DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: [Date]

Behavioral Health Information Notice No: 26-XXX
Supersedes Behavioral Health Information Notice No: 25-011

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration Option to Receive Federal Financial Participation for Specialty Mental Health Services in Institutions for Mental Diseases.

REFERENCES: Welf. & Inst. Code § 14184.400, subd. (c) and 14184.102, subd. (d)SMDL#18-011; BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions; and BH-CONNECT Approval Letter Technical Corrections and Protocols, SMI Implementation Plan.

PURPOSE: To inform behavioral health plans (BHPs) of requirements to receive Federal Financial Participation (FFP) for short-term Specialty Mental Health Services (SMHS) delivered in Institutions for Mental Diseases (IMDs)

BACKGROUND:

The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT is comprised of a new five-year Medicaid Section 1115 demonstration, State Plan Amendments (SPAs) to expand coverage of evidence-based practices (EBPs) available under Medi-Cal, and complementary guidance and policies to strengthen behavioral health services statewide.

This Behavioral Health Information Notice (BHIN) establishes the process for BHPs[1] that administer SMHS to participate in the BH-CONNECT option to receive FFP for mental health services provided to adult Medi-Cal members ages 21-64 during short-term stays in IMDs (hereafter "MH IMD FFP Program"), consistent with requirements set forth by the BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions and the Centers for Medicare and Medicaid Services (CMS) in State Medicaid Director Letter #18-011.[2] BHPs that opt into the MH IMD FFP Program, and BHPs that do not, remain subject to all existing requirements and obligations to cover and use county funding for medically necessary services provided to Medi-Cal members in IMDs, including but not limited to obligations described in California Welfare & Institutions Code § 5600, et. seq., and BHIN 20-008.

POLICY:

Effective January 1, 2025 and until the end of the demonstration, BHPs may opt into the MH IMD FFP Program, which will authorize them to receive payment, including FFP, for Medi-Cal-covered SMHS provided to adult Medi-Cal members ages 21 to 64 during short-term stays in residential or inpatient psychiatric settings classified as IMDs if they meet specified

[1] Only BHPs that administer SMHS are eligible to participate in the MH IMD FFP Program. This program is limited to SMHS and does not include residential or inpatient SUD services covered under Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS).

[2] Services provided to members residing in IMDs may be subject to payment exclusions pursuant to 1905(a)(30)(B) of the Social Security Act. To the extent that this BHIN conflicts with California provisions that reiterate these federal payment exclusions for members residing in IMDs, this BHIN shall control. All payment exclusions not subject to the MH IMD FFP Program shall remain in effect.

requirements.[3] FFP is not available under this program for services provided to members under the age of 21 or over the age of 64.[4] Some specified requirements must be met by the BHP; other requirements must be met by the participating IMDs as ensured by the contracting BHP, as noted below.

MH IMD FFP PROGRAM OPT-IN REQUIREMENTS

To opt into the MH IMD FFP Program, BHPs must[5]:

1. Submit to, and receive from, the Department of Health Care Services (DHCS) approval of an IMD FFP Plan*;* **and**
2. Provide a full suite[6] of SMHS EBPs on a timeline specified by DHCS; **and**

[3] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 8.5, p. 39) pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

[4] In accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act, all counties, irrespective of their choice to opt into the MH IMD FFP Program, must ensure that all members under age 21 receive medically necessary services to correct or ameliorate health conditions that are coverable under Section 1905(a)of the Social Security Act. Nothing in this BHIN limits or modifies the scope of the EPSDT mandate. All counties are responsible for the provision of medically necessary services pursuant to the EPSDT mandate, including inpatient psychiatric services for individuals under the age of 21, pursuant to 1905(a)(16) and 42 CFR § 440.160. FFP may be claimed for such services if all state and federal requirements are met. Counties should refer to BHIN 21-073 and any subsequent guidance or directives regarding medical necessity criteria for SMHS and BHIN 22-003 and any subsequent guidance or directives regarding Medi-Cal SUD treatment services for beneficiaries under age 21.

[5] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 8.1, pp. 32-33), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

[6] The "full suite" includes Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis, Individual Placement and Support (IPS) Supported Employment, Enhanced Community Health Worker (CHW) Services, and Peer Support Services, including the Forensic Specialization.

3. Ensure FFP is claimed only for short-term stays in facilities that are licensed or accredited;[7] **and**
4. Meet the requirements identified in the Program Accountability Requirements section of this BHIN to ensure that IMDs are used only when there is a clinical need and for no longer than medically necessary, using individualized, person-centered approaches, and that IMDs meet quality standards; **and**
5. Reinvest FFP received for patient care services provided in IMDs to support community-based behavioral health service provision, quality improvement, or capacity expansion to benefit Medi-Cal members served by the BHP. FFP received for care provided in IMDs shall not supplant current funding sources for behavioral health services. Allowable use of FFP includes, but is not limited to:
    - Providing additional Medi-Cal reimbursable behavioral health services;
    - Hiring additional behavioral health clinicians, providers and staff;
    - Investing in behavioral health quality improvement infrastructure; and
    - Enhancing provider payment rates (e.g., to build capacity and expand workforce).

AVAILABILITY OF FFP

FFP shall only be claimed by BHPs for IMD stays of 60 days or fewer.[8] Stays of 61 days or more are not eligible for FFP under any circumstances; if an IMD stay exceeds 60 days, FFP is not available for any day of the stay. BHPs must ensure that medically necessary, covered

[7] BHPs may identify a subset of IMDs within the service area that are eligible for FFP and meet the IMD-specific requirements for participation in the MH IMD FFP Program. A BHP's service area may include IMDs within county borders and IMDs serving the BHP's members in other counties. Not all IMDs within the county must meet MH IMD FFP Program requirements; services rendered by those that do not meet requirements will remain ineligible for Medi-Cal FFP under this Program.

[8] FFP may only be claimed for services provided to members who are short-term residents in IMDs. The 60-day limit is outlined in BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 8.5, p. 39), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

services are provided to members for whom stays of more than 60 days are clinically indicated and must review the medical necessity and appropriateness of covered services delivered to all Medi-Cal members within the Participating Psychiatric Settings, as defined in the Licensure and/or Accreditation section of this BHIN. In circumstances where a stay exceeds 60 days, BHPs must use alternative funds to cover the full stay and may not claim, receive, or retain FFP for any portion of the member's IMD stay.

Facilities shall not, under any circumstances, discharge a member for the purpose of readmitting them to claim FFP. Each participating BHP shall monitor the readmissions rate for all stays for which the BHP claims FFP to ensure appropriate practices. BHPs are expected to provide care coordination and transitions to community-based care as well as crisis stabilization services to reduce readmissions.[9]

All participating BHPs shall monitor participating facilities to ensure an average length of stay (ALOS) of no more than 30 days among all the IMD stays for which the BHP claims FFP. DHCS will calculate ALOS annually, at minimum, to ensure compliance with the requirement.[10] Only Medi-Cal enrolled members who have an IMD stay for which FFP is claimed under this program are included when calculating the ALOS.

IMD FFP PLAN AND OPT-IN PROCESS

In advance of claiming FFP in the MH IMD FFP Program, BHPs must submit and secure DHCS approval of an IMD FFP Plan. A BHP cannot access FFP through this program until the BHP's IMD FFP Plan is approved by DHCS.

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[9] One goal of BH-CONNECT demonstration is reduced readmissions. Readmissions will be reviewed by an independent evaluator to inform the overall MH IMD FFP Program budget neutrality analysis.

[10] Under BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 8.5, pg. 39), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011. and the CMS SMI/SED Demonstration Opportunity Technical Assistance Questions and Answers— California must maintain a 30-day statewide average length of stay for members who receive covered IMD services. If the state cannot demonstrate that it is maintaining this 30-day average, the maximum length of stay eligible for coverage may be reduced from 60 days to 45 days. DHCS must report statewide ALOS to CMS annually within the Annual Monitoring Report, per CMS SMI/SED Demonstration Opportunity Technical Assistance Questions and Answers.

The BH-CONNECT IMD FFP Plan template and submission instructions are available at https://www.dhcs.ca.gov/CalAIM/Pages/Opt-in-to-BH-CONNECT.aspx.

Only one IMD FFP Plan is required per BHP for the duration of the demonstration and must be signed by the Behavioral Health Director or their designee. BHPs may submit IMD FFP Plans to opt into the demonstration on a rolling basis.

Upon approval of the BHP's IMD FFP Plan, qualifying IMD stays may be claimed back to the date upon which the BHP can demonstrate coverage and implementation of both Peer Support Services and Enhanced Community Health Worker (CHW) Services, as described in the Coverage of BH-CONNECT EBPs section of this BHIN.

Participating BHPs must also submit an IMD FFP Progress Report every two years following initial IMD FFP Plan approval using a template provided by DHCS to demonstrate continued compliance with program requirements. IMD FFP Progress Reports will build upon each BHP's approved IMD FFP Plan.

COVERAGE OF BH-CONNECT EBPS

BHPs that opt into the MH IMD FFP Program must cover and implement all of the following BH-CONNECT EBPs as SMHS:[11]

- Enhanced CHW Services
- Peer Support Services, including the Forensic Specialization[12]
- Assertive Community Treatment (ACT) and Forensic ACT (FACT)

[11] Clubhouse Services are also available as part of the BH-CONNECT EBPs but are not required to opt into the MH IMD FFP Program. Independent of the MH IMD FFP Program, BHPs and DMC programs may cover some or all of the BH-CONNECT EBPs in any combination. Additional information about coverage of BH-CONNECT EBPs is available in BHIN 25-009 or subsequent guidance.

[12] Effective July 2022, Peer Support Services are available as an optional benefit in the SMHS, DMC and DMC-ODS delivery systems. BHPs that opt to cover the full suite of BH-CONNECT EBPs must also cover Peer Support Services including the forensic specialization, using the process described in BHIN 22-026 or subsequent guidance.

- Coordinated Specialty Care (CSC) for First Episode Psychosis
- Individual Placement and Support (IPS) Supported Employment

The timeline required for BHPs to implement EBPs to claim FFP for IMD stays is shown in Table 1. BHPs must also complete the EBP opt-in process described in BHIN 25-009 or subsequent guidance prior to commencing coverage of Enhanced CHW Services, ACT, FACT, CSC and IPS Supported Employment.

An EBP shall be considered covered and implemented on the date of service of the first submitted and approved claim. If a BHP fails to cover and implement any of the EBPs on the required timeline, FFP will not be available until the BHP can demonstrate that the EBP has been implemented.[13]

Table 1. Full Suite of BH-CONNECT EBPs

Service	***Implementation Timeline***
Enhanced CHW Services	Prior to claiming FFP for IMD stays
Peer Support Services	Prior to claiming FFP for IMD stays
Peer Support Services with Forensic Specialization	Within 1 year of claiming FFP for IMD stays
ACT	Within 1 year of claiming FFP for IMD stays
FACT	Within 2 years of claiming FFP for IMD stays
CSC	Within 2 years of claiming FFP for IMD stays
IPS	Within 3 years of claiming FFP for IMD stays
Clubhouse Services	Not Required

[13] DHCS will not retroactively recoup funds for claims that were made prior to the EBP implementation deadline, but additional FFP may not be available until the BHP meets the EBP implementation requirements.

LICENSURE AND/OR ACCREDITATION

There are three types of hospitals and residential treatment settings for which BHPs may receive FFP under the MH IMD FFP Program, hereafter referred to as "Participating Psychiatric Settings."[14]

- Mental Health Rehabilitation Centers (MHRCs) [15]
- Psychiatric Health Facilities (PHFs)
- Freestanding Acute Psychiatric Hospitals (APHs)

BHPs must ensure the Participating Psychiatric Settings are licensed or otherwise authorized by the State to provide primarily mental health treatment and must ensure ongoing compliance with state licensing and certification requirements, including through unannounced visits.[16] Participating Psychiatric Settings that are not certified as meeting the conditions for participation in Title 42 of the Code of Federal Regulations (42 CFR) Part 482 shall be accredited by a nationally recognized accreditation entity in addition to meeting state licensure requirements.

BHPs shall ensure that Participating Psychiatric Settings have obtained licensure and/or accreditation prior to claiming FFP under the MH IMD FFP Program.

[14] The FFP for IMD Program is not available for individuals under 21. Qualified Residential Treatment Programs (QRTPs) are not included in the FFP for IMD Program. Additional information on QRTPs is in BHIN 21-055. As required pursuant to EPSDT, medically necessary inpatient psychiatric services and residential treatment for youth under 21 remain covered by Medi-Cal.

[15] For purposes of claiming FFP, stays in MHRCs are subject to the 60-day limit and 30-day ALOS benchmark described above. Given existing trends of longer lengths of stay in these settings, BHPs shall exercise discretion in selecting MHRCs for participation in this program and shall carefully monitor length of stay requirements.

[16] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions, (STC 8.3(c)(i)(2) p.34), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

BILLING AND CLAIMING

Upon approval of the BHP's IMD FFP Plan, qualifying IMD stays may be claimed back to the date upon which the BHP can demonstrate coverage and implementation of both Peer Support Services and Enhanced CHW Services.

BHPs shall not submit claims applicable to the MH IMD FFP Program for payment until the end of a member's qualifying stay of 60 days or fewer. Claims for qualifying IMD stays may be submitted through the demonstration end date of December 31, 2029. Detailed claiming instructions are in the Short Doyle Medi-Cal Billing Manual for Specialty Mental Health.[17]

Participation in the MH IMD FFP Program does not alter existing rate structures:

- For qualifying stays in MHRCs and PHFs, BHPs shall claim the established rates for services provided in these facility types.
- For qualifying stays in Freestanding APHs that are Short-Doyle Medi-Cal hospitals, BHPs shall claim the established rates for acute psychiatric inpatient hospital services and administrative day services contained in the appropriate fiscal year's fee schedule for SMHS Psychiatric Inpatient Rates.[18]
- For qualifying stays in Freestanding APHs that are Fee-for-Service Medi-Cal (FFS/MC) hospitals, the hospital shall claim their established usual and customary charge and DHCS will pay the rate the hospital negotiated with the MHP or the

[17] DHCS will initiate claiming systems updates upon approval of a BHP's IMD FFP Plan, however, there may be a short delay between when a BHP's IMD FFP Plan is approved and when systems updates are in place to claim for qualifying IMD stays. DHCS will work with BHPs to ensure all eligible claims are processed as soon as systems updates are complete.

[18] The fee schedules contain rates that DHCS reimburses Mental Health Plans (MHPs) for SMHS rendered to Medi-Cal members. MHPs negotiate rates with and reimburse individual network providers and are not required to reimburse network providers at the posted rates. Rates are developed using a county-wide average of direct and indirect costs and can be found here: Medi-Cal Behavioral Health Fee Schedules

regional rate.[19] Additional information about FFS/MC hospital negotiated rates is in BHIN 25-038.

BHPs must also adhere to all applicable claiming and documentation requirements, as described in this BHIN, BHIN 22-017, BHIN 23-068, and all other state and federal guidance. Member and provider contact post-discharge, as described below, should be claimed using appropriate outpatient codes.

PROGRAM ACCOUNTABILITY REQUIREMENTS

BHPs are responsible for oversight and accountability for the SMHS[20] provided in Participating Psychiatric Settings and shall perform the accountability requirements described in this section. The accountability requirements ensure quality of care, improve care coordination and support transitions to community-based care, and tailor services to member needs.

BHPs are required to describe how they will meet the following accountability requirements in their IMD FFP Plans.

1. **Screenings.**[21] BHPs must ensure Participating Psychiatric Settings screen all admitted members for co-morbid physical health conditions, substance use disorders and suicidal ideation, and demonstrate the capacity to address co-morbid health conditions during short-term stays in these treatment settings with on-site staff, telemedicine, and/or partnerships with local physical health providers.

[19] 9 CCR § 1820.110(f); 9 CCR § 1820.110(a); 9 CCR 1820.115.

[20] Medicaid-covered mental health services provided in IMDs are referred to in the BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions as "SMI Services," and in Medi-Cal include the full range of otherwise covered SMHS. In addition to complying with the MH IMD FFP Program Accountability Requirements outlined in this section, BHPs must ensure that SMHS covered as part of the MH IMD FFP Program comply with all applicable Medi-Cal requirements.

[21] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c)(i)(6), pp. 34-35), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

2. **Discharge Planning.**[22] BHPs must ensure Participating Psychiatric Settings carry out extensive pre-discharge planning and include community-based providers in care transitions by providing a written aftercare plan to the member prior to discharge from the facility. Planning shall include and document coordination of care with the Medi-Cal Managed Care Plan (MCP) according to joint processes established within the Memorandum of Understanding between MCPs and BHPs.

   The written aftercare plan shall include, to the extent known:

   - The nature of the illness and follow-up required.
   - Medications including side effects and dosage schedules.
     - If the patient was given an informed consent form with their medications, the form shall satisfy the requirement for information on side effects of the medications.
   - Expected course of recovery.
   - Recommendations regarding treatments that are relevant to the patient's care.
   - Referrals to providers of medical and behavioral health services.
   - An assessment of the member's housing situation, particularly when discharging members who have previously experienced homelessness, are likely to experience homelessness, or may be returning to unsuitable/unstable housing, and referrals to community-based housing services providers when needed and available.[23]
   - Other relevant information.

[22] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c)(ii)(1), p. 35), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

[23] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c)(ii)(2), p. 35), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

Further, BHPs must ensure Participating Psychiatric Facilities comply with the following requirements:

- Assertive discharge planning after psychiatric hospitalization.[24] Assertive discharge planning is person-centered, focused, tailored to specific support needs, and is highly participatory. It may include:
    - Immediate access to structured clinical interventions within a step-down level of care.
    - Appointments with primary care or other medical follow up.
    - Arranged access to prescription medications.
    - Overdose-risk prevention, including offering naloxone with brief instruction, and ensuring timely linkage to medications for treatment of opioid use disorder.
    - Family and support system engagement and psychoeducation.
    - Peer support engagement.
    - Vocational or educational support.
    - Crisis response planning.
    - Risk factor analysis and collaborative safety planning, including lethal-means safety counseling.
    - Strategies to address social determinants of health.
    - Defining and implementing preferred methods for proactive outreach to individuals within the first 24–72 hours following discharge to ensure timely connection to follow-up care and support services.

[24] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c), p. 162), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

- Compliance with standards and specifications associated with Electronic Notification requirements in accordance with 42 CFR 482.61(f), as specified in the CMS Interoperability and Patient Access Final Rule.
- Coordination of behavioral health services including:
    - Admission, discharge, and transfer notifications from acute care hospitals, psychiatric hospitals, state hospitals, and skilled nursing facilities; and
    - Data sharing between Medi-Cal Partners, defined as any person or organization that provides Medi-Cal reimbursable health and social services to Medi-Cal members, including BHPs and MCPs.[25]
- Service coordination with all applicable providers regardless of the provider's participation in Medi-Cal.

3. **Member and Provider Contact Post-Discharge.**[26] BHPs must ensure that Participating Psychiatric Settings or the BHP contacts members and community-based providers within 72 hours of discharge to ensure that follow-up care is accessed. Contact should occur through the most effective means possible, which may include but is not limited to email, text messaging, and/or telephone calls. Participating Psychiatric Settings or BHPs may attempt multiple methods of contact.

4. **Prevent or Decrease Length of Stay in Emergency Departments.**[27] BHPs must implement strategies to prevent or decrease the length of stay in emergency departments among members with Serious Mental Illness (SMI) or Serious

[25] More information is available at https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf.

[26] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c)(ii)(3), p. 35), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

[27] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c)(ii)(4), p. 35), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

Emotional Disturbance (SED). This may include the use of Peer Support Specialists, CHWs, and psychiatric consultants in emergency departments, and real-time data exchange capabilities, such as event-based notifications to help with discharge and referral to treatment providers.

5. **Closed Loop Referrals**[28] **and E-Referrals.**[29] BHPs must ensure Participating Psychiatric Settings facilitate closed loop referrals and e-referrals upon DHCS publication of closed loop referral implementation guidance, which is forthcoming.
6. **Bed Tracking and Availability.**[30] BHPs must ensure Participating Psychiatric Settings participate in statewide tracking on the availability of inpatient and crisis stabilization beds in accordance with state and federal Health IT (HIT) Plan standards and regulations[31] upon DHCS launch of a bed capacity data solution as described in Section 131420 of the Health and Safety Code, no later than December 31, 2026. Implementation guidance is forthcoming.
7. **Assessments.**[32] Consistent with BHIN 25-020, BHPs must utilize standardized, statewide screening and transition of care tools to promote appropriate referrals and timely care coordination. Medi-Cal members that receive SMHS shall also receive comprehensive assessments consistent BHIN 23-068, and future guidance. Additionally, effective July 1, 2029, BHPs must ensure that Participating

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[28] DHCS defines a Closed-Loop Referral (CLR) as a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a Known Closure. A Known Closure occurs when a Member's initial referral loop is completed with a Known Closure reason such as the Member receiving services. Guidance and implementation requirements for behavioral health closed loop referrals are forthcoming.

[29] CMS defines e-referral as a CLR facilitated electronically.

[30] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c)(iii)(3), p. 36), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

[31] More information is available at eCFR: 42 CFR 495.332 -- State Medicaid health information technology (HIT) plan requirements.

[32] BH-CONNECT Section 1115(a) Demonstration Special Terms and Conditions (STC 8.3(c)(iii)(4), p. 36), pursuant to CMS SMI/SED demonstration opportunity requirements described in SMD 18-011.

Psychiatric Settings and utilization review entities use the Level of Care Utilization System (LOCUS) assessment tool to determine appropriate level of care and length of stay.[33] Implementation guidance is forthcoming.

Upon availability of new data contained in BHPs' Behavioral Health Services Act Implementation Plans and/or Behavioral Health Oversight, Accountability, and Transparency Reports, DHCS may require BHPs participating in the MH IMD FFP program to take additional steps to demonstrate that they are filling identified gaps in their behavioral health continuums of care.

IMD FFP Plans shall also describe how the BHP will reinvest FFP received for patient care services provided in IMDs to benefit Medi-Cal members served by the BHP, as described in the MH IMD FFP Program Opt-In Requirements section of this BHIN.

COMPLIANCE MONITORING

BHPs are responsible for ensuring accountability and compliance with program requirements applicable to the BHP as well as Participating Psychiatric Settings. DHCS will evaluate BHP compliance, including through approval of the IMD FFP Plan and interim IMD FFP Progress Reports, as described in the "IMD FFP Plan and Opt-In Process" section above.

DHCS monitors and oversees BHPs and their operations as required by state and federal law. DHCS will monitor BHPs for compliance with the requirements outlined above, and deviations from the requirements may require corrective action plans or other applicable remedies. This oversight may include, but is not limited to, verifying that services provided to Medi-Cal members are medically necessary, and that documentation complies with the applicable state and federal laws, regulations and the MHP contract.

Recoupment shall be focused on identified overpayments and fraud, waste, and abuse.

[33] All BHPs, regardless of participation in the MH IMD FFP Program, will be required to implement the LOCUS.

Sincerely,

Original signed by

Ivan Bhardwaj, Chief

Medi-Cal Behavioral Health – Policy Division

Enclosure (1)