DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

December 16, 2024

Tyler Sadwith
State Medicaid Director
California Department of Health Care Services
1501 Capital Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Director Sadwith:

The Centers for Medicare & Medicaid Services (CMS) is approving California's (the "state") request for a section 1115 project, entitled "Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)" section 1115(a) demonstration (Project Numbers 11-W-00472/9 and 21-W-00080/9 (the "demonstration"), in accordance with section 1115(a) of the Social Security Act ("the Act"). Approval of this request will allow the state, through various waiver and expenditure authorities, to test the effectiveness of innovative practices aimed at strengthening the continuum of community-based behavioral health services. With this approval, the demonstration will be effective January 1, 2025 through December 31, 2029, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS is also concurrently approving: 1) the Serious Mental Illness (SMI) Implementation Plan and the Health Information Technology (HIT) Plan, which authorize the state to receive federal financial participation (FFP) for the Serious Mental Illness (SMI) Program under this demonstration as Attachment D; 2) the Health-Related Social Needs Services Matrix as Attachment H; and 3) the Approved Designated State Health Programs List as Attachment J.

CMS has determined that California's BH-CONNECT demonstration is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality medical assistance and improving health outcomes for Medi-Cal beneficiaries living with significant behavioral health needs. Under this demonstration, CMS is approving new initiatives related to strengthening the behavioral health workforce, incentivizing improvements in the behavioral health delivery system, promoting services addressing health-related social needs (HRSN), supporting the health of children and youth involved in the child welfare system, reducing stays in institutional settings for significant behavioral health needs, and providing treatment for SMI.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent that those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration

Approval of California's BH-CONNECT demonstration includes the following new initiatives: (1) Access, Reform and Outcomes Incentive Program, (2) Workforce Initiatives, (3) Activity Funds Initiative, (4) Serious Mental Illness Program, (5) Community Transition In-Reach Services, and (6) HRSN. The overall goals of this demonstration include:

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

1) Access, Reform and Outcomes Incentive Program

In the approval, CMS is granting the state's request for expenditure authority to implement an innovative Access, Reform and Outcome Incentive Program for participating counties. This initiative is a key component of California's strategy to transform the state's behavioral health system. The initiative is expected to drive behavioral health delivery system reform by improving access and outcomes in participating counties. CMS will authorize up to $1.9 billion (total computable) over five years in expenditure authority for participating Behavioral Health Plans (BHPs) to strengthen and improve quality and behavioral health outcomes among Medicaid beneficiaries.

The Access, Reform and Incentive Program is limited to up to eighty percent of California counties. The state will select counties where the funding is most needed to improve performance in the areas of behavioral health access, outcomes and delivery system reform. The state will submit the Incentive Program Protocol, subject to CMS approval, that outlines the measures and performance targets that BHPs must achieve to earn incentive payments. A share of total program funding will be at risk if the participating BHPs fail to demonstrate progress toward meeting a set of accountability measures, to be defined in the Incentive Program Protocol. To the extent unearned incentives remain after the annual performance period, any remaining funds will be used for incentive payments through a High-Performance Pool for BHPs

meeting higher standards of access and outcome improvements in the same performance period, based on a subset of measures defined in the aforementioned protocol.

The expenditure authority is expected to promote the objectives of the Medicaid program by enhancing the state's ability to identify behavioral health outcomes among Medicaid beneficiaries that need improvement and by incentivizing improvements to achieve consistent access to high-quality behavioral healthcare. Participating BHPs will be incentivized to improve access to behavioral health services, health outcomes and quality of life, and targeted behavioral health delivery systems reforms. Comprehensive data and robust analysis will help inform BHP interventions and can facilitate rewarding progress in improving access to care and health outcomes as evidenced by achieving defined targets over time. To the extent participating BHPs implement care delivery and other initiatives that succeed in improving the care that is furnished to Medicaid beneficiaries, they are eligible to earn performance-based incentive payments based upon improvements on measures identified jointly by the state and CMS. Participating BHPs will also be rewarded for behavioral health system reforms targeted at driving improvement in health outcomes and access to new evidence-based practices.

2) Workforce Initiatives

CMS is authorizing up to $1.9 billion (total computable) over the demonstration period to support workforce recruitment and retention to promote the increased availability of behavioral health care providers who serve Medicaid and demonstration beneficiaries. California, like other states, continues to face health care provider shortages, as well as challenges in recruiting and retaining a diverse workforce, and the COVID-19 public health emergency (PHE) magnified these issues. California will implement five workforce initiatives, including new behavioral health scholarship, loan repayment, community-based provider training, residency training, and recruitment and retention programs, that will target workforce shortages in behavioral health care, support the delivery of services, and increase access to culturally appropriate services. All workforce initiatives will require practitioners to fulfill service commitments at safety net settings serving a significant population of Medicaid and/or uninsured individuals. Safety net settings are defined as Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), Rural Health Clinics (RHC), or settings with the following payer mix:

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

Demonstration funding for these initiatives cannot supplant state and federal funding or duplicate existing workforce programs.

3) Activity Funds Initiative

This demonstration will authorize expenditure authority under Medicaid and CHIP over 5 years for coverage of "activity funds" – services and items to improve behavioral health outcomes through supporting the social and emotional well-being of certain children and youth in the child

welfare system. Children and youth involved in the child welfare system often do not have access to activities that support physical health and mental wellness. Activity funds would support activities, such as physical wellness activities that promote a healthy lifestyle. To be eligible, a child or youth must have a behavioral health condition, or be at high risk for a behavioral health condition. The items and services authorized in this initiative are similar to what can otherwise be coverable under the section 1915(i) home and community-based services state plan benefit, and will support an eligible beneficiary's inclusion in the community and promote improved physical and behavioral health outcomes. These items or services are designed to help participants find a form or expression beyond words or traditional therapies in an effort to reduce anxiety, aggression, and other clinical issues.

4) Serious Mental Illness (SMI) Program

This demonstration will authorize FFP for otherwise covered Medicaid services, including inpatient psychiatric hospital services, provided to otherwise-eligible Medicaid beneficiaries who are primarily receiving treatment for a SMI who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD). These services will be provided as part of a comprehensive continuum of care to treat SMI including outpatient, community-based services. CMS is also approving the SMI Implementation Plan, included as Attachment XX of the STCs. With this demonstration authority, the state seeks to achieve the following goals, which align with the State Medicaid Director Letter (SMDL) #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.[1]" CMS expects California to achieve the goals on a statewide basis. These action are a condition of receiving FFP for services provided in IMDs per the STCs:

1. Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings;
2. Reduce preventable readmissions to acute care hospitals and residential settings;
3. Improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care; and,
5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

CMS reaffirms the national priority addressed by this demonstration opportunity to expand access to high quality community-based behavioral health services. As a condition of this award and as described in the milestones outlined in SMDL #18-011, the state is expected to strengthen their entire behavioral health delivery system, and to meet all monitoring, reporting, and transparency requirements as outlined in the attached STCs, including reporting on the quality of care provided in participating IMDs. This commitment includes actions to ensure a continuum of care is available to address more chronic, on-going behavioral health care needs of beneficiaries

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

with SMI, to provide a full array of crisis stabilization services, to engage beneficiaries with SMI in treatment as soon as possible, to ensure good quality of care in IMDs, and to improve connections to community-based care following stays in acute care settings. CMS expects that as the state enhances the community-based behavioral health treatment system and increases opportunities for early intervention, there will be greater access to community-based services to address the mental health care needs of beneficiaries with SMI, thereby reducing the reliance on inpatient treatment facilities.

This demonstration will limit IMD expenditure authority to services delivered to Medicaid beneficiaries in participating BHPs that agree to certain conditions and are approved by the state. This approval grants waivers for statewide operation, comparability and amount, duration and scope, so as to limit IMD reimbursement to participating BHPs.

5) Community Transition In-Reach Services

CMS is authorizing expenditure authority for transitional care management services to support individuals with significant behavioral health needs who are returning to the community after long-term stays in inpatient, subacute, and residential facilities, including IMD settings. Individuals who are experiencing or at risk of experiencing lengths of stay of 120 days or more are eligible to receive Community Transition In-Reach Services, up to 180 days prior to discharge. The services will be provided by community-based multidisciplinary teams, not the inpatient, subacute, or residential settings themselves, to improve the connections to community-based providers.

This demonstration will limit expenditure authority to Community Transition In-Reach Services delivered to Medicaid beneficiaries in participating BHPs that agree to certain conditions and are approved by the state. This approval grants waivers for statewide operation, comparability and amount, duration and scope, to allow the state to limit reimbursement for these services to participating BHPs.

The goal of this program is to improve care coordination and transition to community-based care for beneficiaries with the most complex and significant behavioral health conditions. California is implementing a process to ensure that inpatient, subacute, and residential settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services, with community-based providers delivering these transition services.

As described above, CMS is also approving authority for a SMI Program, which has an expectation that the state will meet goals related to strengthening the behavioral health delivery system. Approval of Community Transition In-Reach Services in conjunction with authority for short-term stays in IMDs ensures that the state is committed to improving access to high-quality community-based treatments.

6) Short-Term Rental Assistance

CMS is authorizing the state to provide a housing service that addresses HRSN, as evidence indicates that this benefit is a critical driver of an individual's access to health services that keep them well.[2,3] Under this demonstration, California will receive authority to provide short-term rental assistance. This is defined as a room and board only support and includes room alone or room and board together, without clinical services included in the rental assistance payment.

This is California's second demonstration that will offer a HRSN housing intervention service with room and board. CMS will apply separate duration caps to both categories of housing assistance (that is, episodic interventions with clinical services with room and board, and room and board only support) under CalAIM and BH-CONNECT. Episodic interventions with clinical services with room and board covered under CalAIM will be allowed up to a combined 6 months, per rolling year. Separately, room and board-only support, covered under BH-CONNECT, will be allowed up to a combined 6 months, per household, per demonstration period. For each of these 6-month caps, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months for all types of HRSN housing interventions covered under both of California's section 1115 demonstrations (CalAIM and BH-CONNECT) when providing room and board supports, per beneficiary, in any 12-month period.

Short-term rental assistance will be provided through the managed care delivery system and will initially be optional for managed care plans to provide. However, the service will become mandatory for Medi-Cal managed care plans to provide for certain beneficiaries beginning no sooner than January 1, 2026 and mandatory for all populations no sooner than January 1, 2027.

The short-term rental assistance service authorized in this demonstration must be clinically appropriate for the eligible beneficiary. Individuals eligible to receive this service are Medicaid or CHIP eligible with clinical and social risk factors and a documented medical need for this service. Attachment H, which is being approved with this demonstration, reflects a comprehensive list of the populations, clinical criteria, and social risk factors that the state will incorporate into the post-approval protocol, Attachment G. Below are the transitioning populations of focus to whom the state expects to provide short-term rental assistance:

1. Are transitioning out of an institutional care or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use

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[2] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federalpolicy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[3] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

disorder treatment facility, or an inpatient or residential mental health treatment facility, or nursing facility.

2. Are transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntary through operation of law enforcement authorities.

3. Are transitioning out of foster care.

4. Are transitioning out of short-term recuperative care or short-term post-transition housing.

5. Are transitioning out of transitional housing or rapid re-housing.

6. Are transitioning out of a homeless shelter/interim housing, including domestic violence shelters or domestic violence housing.

7. Meet the criteria of homelessness as described at 24 CFR § 91.5(1)(i).

8. Meet eligibility criteria for a Full Service Partnership (FSP) program.

CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

Coverage of this targeted HRSN service is likely to assist in promoting the objectives of Medicaid because it is expected to help beneficiaries stay connected to coverage and access to needed health care. The housing service authorized in the demonstration is expected to stabilize the housing situations of eligible Medicaid beneficiaries and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled. By providing the short-term service needed to stabilize housing, this demonstration will test whether the individual's health outcomes will improve in addition to their utilization of appropriate care.

Moreover, access to this service for individuals with poorer health outcomes may help to reduce health disparities. Expanding who can receive this service is expected to help a broader range of Medicaid beneficiaries not only receive, and benefit from, the medical assistance to which they are entitled, but also, this service is expected to further reduce health disparities often rooted in socioeconomic factors.[4] Thus, broadening the availability of this HRSN service is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

[4] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

Designated State Health Programs (DSHP)

In December 2017, CMS issued SMDL #17-005, titled "Phase-out of Expenditure Authority for Designated State Health Programs in Section 1115 Demonstrations," in which CMS announced it no longer would accept state proposals for new or extended section 1115 demonstrations that rely on federal matching funds for DSHP. The 2017 SMDL explained that CMS has approved section 1115 demonstrations that provided federal funding for DSHP that had previously been funded only with state funds, because (absent the section 1115 authority) state expenditures on these programs did not qualify for federal matching funds. These approvals of section 1115 demonstrations enabled the state to use the "freed up" state dollars that it otherwise would have been spent on the DSHP, on demonstration expenditures. CMS has rescinded this previous guidance, effective December 23, 2022,[5] and is implementing an updated approach to DSHP as discussed below and as reflected in other recent section 1115 demonstration approvals.[6]

Recently, states have proposed demonstrations that seek federal matching funds for a state-funded DSHP so that they can "free up" state funding for Medicaid-covered initiatives. CMS is approving section 1115 demonstrations that provide federal funding for DSHPs under defined criteria within the STCs that limit both the size and scope of DSHP and apply additional parameters and guardrails. Specifically, CMS is approving federal expenditure authority for DSHP, only if the state uses the "freed up" state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services. CMS expects that any new DSHP-funded demonstration initiative will add to the state's Medicaid program, not supplant existing services or programs.

CMS's revised approach to DSHP demonstrates CMS's continuing commitment to the federal-state financial partnership as a hallmark of Medicaid. CMS approves the BH-CONNECT as it is consistent with CMS's revised approach to approving expenditure authority for DSHP under section 1115 demonstrations. As described in the STCs, the state will be required to contribute state funds other than those freed up by the federal investment in DSHP for expenditures under the DSHP-funded demonstration initiative. DSHP authority will be time-limited, and the state will be required to submit a sustainability plan. The sustainability plan must describe the scope of DSHP-funded initiatives the state wants to maintain, and the state's strategy to secure resources to maintain these initiatives beyond the current demonstration approval period.

As described in the STCs, California is contributing non-DSHP funds (e.g., general revenue) as the non-federal share of the DSHP-funded initiatives on an annual basis. With this, CMS is authorizing up to $1,615,000,000 in DSHP expenditure authority to support DSHP-funded demonstration initiatives, which are workforce initiatives. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements, as required in STC 3.7.

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[5] https://www.hhs.gov/guidance/document/phase-out-expenditure-authority-designated-state-health-programs-section-1115

[6] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf, and https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-appvl-01092024.pdf.

As with CMS's other recent approvals of expenditure authority for DSHP, the state can claim federal matching funds up to the amount of the approved DSHP cap only if budget neutrality "savings" are available for that purpose. The state will be permitted to use the "freed-up state funds" that result from payment of the federal matching funds for its DSHP only on initiatives that improve access to covered services. As a result, CMS has determined that its approval of expenditure authority for the state's DSHP initiative is likely to result in an increase in overall service coverage of low-income individuals in the state, improve health outcomes for Medicaid beneficiaries and other low-income populations in the state, and increase efficiency and quality of care. This will also help to ensure that approving these federal expenditures will not have a significant negative impact on Medicaid fiscal integrity.

The state must contribute $142,500,000 in original, non-freed up DSHP funds, over the course of the remaining demonstration period ending on December 31, 2029, towards its DSHP-funded initiatives. Additional requirements for DSHP are set forth in the STCs, including allowable and prohibited DSHP expenditures. The state may claim federal matching funds for DSHP upon CMS approval of the specific DSHP in Attachment J. CMS has generally not approved DSHP requests for expenditures that are already eligible for federal matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, or that are not likely to promote the objectives of Medicaid (e.g., bricks and mortar, animal shelters and vaccines, and revolving capital funds). CMS will limit its approval of specific DSHP state programs that: (1) are population- or public health-focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the DSHP will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals.

Provider Rate Increase Condition

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

In addition, the state will be required to meet enhanced provider access and rate increase requirements under certain circumstances. The requirements are in effect for a demonstration year to the extent that the state collects more revenue applicable to a demonstration year from its Managed Care Organization Provider Tax than would be otherwise be permitted through the CMS-approved December 15, 2023, tax waiver of the broad-based and uniformity requirements.

These provider payment rate increases and enhanced reporting requirements apply to Medi-Cal Managed Care plans. California will continue provider payment rates that took effect January 1, 2024 for primary care, maternal (obstetrical and doula) care and outpatient (non-specialty) mental health and increase payment levels for the following: evaluation & management codes for office visits, preventive services, and care management; obstetric services; non-specialty mental health services (mild and moderate mental health services provided by managed care plans); vaccine administration; evaluation & management codes for emergency department physician services; and other procedure codes commonly utilized by primary care, specialist, and emergency department providers. California will conduct enhanced transparency and provide to CMS annual payment analysis for calendar years 2025 and 2026.

Of the allowable streamlined eligibility and enrollment strategies outlined to continue in the CMCS Informational Bulletin (CIB) "Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes,"[7] California will maintain strategies to streamline income and resource verification during the *ex parte* renewal process at the time of demonstration approval through June 30, 2025. The State Medicaid Agency will complete an *ex parte* renewal when no data sources return income information (Zero-Dollar and 100 percent FPL Income strategies) in accordance with the parameters outlined in the CIB and will document the continued use of these strategies in their verification policies and procedures.

Waivers for New Enhanced Community-Based Services

CMS is approving waivers to permit implementation of certain state plan services on a limited basis. Peer support services, supported employment and enhanced community health worker services will be implemented in counties that opt to provide the services. The authorities in this demonstration apply to electing Drug Medi-Cal State Plan counties.

Requests not Being Approved at this Time

CMS and California are continuing discussions regarding some of the state's pending requests under the demonstration application submitted October 20, 2023 and addendum submitted July 26, 2024. Over the course of the negotiations, CMS and the state prioritized the requests that are being approved today. At this time, CMS is not approving the Cross Sector Incentive Program and certain services under the Activity Funds initiative. Two workforce proposals were beyond the scope of CMS' workforce policy; therefore, CMS is not approving those programs at this time.

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

Additionally, California requested expenditure authority to allow mental health plans to have the option to provide up to six months room and board in Enriched Residential Settings for individuals with significant behavioral health conditions. To qualify as an Enriched Residential Setting under the state's proposal, a facility must have no more than 16 beds and be voluntary and unlocked. CMS appreciates the state's proposal to find additional opportunities to expand the continuum of care for Medi-Cal members with significant behavioral health needs who are experiencing long stays in an institutional setting, who are or at risk of experiencing homelessness, or who need recovery-oriented residential care. Before CMS consideration of this request, the state should develop, seek public comment on, and submit additional details on: (1) defining provider qualifications (certification, licensure, etc.) and how California will provide robust and conflict-free oversight of the providers; (2) defining who is eligible for these services, to ensure individuals are placed in the least restrictive setting and the pilot is targeting the right individuals; (3) defining how the setting is committed to being truly integrated, with independent choice; and (4) proposed metrics the state would report on for the pilot with a focus on measuring health disparities, as well as oversight and monitoring.

Budget Neutrality[8]

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration. The demonstration is projected to be budget neutral to the federal government, meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the STCs.

Under this demonstration, CMS is treating expenditures for the SMI Program, Community Transition In-Reach Services and the Activity Funds Initiative as hypothetical for the purposes of budget neutrality. This is consistent with CMS's current approach to hypothetical expenditures. Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality in the manner discussed below to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in

[8] For more information on CMS's current approach to budget neutrality, see https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

For each of these MEGs, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each MEG in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

CMS is treating HRSN expenditures authorized under this approval as "hypothetical" for the purposes of the budget neutrality calculation. Some of these expenditures could be covered under other title XIX authority, and treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. Other HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915 services for beneficiaries who are not otherwise eligible for them under section 1915, but there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures.

Additionally, treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs, based on robust academic-level research, but predicting these downstream effects on overall Medicaid program costs is extremely difficult. To ensure that treating certain HRSN expenditures as hypothetical will not have a significant negative impact on Medicaid fiscal program integrity, CMS is applying a budget neutrality spending ceiling to HRSN services expenditures, and is referring to these expenditures as the "Supplemental HRSN Aggregate Ceiling (SHAC)" expenditures in the STCs. The SHAC differs from the usual limit CMS places on hypothetical expenditures (the "supplemental test" discussed above) in several respects. The expenditures subject to the SHAC are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects. The upper limit on the SHAC is based on a range of estimates of the likely cost of these expenditures over a 5-year period, and is set at a mid-point in that range, but in no case can it exceed 3 percent of the state's total computable Medicaid spending. If the state exceeds these limits, it will not be permitted to offset the additional costs with savings from the rest of the demonstration.

Finally, the state's workforce initiatives, DSHP and Access, Reform and Outcomes Incentive Program are costs not otherwise matchable that require budget neutrality savings to offset the expenditures.

CMS has also updated its approach to mid-course corrections to budget neutrality calculations in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

CHIP Allotment Neutrality

Under this demonstration, the state is eligible to receive title XXI funds for allowable title XXI demonstration expenditures, up to the amount of its title XXI allotment. Title XXI funds must be first used to fully fund costs associated with CHIP state plan populations. The demonstration expenditures are limited to remaining funds.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and robust evaluation of the demonstration in accordance with the STCs. This includes the submission of Monitoring Reports, which include both relevant metrics data as well as narrative details describing progress with implementing the various demonstration components. The state will submit the accountability metrics associated with the Access, Reform and Outcomes Incentive Program annually via the Monitoring Reports. In addition, the state is also required to conduct an independent Mid-Point Assessment of the SMI Initiative, as provided in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies.

The state is required to submit an Evaluation Design for CMS approval to direct Interim and Summative Evaluation Reports of whether the initiatives approved under the demonstration are effective in producing the desired outcomes for the individuals and the state's overall Medicaid program. Evaluation of the demonstration must align with the requirements detailed in the STCs, including examining impacts on access to and quality of care, utilization of services, and beneficiary health outcomes. For the Community Transition In-Reach Services, the evaluation strategy must include a rapid-cycle assessment that provides timely information on program implementation and preliminary outcomes, including discharge from residential settings and readmissions to acute levels of care. The state's monitoring and evaluation efforts must also

facilitate understanding the extent to which the demonstration might support reducing existing disparities in access to and quality of care and health outcomes.

Consideration of Public Comments

The federal comment period for the BH-CONNECT application opened on October 27, 2023 and closed on November 26, 2023, and CMS received 12 comments related to the demonstration. Overall, the commenters are generally supportive of the demonstration with many commenters specifically citing their support for the overall goal of strengthening California's behavioral health system. Some comments were not related to components of the BH-CONNECT demonstration.

Two commenters strongly opposed the IMD provisions of the demonstration for various reasons. In contrast three commenters supported the IMD waiver. One commenter asserted that the IMD waiver would be inconsistent with the Americans with Disabilities Act. One commenter asserted that the IMD exclusion cannot be waived. CMS is approving the expenditures associated with SMI IMD section 1115(a)(2) of the Act. Section 1115(a)(2) of the Act grants the Secretary the authority, in the context of a demonstration project under section 1115(a), to provide federal matching of state expenditures that would not otherwise be federally matchable under the terms of section 1903. Specifically, with respect to state expenditures under a section 1115 "demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [Medicaid]," expenditures that would "not otherwise" be matchable under section 1903 may "be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans . . . as may be appropriate." This "expenditure authority" has been exercised by the Secretary for decades to conduct demonstration projects that provide coverage for individuals or services that could not otherwise be covered under a State's Medicaid State plan. This has allowed the Secretary to expand eligibility for benefits to individuals who would not otherwise be eligible, and for services that would not otherwise be covered. This interpretation has been upheld in court as a valid exercise of the Secretary's demonstration authority under section 1115. For example, federal courts have upheld demonstration projects that covered individuals under section 1115(a)(2) who would not otherwise be eligible for coverage. *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007); *Wood v. Betlach*, No. CV-12-08098, 2013 WL 3871414 (D. Ariz. July 26, 2013).

Additionally, one commenter shared concerns that it does not view receiving FFP for mental health services in IMDs as a valid experiment and one commenter shared its view that the proposed hypotheses have already been tested. CMS has determined that California's request serves a research and demonstration purpose as outlined in the SMDL #18-011. As noted above, testing the benefits of covering individuals and services that could not otherwise be covered promotes the coverage objective of Medicaid, and helps states and CMS gather information to inform any potential future legislation. CMS believes that this authority will yield useful data as this demonstration includes robust monitoring and evaluation requirements.

Two commenters opposed approval of a waiver of length-of-stay requirements for foster children residing in QRTPs, for which the state is no longer seeking this approval.

Three commenters recommended state plan authority to implement services statewide instead of using waiver authority to allow counties to opt in to offering certain services. One of these commenters was strongly opposed to the waiver of statewideness.

Five commenters supported the Workforce Initiative. One commenter recommended limiting the funding to support of community-based services. Another commenter recommended inclusion of training in Adverse Childhood Experiences (ACES) informed care.

Two commenters provided comments on data collection and reporting for BH-CONNECT. CMS recognizes the importance of robust reporting of health outcomes and utilization metrics aligned with the demonstration's policies and objectives. As part of our demonstration monitoring, CMS will work with the state to collect the appropriate data and track progress for the HRSN initiative, as outlined in the monitoring and reporting requirements in the STCs.

Five commenters had specific comments related to transitional rent. One commenter recommended extending transitional rent services beyond 6 months. Three commenters recommended the inclusion of other housing-related supportive services, such as pre-tenancy and tenancy sustaining services. One commenter recommended establishment of parameters for partnerships between managed care organizations and counties. One commenter expressed concern that necessary behavioral health supports may not be provided to ensure these Medi-Cal recipients maintain successful housing, especially when ACT, FACT, CSC for FEP, IPS Supported Employment, CHW services, and clubhouse services are also only going to be available at county option and are not required to be in place with the transitional rent services.

For the Activity Funds Initiative, one commenter expressed support along with recommendations to broaden the eligibility criteria and to ensure that the funding is not used to pay for services covered under EPSDT. This initiative provides goods and services that are not otherwise covered in Medicaid to children and youth involved in the child welfare system with a behavioral health condition, or at risk for a behavioral health condition.

Four commenters submitted comments on the proposals for three incentive programs. Comments were supportive of the goals, while also noting that more details were needed. One commenter objected to incentive program participation as optional for counties. One commenter recommended including additional measures for the Cross-Sector Incentive Program. CMS is not approving the Cross-Sector Incentive Program at this time.

California submitted an addendum to the BH-CONNECT demonstration application on July 26, 2024, which is being approved with this action. The federal comment period opened on August 1, 2024 and closed on August 31, 2024 and CMS received 11 comments related to the demonstration. Some comments were not related to components of the BH-CONNECT demonstration.

Four commenters expressed support for Community Transition In-Reach Services with suggestions to improve the initiative. One commenter recommended removing the restriction of these services to 180 days prior to discharge due to the variability in the length of stay in facilities and community settings. Another commenter requested additional settings be included. One commenter recommended ensuring that people exiting the intuitional setting are not

discharged to homelessness. This commenter also recommended expanding Community Transition In-Reach Services to individuals exiting carceral settings. California has approval under CalAIM for pre-release services.

One commenter shared a concern that approval of this initiative will promote and expand institutional care. One commenter expressed concern that approval of an IMD exclusion waiver would affect compliance with international legal standards and guidance on working with people with psychosocial disabilities.

Six commenters opposed and three commenters supported the approval of Room and Board in Enriched Residential Settings. CMS is not approving this request at this time.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that this extension is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed set of waiver authorities, expenditure authorities, and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer, Diona Kristian, is available to answer any questions concerning this demonstration, and her contact information is as follows:

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Center for Medicaid and CHIP Services
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If you have any questions regarding this approval, please contact Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

Chiquita Brooks-LaSure

Enclosure

cc: Cheryl Young, State Monitoring Lead, Medicaid and CHIP Operations Group