and MHP services may be accessed, including during nonbusiness hours.

d. MHP must provide the MHP Liaison and MHP service providers with training and educational materials on MCP Covered Services to support MHP in assisting Members with accessing Covered Services.

[The Parties may add requirements such as:

- *The Parties must together develop training and education resources covering the services provided or arranged by the Parties, and each Party must share its training and educational materials with the other Party to ensure the information included in their respective training and education materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and MHP policies and procedures, and with clinical practice standards.*
- *Parties must develop and share outreach communication materials and initiatives to share resources about MCP and MHP with individuals who may be eligible for MCP Covered Services and/or MHP services.]*

7. **Screening, Assessment, and Referrals.**

a. **Screening and Assessment.** The Parties must adopt joint policies and procedures that address how Members must be screened and assessed for the services, including administering the applicable Screening and Transition of Care Tools for Medi-Cal Mental Health Services as set forth in APL 22-028 and BHIN 22-065.

i. MCP and MHP must use the required screening tools for Members who are not currently receiving mental health services, except when a Member contacts the mental health provider directly to seek mental health services.

ii. MCP and MHP must use the required Transition of Care Tool to facilitate transitions of care for Members when their service needs change.

iii. The policies and procedures must incorporate agreed-upon and/or required timeframes; list specific responsible parties by title or department; and include any other elements required by DHCS for the mandated statewide Adult Screening Tool for adults aged 21 and older, Youth Screening Tool for youth under age 21, and Transition of Care Tool, for adults aged 21 and older and youth under age 21, as well as the following requirements:

1. The process by which MCP and MHP must conduct mental health screenings for Members who are not currently receiving mental health services when they contact MCP or MHP to seek mental health services. MCP and MHP must refer such Members to the appropriate care delivery system using the Adult or Youth Screening Tool for Medi-Cal Mental Health Services based on their screening result.
2. The process by which MCP and MHP must ensure that Members receiving mental health services from one delivery system receive timely and coordinated care when their existing services are being transitioned to the other delivery system or when services are being added to their existing mental health treatment from the other delivery system in accordance with APL 22-028 and BHIN 22-065.

b. **Referrals.**

i. The Parties must adopt a “no wrong door” referral process for Members and work collaboratively to ensure that Members may access services through multiple pathways and are not turned away based on which pathway they rely on, including but not limited to adhering to all applicable No Wrong Door for Mental Health Services Policy requirements described in APL 22-005 and BHIN 22-011. MCP must refer Members using a patient-centered, shared decision-making process.

ii. The process by which MCP and MHP coordinate referrals based on the completed Adult or Youth Screening Tool in accordance with APL 22-028 and BHIN 22-065, including:

1. The process by which providers refer to MHP and MCP.
2. The process by which Members who decline screening are assessed.
3. The process by which MCP:
    a. Accepts referrals from MHP for assessment, and the mechanisms of communicating such acceptance and that a timely assessment has been made available to the Member.

b. Provides referrals to MHP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of referral and that a timely assessment has been made available to the Member by MHP.

c. Provides a referral to an MHP Network Provider (if processes agreed upon with MHP), and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by the MHP Network Provider.

4. The process by which MHP:

a. Accepts referrals from MCP for assessment, and the mechanisms for communicating such acceptance and that a timely assessment has been made available to the Member.

b. Provides referrals to MCP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by the MCP.

c. Provides a referral to an MCP Network Mental Health Provider (if processes agreed upon with the MCP), and the mechanisms of confirming the MCP Network Mental Health Provider accepted the referral and timely assessed the Member.

d. Provides a referral to MCP when the screening indicates that a Member under age 21 would benefit from a pediatrician/PCP visit.

5. The process by which MCP and MHP coordinate referrals using the Transition of Care Tool in accordance with APL 22-028 and BHIN 22-065.

6. The process by which MCP (and/or its Network Providers):

a. Accepts referrals from MHP, and the mechanisms of communicating such acceptance, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

b. Provides referrals to MHP and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a provider who accepts their care and that services have been made available to the Member.

c. Provides a referral to an MHP Network Provider (if processes agreed upon with MHP), and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a provider who accepts their care and that services have been made available to the Member.

d. MCP must coordinate with MHP to facilitate transitions between MCP and MHP delivery systems and across different providers, including guiding referrals for Members receiving NSMHS to transition to an SMHS provider and vice versa, and the new provider accepts the referral and provides care to the Member.

7. The process by which MHP (and/or its Network Providers):

a. Accepts referrals from MCP, and the mechanisms of communicating such acceptance, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

b. Provides referrals to MCP, and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

c. Provides a referral to an MCP Network Provider (if processes agreed upon with MCP), and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

iii. MHP must refer Members to MCP to be assessed for Care Coordination and other similar programs and Covered Services for which they may qualify, including, but not limited to, Enhanced Care Management ("ECM"), Complex Care Management ("CCM"), or Community Supports. If MHP is an ECM Provider, MHP provides ECM services pursuant to that separate agreement between MCP and MHP for ECM services; this MOU does not govern MHP's provision of ECM.

iv. MCP must have a process for referring eligible Members for substance use disorder ("SUD") services to a Drug Medi-Cal certified program or a Drug Medi-Cal Organized Delivery System ("DMC-ODS") program in accordance with CCR tit. 22, § 51341.1(d) (1-6).

c. **Closed Loop Referrals.** By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding Closed Loop Referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Policy Guide,[1] APL 22-024, and the 2024 Managed Care Contract, as amended from time to time, and as set forth by DHCS through APL, or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and MHP comply with the applicable provisions of Closed Loop Referrals guidance within ninety (90) days of issuance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.

8. **Care Coordination and Collaboration.**

a. **Care Coordination.**

i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the specific requirements set forth in this MOU *[and in any exhibits].*

[1] CalAIM Population Health Management Policy Guide available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.

iii. MCP must have policies and procedures in place to maintain collaboration with MHP and to identify strategies to monitor and assess the effectiveness of this MOU. The policies and procedures must ensure coordination of inpatient and outpatient medical and mental health care for all Members enrolled in MCP and receiving SMHS through MHP, and must comply with federal and state law, regulations, and guidance, including, without limitation, CAL. WELF. & INST. CODE § 5328.

iv. The Parties must adopt joint policies and procedures for coordinating Members' care that address:

1. The specific point of contact from each Party, if someone other than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing Care Coordination for all Members under this MOU;

2. A process for coordinating care for individuals who meet access criteria for and are concurrently receiving NSMHS and SMHS consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011 to ensure the care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships;

3. A process for coordinating the delivery of medically necessary Covered Services with the Member's Primary Care Provider, including, without limitation, transportation services, home health services, and other Covered Services;

4. Permitting Members to concurrently receive NSMHS and SMHS when clinically appropriate, coordinated and not duplicative consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011.

5. A process for ensuring that Members and Providers can coordinate coverage of Covered Services outlined by this MOU outside normal business hours, as well as providing or arranging for 24/7 emergency access to SMHS and NSMHS.

v. **Transitional Care.**

1. The Parties must develop a process describing how MCP and MHP will coordinate transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home or community-based settings[2], or transitions from outpatient therapy to intensive outpatient therapy. For Members who are admitted to an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where MHP is the primary payor, MHPs are primarily

[2] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf

responsible for coordination of the Member upon discharge. In collaboration with MHP, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[3] including, but not limited to:

a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by MHP (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities).

b. Approving prior authorizations and coordinating services where MCP is the primary payer (e.g., home services, long-term services and supports for dual-eligible Members);

c. Ensuring the completion of a discharge risk assessment and developing a discharge planning document;

d. Assessing Members for any additional care management programs or services for which they may qualify, such as ECM, CCM, or Community Supports and enrolling the Member in the program as appropriate; and

e. Notifying existing Care Managers of any admission if the Member is already enrolled in ECM or CCM.

f. Assigning or contracting with a care manager to coordinate with behavioral health or county care coordinators for each eligible Member to ensure physical health follow up needs are meet as outlined by the Population Health Management Policy Guide.

2. The Parties must include a process for updating and overseeing the implementation of the discharge planning documents as required for Members transitioning to or from MCP or MHP services.

3. For inpatient mental health treatment provided by MHP or for inpatient hospital admissions or emergency department visits known to MCP, the process must include the specific method to notify each Party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services.

4. The Parties must have policies and procedures for addressing changes in a Member's medical or mental health condition when transferring between inpatient psychiatric service and inpatient medical services, including direct transfers.

vi. **Clinical Consultation.**

1. The Parties must implement a process for MCP and MHP to provide clinical consultations to each other regarding a Member's mental illness, including consultation on diagnosis, treatment, and medications for Member's whose mental illness is being treated by a Party, regardless of whether MCP or MHP is responsible for arranging or covering the Member's treatment or services.

[3] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf; *see also* PHM Roadmap and Strategy: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf

2. The Parties must implement a joint process for reviewing and updating a Member's care plan, as clinically indicated (e.g., following crisis intervention or hospitalization), including when the care plan must be updated, and coordinating with outpatient mental health Providers.

vii. **Enhanced Care Management.**

1. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) consistent with DHCS guidance regarding ECM, including:

a. That MCP prioritize assigning a Member to an SMHS Provider as the ECM Provider if the Member receives SMHS from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions; and

b. A process for SMHS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria.

c. A process for avoiding duplication of services for individuals receiving ECM with SMHS Targeted Case Management ("TCM"), Intensive Care Coordination ("ICC"), and/or Full-Service Partnership ("FSP") services as set forth in the CalAIM ECM Policy Guide, as revised or superseded from time to time, and coordination activities.

viii. Community Supports.

1. Coordination must be established with applicable Community Supports providers under contract with MCP, including:

a. The identified point of contact, from each Party to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination as mutually agreed upon in MCP and MHP protocols;

b. Identification of the Community Supports covered by MCP; and

c. A process specifying how MHP will make referrals for Members eligible for or receiving Community Supports.

ix. Eating Disorder Services.

1. MHP is responsible for the SHMS components of eating disorder treatment, including, but not limited to, those in APL 22-003 and BHIN 22-009, as revised or superseded from time to time, and must develop a process to ensure such treatment is provided to eligible Members, specifically:

a. MHP must provide for medically necessary psychiatric inpatient hospitalization and outpatient SHMHS.

b. MCP must also provide or arrange for NSMHS for Members requiring eating disorder services.

2. For partial hospitalization and residential eating disorder programs, MHP is responsible for medically necessary SMHS components, while MCP is responsible for the medically necessary physical health components.

a. MCP is responsible for the physical health components of eating disorder treatment, including emergency room services, and inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.

9. **Quarterly Meetings.**

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU but not less frequently than quarterly to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communicating with others within their organizations about such activities. [*Parties may agree to meet more frequently.*]

i. The Parties must each post on its website the date and time of the quarterly meetings and, as applicable, distribute to meeting participants a summary of any follow-up action items or corrective actions that are necessary to fulfill the Parties' obligations under the Model Contract and this MOU.

ii. The Parties must invite the other Party's executives to participate in quarterly meetings to ensure appropriate committee representation, including local presence, to discuss and address care coordination and MOU-related issues.

iii. The Parties must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

iv. Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

b. **Local Representation.** MCP must participate, as appropriate, at meetings or engagements to which MCP is invited by MHP, such as local county meetings, local community forums, and MHP engagements, to collaborate with MHP in equity strategy and wellness and prevention activities.

10. **Quality Improvement.** The Parties must establish policies and procedures for the oversight of the MOU requirements, including, without limitation, requirements related to QI activities, including, but not limited to, any applicable performance measures and QI initiatives as well as reports that track cross-system referrals, Member engagement, and service utilization and to prevent duplication of services rendered. Such QI activities must include processes to monitor the extent to which Members are able to access mental health services across SMHS and NSMHS, and Covered Service utilization.

[The Parties may add requirements such as: The Parties must adopt joint policies and procedures establishing and addressing QI activities for coordinating the care and delivery of services for Members.]

11. **Data Sharing and Confidentiality.** The Parties must adopt joint policies and procedures to ensure data is exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below. The Parties will

share protected health information ("PHI") for the purposes of medical and behavioral health Care Coordination pursuant to CAL. CODE REGS. tit. 9, § 1810.370(a)(3) and in compliance with the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 C.F.R. Part 2, as well as other state and federal privacy laws.

a. **Data Exchange.** MCP and MHP must share information necessary to facilitate referrals and coordinate care under this MOU *[and any Exhibit*]. The Parties must have policies and procedures for timely and frequently exchanging Member information and data, including behavioral health and physical health data; maintaining the confidentiality of exchanged information and data; bidirectional monitoring of data exchange processes; and obtaining Member consent. The data elements to be shared must be agreed upon jointly by the Parties, reviewed annually, and set forth in this MOU. Additional data elements to be shared by the parties are set forth in Exhibit C. The Parties must share, at a minimum, Member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health and/or welfare. MHP and MCP must enact policies and procedures to implement the following with regard to information sharing:

i. A process for timely exchanging information about Members eligible for ECM, regardless of whether the Specialty Mental Health provider is serving as an ECM provider;

ii. A process for MHP to send regular real time or batches of referrals to ECM and Community Supports to MCP;

iii. A process for MHP to send admission, discharge, and transfer data to MCPs when Members are admitted to, discharged from, or transferred from facilities contracted by MHP (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities), and for MCP to receive this data; and

iv. A process to implement mechanisms to alert MCP of behavioral health crises (e.g., MHP alerts MCP of uses of mobile health, psych inpatient, and crisis stabilization and MCP alerts MHP of Member's visits to emergency departments and hospitals).

v. A process for MCP to send admission, discharge, and transfer data to MHP when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (e.g., emergency department, inpatient hospitals, nursing facilities), and for MHP to receive this data.

[The Parties may add requirements such as:

- *MCP and MHP must enter into the state's Data Exchange Framework Data Sharing Agreement ("DSA") (Exhibit C) for the safe sharing of information.*
- *If Member authorization is required, the Parties must agree to a standard consent form to obtain a Member's authorization to share and use information for the*

purposes of treatment, payment, and care coordination protected under 42 C.F.R. Part 2.]

b. **Behavioral Health Quality Improvement Program**. If MHP is participating in the Behavioral Health Quality Improvement Program ("BHQIP"), then MCP and MHP are encouraged to execute a DSA. If MHP and MCP have not executed a DSA, MHP must sign a Participation Agreement (Exhibit E) to onboard with a Health Information Exchange that has signed the California Data Use and Reciprocal Support Agreement ("CalDURSA") and joined the California Trusted Exchange Network ("CTEN").

c. **Interoperability.** MCP must make available to Members their electronic health information held by MCP pursuant to 42 C.F.R. § 438.10 and in accordance with APL 22-026. MCP must make available an application programming interface ("API") that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's and MHP's respective websites pursuant to 42 C.F.R. § 438.242(b) and 42 C.F.R. § 438.10(h).

12. **Disaster and Emergency Preparedness.** The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of MHP services and MCP Covered Services for impacted Members.

13. **Dispute Resolution.**

a. In the event of any dispute arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. Pending resolution of any such dispute, MHP must continue without delay to carry out all its responsibilities under this MOU unless the MOU is terminated. MCP must not be required to make payments for any services that are the subject of the dispute resolution process until such dispute has been resolved by the Parties. If the dispute cannot be resolved within fifteen (15) calendar days of initiating such negotiations or such other time period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law.

b. The Parties may agree to an expedited dispute resolution process if a Member has not received a disputed service(s) and the Parties determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, the Parties will have one working day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 and BHIN 21-034 apply to disputes between MCP and MHP where the Parties cannot agree on the appropriate place of care. Nothing in this MOU or provision must constitute a waiver of any of the government claim filing requirements

set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, state, and federal law.

c. MHP must designate a person or process to receive notice of actions, denials, or deferrals from MCP, and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination.

d. MCP must monitor and track number of disputes with MHP where the Parties cannot agree on an appropriate place of care and, upon request, must report all such disputes to DHCS.

e. Once MHP receives a deferral from MCP, MHP must respond by the close of the business day following the day the deferral notice is received, consistent with CAL. WELF. & INST. Code § 14715.

f. Disputes between MCP and MHP that cannot be resolved in a good faith attempt between the Parties must be forwarded to DHCS via a written "Request for Resolution" by either MHP or MCP within three business days after failure to resolve the dispute, consistent with the procedure defined in CAL. CODE REGS. tit. 9, § 1850.505, "Resolutions of Disputes between MHPs and Medi-Cal Managed Care Plans", BHIN 21-034, and APL 21-013. Any decision rendered by DHCS regarding a dispute between MCP and MHP concerning provision of Covered Services is not subject to the dispute procedures set forth in the Primary Operations Contract Exhibit E, Section 1.21 (Contractor's Dispute Resolution Requirements);

g. A dispute between MHP and MCP must not delay medically necessary SMHS, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries as required by CAL. CODE REGS. tit. 9, § 1850.525.

h. Until the dispute is resolved, the following must apply:

i. The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or

ii. When the dispute concerns MCP's contention that MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care-based treatment or because MHP has incorrectly determined the Member's diagnosis to be a diagnosis not covered by MHP, MCP must manage the care of the Member under the terms of its contract with the State until the dispute is resolved. MHP must identify and provide MCP with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to MCP provider responsible for the Member's care; or

iii. When the dispute concerns MHP's contention that MCP is required to deliver physical health care-based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, MHP must be responsible for providing or arranging and paying for those services until the dispute is resolved.

i. Decisions rendered by DHCS that finds MCP is financially liable for services, MCP must comply with the requirements in CCR tit. 9, § 1850.530.

14. **General.**

a. **MOU Posting.** MCP must post this MOU on its website.

b. **Documentation Requirements.** MCP must retain all documents demonstrating compliance with this MOU for at least ten (10) years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP must submit the requested MOU within ten (10) Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by personal delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail are deemed given on the date of delivery indicated on the return receipt. Each Party may change its address for purposes of receiving notice hereunder by giving notice of such change to the other Party in the manner provided for herein.

d. **No Delegation.** The Parties cannot delegate this MOU; provided, however, MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Model Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a party to this MOU. Further, the Parties may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU.

e. **Annual Review.** MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified in a writing executed by the Parties, provided, however, that this MOU is deemed automatically amended or modified to incorporate any provisions required by applicable law or any applicable guidance issued by a state or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the state of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create any relationship between MHP and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither MHP nor

MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitutes one and the same instrument.

j. **Superseding MOU.** This MOU and all exhibits constitute the final and entire agreement between the Parties and supersede any and all prior oral or written agreements, negotiations, or understandings between the Parties pertaining to the subject matter herein. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP

Signature:
Name:
Title:
Notice Address:

MHP

Signature:
Name:
Title:
Notice Address:

[Subcontractor]

Signature:
Name:
Title:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:

Exhibits A & B

[Placeholder for exhibits to contain MCP-MHP and MHP Liaisons as referenced in Sections 4.b and 5.b]

Exhibit C

Data Elements

[The Parties may add data elements to incorporate and/or any Data Sharing Agreement between the Parties]

TAB 7

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, October 19, 2023

Agenda Item: Nominate 2024 SMC Chair-Elect

Enclosures: None

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the opportunity for committee members to nominate the next Systems and Medicaid Committee (SMC) Chair-Elect. The Chair-Elect is responsible for supporting the Chairperson with leading committee activities.

Background/Description:
Each standing committee shall have a Chairperson and Chair-Elect. The Chairperson serves a term of one year with the option for re-nomination for one additional year.

Uma Zykofsky is slated to become the Chairperson for the Systems and Medicaid Committee at the January 2024 Quarterly Meeting. The committee members shall nominate a Chair-Elect to be submitted to the Council's Officer Team for appointment.

The role of the Chair-Elect is outlined below:

- Facilitate the committee meetings as needed, in the absence of the Chairperson.
- Assist the Chairperson and staff with setting the committee meeting agendas and other committee planning.
- Participate in the Executive Committee Meetings on Wednesday mornings during the week of quarterly meetings.
- Participate in the Mentorship Forums in person the Thursday evening of the quarterly meetings.