Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee Hybrid Meeting

July 20, 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Webinar Tips

- Please use **either a** computer **or** phone for audio connection.
- Please mute your line when not speaking.
- For questions or comments, email: SACInquiries@dhcs.ca.gov or BehavioralHealthSAC@dhcs.ca.gov.

Director's Update

Michelle Baass, Director, and Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director

DHCS

Approved DHCS Budget

Budget Act Update

- The Governor has signed the Budget Act for fiscal year (FY) 2023-24 which includes $156.6 billion in total funds for DHCS (approx. $38.3 billion General Fund) fully funding DHCS programs.
- The Budget Act contains new and current proposals:
  - Medi-Cal provider rate increases
  - Managed Care Organization (MCO) Tax
  - Modernization of California's behavioral health system
  - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration
  - Children and Youth Behavioral Health Initiative – Fee Schedule Third Party Administrator

Budget Act (Continued)

- The budget includes the renewal of the MCO tax, effective April 1, 2023 through December 31, 2026.
- Providing $19.4 billion in funding over the period of the tax.
  - Of this amount, **$11.1 billion will be dedicated to new investments** in Medi-Cal including increasing rates for Primary Care (inclusive of Nurse Practitioners and Physician Assistants), Maternity Care (inclusive of OB/GYN and doulas) and non-specialty mental health services effective January 1, 2024.
  - The remaining **$8.3 billion will be used to support the Medi-Cal program** and achieve a balanced budget.

Budget Act (Continued)

- The budget includes $6.1 billion over five years to implement **BH-CONNECT**, effective January 1, 2024.
- The budget adds a new Workforce Initiative to the BH-CONNECT waiver, which will provide $480 million a year for five years ($2.4 billion total funding), to strengthen the pipeline of BH professionals, including improving short-term recruitment and retention efforts.
- DHCS will seek approval of a Medicaid Section 1115 demonstration waiver in summer/fall 2023.

Budget Act (Continued)

- The Budget includes $250 million to initially fund the non-federal share of behavioral health-related services at the start of the **CalAIM Behavioral Health Payment Reform**.
- The Budget includes funding to support **county Community Assistance, Recovery & Empowerment (CARE) Act** costs: $67.3 million in FY 2023-24 and $151.5 million ongoing, with an additional $15 million for Los Angeles County for early implementation start-up costs.

Update on Justice-Involved Waiver

Release of Draft Policy and Operational Guide for Stakeholder Comment

- On June 12, 2023, DHCS released draft guidance that memorializes policy and operational requirements for implementing the Medi-Cal Justice-Involved Reentry Initiative.
- The draft guidance is intended to lay out the policy, design and operational processes that will serve as the foundation to implementing the Reentry Initiative.
- As implementing partners begin to advance the process of standing up the Reentry Initiative, and as CMS continues to refine its sub-regulatory guidance for states that receive 1115 demonstration approval, it is expected that this guide will be updated on an on-going basis.
- DHCS expects to finalize guidance in summer 2023.

Providing Access and Transforming Health (PATH) Capacity Building for Justice-Involved (JI) Program

The approved CalAIM 1115 waiver authorizes $410 million for the PATH Justice-Involved Capacity Building Program to support collaborative planning and IT investments intended to support implementation of Behavioral Health Links in the 90 days prior to release.

Funding from the PATH JI Round 3 will provide implementation grants to correctional facilities (including CDCR, sheriff's offices, probation offices) or their delegates, and County Behavioral Health Agencies.

Funding is intended to support eligible entities as they stand-up processes, protocols, and IT system modifications that are necessary to implement or modify processes to support the provision of Pre-Release Services and Behavioral Health Links.

This funding can be used for investments in personnel, capacity, or IT systems that are needed to effectuate pre-release service processes.

DHCS has provided detailed guidance on PATH applications, available on the CalAIM JI website.

Timing for Release of PATH Funds

DHCS memorialized policy requirements and operational expectations in draft Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

PATH Guidance: DHCS released the PATH Round 3 application and guidance in May 2023.

- DHCS streamlined PATH Round 3 applications to collect essential information about applicants.
- Applicants will receive 10% of maximum amount of funding they are eligible to apply for upon application review and approval.
  - This initial funding can support applicants in developing their larger Implementation Plan; additional funding will be provided upon approval of the Implementation Plan.
- Applications are due on **July 31, 2023.**

TA Survey: To support planning and implementation of Pre-Release Services and Behavioral Health Links, DHCS is requiring all correctional facilities and all County Behavioral Health Agencies to complete a survey to gauge the level of TA needed to successfully implement the initiative. **To receive PATH JI Round 3 funding, eligible entities must complete this survey. For more information, please review the PATH JI webpage and email justice-involved@ca-path.com with questions**

Update on Medi-Cal Redeterminations

- *Yingjia Huang, Assistant Deputy Director, Health Care Benefits and Eligibility*

Early Data – A Snapshot

- DHCS Continuous Coverage Eligibility Unwinding Dashboards
- California resumed redeterminations in April 2023 at the conclusion of the federal continuous coverage protection, simultaneous to continuing our regular enrollment process.
- Our dashboard provides a snapshot of current Medi-Cal enrollment, beginning with our baseline in March 2023. This is updated on a monthly basis.

Understanding the California Context

To better understand the results of the unwinding data report, we looked at historical information.

- Prior to the COVID-19 pandemic, approximately 80% of total renewals due in any average month continue onto ongoing Medi-Cal after we complete the 90-day cure period.
- 18-20% of total renewals due in any average month statewide were disenrolled from Medi-Cal after the 90-day cure period.
- Approximately 4% of the monthly renewal caseload do re-enroll in the 90 days after disenrollment.

Understanding the California Context (Continued)

- Through California's Continuous Coverage Unwinding Period, over 1 million Medi-Cal members need to be renewed each month. Currently approximately 26-29% are automatically renewed through the ex-parte process, with the remaining needing to fill out renewal packets to re-verify certain information (i.e.) in their cases. DHCS is working with the United States Digital Service (USDS) to review opportunities to improve our ex-parte rates.
- The Medi-Cal disenrollment data in our dashboards are **preliminary since it does not reflect renewals in process and the reinstatements during the cure period.**
- As a reminder, Medi-Cal members have 90 days after disenrollment to "cure" and provide the necessary outstanding information to their local Medi-Cal office to restore their coverage back to their original renewal date.

Early Insights: June 2023 Data

- For June redeterminations, more than 81% of the 1,052,030 eligible for renewal returned their packet to county offices for review or completed their renewals through ex parte.
- Effective July 1, approximately 225,000 Medi-Cal members, or around 21%, were disenrolled for the month of June. The main reason was for not returning a packet. Only 2.4% were disenrolled for another reason.
- If one assumes a similar reinstatement rate of approximately 4% within the 90-day cure period of members that were previously disenrolled, we are projecting a June 2023 disenrollment rate of closer to 17% after the cure period.
- What we know: Since the data are preliminary, we anticipate a more settled "picture" after the first 90-day cure period ends on September 30, 2023. DHCS will share cure period data in the October report.
- In early August, DHCS will release our unwinding dashboard with additional details of the demographic information for the disenrolled.

Continuing Outreach – Call to Action

- DHCS started sharing monthly redetermination dates for their members with Medi-Cal managed care plans (MCPs). MCPs will receive a list of Medi-Cal members up for redetermination each month.
- DHCS is expanding the sharing of redetermination dates to our Health Enrollment Navigators beginning in August 2023 to assist Medi-Cal members with redeterminations.
  - The 2023-24 Budget Act included $20 million in additional funding for Health Navigators.
- DHCS Coverage Ambassadors: 3,500+ as of July 2023.
- New resource hub for our Ambassadors: Keep Your Medi-Cal (socialpresskit.com)

Additional Federal Flexibilities

- On June 16, 2023, California submitted another five 1902(e)(14)(A) flexibilities to CMS:
  - Renew Medicaid eligibility for individuals with income at or below 100% of the federal poverty level (FPL) and no data returned on an ex parte basis (Approved June 29, 2023).
  - Suspend the requirement to apply for other benefits as a condition of Medi-Cal eligibility.
  - Suspend the requirement to cooperate with the local child support agency in establishing the identity of a child's parents and in obtaining medical support.
  - Renew eligibility if able to do so based on available information, and establish a new eligibility period whenever contact is made with hard-to-reach populations (Approved June 29, 2023).
  - Reinstate eligibility effective on the individual's prior termination date for individuals who were disenrolled based on a procedural reason and are subsequently redetermined eligible for Medicaid during a 90-day reconsideration period.

Behavioral Health Modernization

Michelle Baass, Director, and Tyler Sadwith, Deputy Director, Behavioral Health

DHCS

Key Elements

1. Authorize a general obligation bond to fund:
   - Unlocked community BH residential settings
   - Permanent supportive housing for people experiencing or at risk of homelessness who have BH conditions
   - Housing for veterans experiencing or at risk of homelessness who have BH conditions
2. Modernize the MHSA
3. Improve statewide accountability, transparency, and access to behavioral health services

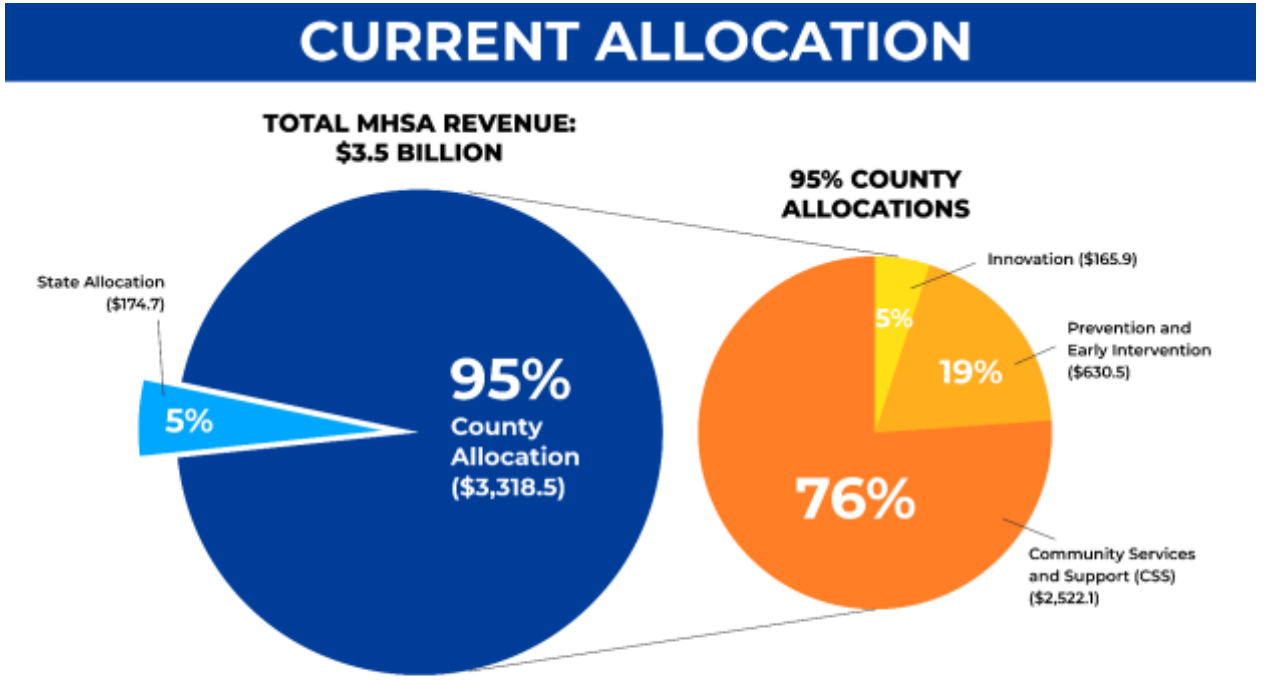
Update Since March

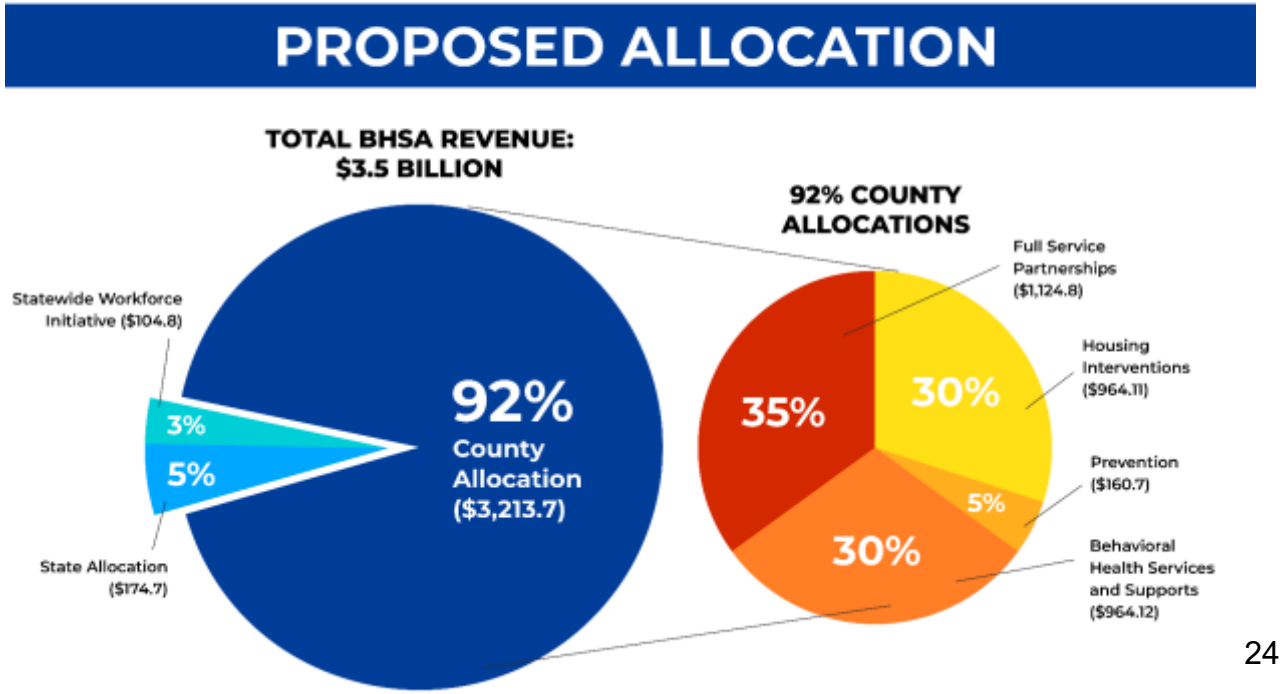
- In March, the Governor released his proposal to modernize California's behavioral health system.
- Since then, we have engaged in multiple webinars, listening sessions, hearings, and meetings to receive comments on this proposal.
- We have updated this proposal to reflect feedback received.
- The updated proposal is reflected in
  - SB 326 (Eggman) – Mental Health Services Act (MHSA) Modernization
  - AB 531 (Irwin) – Behavioral Health Infrastructure Bond Act of 2023

Update Local Categorical Funding Buckets

- **30% for Housing Interventions** for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder.
  - Counties will manage and direct the funds toward local priorities that meet designated purposes including but not limited to rental subsidies, operating subsidies, capital investments and nonfederal share for transitional rent.
- **35% for Full Service Partnerships** which should be optimized to leverage Medicaid as much as is allowable.
- **30% for Behavioral Health Services and Supports** (Behavioral Health Services and Supports (non FSP), Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, innovative pilots, and prudent reserve).
  - A majority of the Behavioral Health Services and Supports allocation must be spent on Early Intervention.
- **5% for Population-Based Prevention** for mental health and substance use disorder prevention programming.
- Counties may pilot and test behavioral health models of care programs, community defined practices or promising practices for the programs specified in all the above. The goal is to build the evidence base for the effectiveness of new statewide strategies to implement an equitable behavioral system.

How do the proposed BHSA funding allocations differ from existing MHSA funding allocations?





Birthing Care Pathway Project

Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director

Palav Babaria, MD, Deputy Director & Chief Quality and Medical Officer, Quality and Population Health Management

Pamela Riley, MD, Chief Health Equity Officer and Assistant Deputy Director for Quality and Population Health Management

DHCS

Overview of Birthing Care Pathway

- DHCS is developing a comprehensive **Birthing Care Pathway** that is envisioned as a **care model to cover conception through 12 months postpartum** with related benefit and payment strategies in Medi-Cal, to **reduce maternal morbidity and mortality** and **address significant racial and ethnic disparities** in maternal health outcomes among **Black, American Indian/Alaska Native (AI/AN), and Pacific Islander individuals.**

Birthing Care Pathway Workgroups

- DHCS will develop **Medi-Cal care delivery policy and program initiatives for pregnant and postpartum individuals** that encompass physical health, behavioral health, and health-related social needs; and translate clinical and care management guidelines into common care processes and workflows across settings.
- To inform the design of the Birthing Care Pathway, DHCS is creating **Clinical Care** and **Social Drivers of Health Workgroups** that will meet in summer and fall 2023.
  - The Clinical Care Workgroup will be charged with **identifying what needs to happen in the hospital/birthing center/provider office and other community-based settings from a Medi-Cal member's perspective** from conception through 12 months postpartum. This workgroup will be composed of OB-GYNs, certified nurse midwives, tribal providers, doulas, birthing centers, family medicine and pediatric providers, Federally Qualified Health Centers, BH providers, Comprehensive Perinatal Services Program (CPSP) providers, providers with Black birthing expertise, and MCPs.
  - The Social Drivers of Health Workgroup will be charged with **identifying programs and providers that currently address and/or are needed to address health-related social needs in the perinatal period.** The workgroup will be composed of community health workers, doulas, CPSP providers, individuals with Black birthing expertise, and Women, Infants, and Children (WIC), housing, and home visiting providers.

Birthing Care Pathway Member Engagement

A foundational priority for DHCS in the Birthing Care Pathway project is to ensure the design is shaped by Medi-Cal members with lived experience.

- DHCS will create a **Member Voice Workgroup** in fall 2023 **comprised of members that are currently or have recently been pregnant or postpartum while enrolled in Medi-Cal**. DHCS will focus particularly on engaging Black, AI/AN, and Pacific Islander members for the Member Voice Workgroup given the disparities in maternal health outcomes among these populations.
- DHCS will also conduct **1:1 interviews** in fall 2023 **with a subset of Medi-Cal members** who are currently or have recently been pregnant or postpartum and invite a small group of members to **journal about their individual pregnancy and postpartum experience in Medi-Cal.**
- The Birthing Care Pathway project will culminate with a **public-facing report** estimated for **summer 2024** outlining the policy recommendations for how DHCS can most effectively reduce maternal morbidity and mortality and address racial and ethnic disparities.

The Birthing Care Pathway project, which is led by DHCS, is generously supported by the California Health Care Foundation and the David & Lucile Packard Foundation.

Medi-Cal Managed Care Plan Contract: Managed Care Plan Transitions and 2024 Readiness

Bambi Cisneros, Assistant Deputy Director, Health Care Delivery Systems

DHCS

2024 Medi-Cal Managed Care Plans

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL MANAGED CARE PLANS BY COUNTY (AS OF 2023 AND 2024)

The following table lists Medi-Cal managed care plans[i] (MCPs) by county, as of January 1, 2023, and as they will be effective January 1, 2024. The changes are the result of an agreement among DHCS and MCPs in December 2022 to transform Medi-Cal into a more equitable health system that will result in better health outcomes for Californians. The table also reflects changes based on the County Plan Model changes that were approved in April 2022 and Assembly Bill 2724 enacted June 30, 2022 which added Section 14197.11 to the Welfare and Institutions Code. Starting in 2024, all MCPs will operate under the new restructured and rigorous contract that requires high-quality, equitable and comprehensive coverage.

County *County Plan Model Type*	2023 MCP(s)	2024 MCP(s)
Alameda *Two-Plan model (2023)* *Single Plan model (2024)*	**Anthem Blue Cross Partnership Plan**	**Alameda Alliance for Health**
	Alameda Alliance for Health	**Kaiser Permanente**[ii]
Alpine *Regional model (2023)* *Two-Plan model (2024)*	**Anthem Blue Cross Partnership Plan**	**Anthem Blue Cross Partnership Plan**[iii]
	California Health & Wellness	**Health Plan of San Joaquin**

- **The full list of Medi-Cal MCPs by county for 2023 and 2024 is available on the DHCS website** at: https://www.dhcs.ca.gov/Pages/MCP-Transition.aspx
- All MCPs are undergoing operational readiness reviews and participation by county is subject to readiness determinations

MCPs by Group

GROUP 1: Existing plans – No change

- CalOptima
- CalViva Health
- CenCal Health
- Gold Coast Health Plan
- Health Plan of San Mateo
- Inland Empire Health Plan
- Kern Health Systems
- LA Care Health Plan
- San Francisco Health Plan
- Santa Clara Family Health Plan

TOTAL : 10 PLANS

GROUP 2: Expansions/ Single plan Model Type

- Alameda Alliance for Health
- Central California Alliance for Health
- Contra Costa Health Plan
- Health Plan of San Joaquin
- Kaiser Foundation Health Plan
- Partnership Health Plan

TOTAL : 6 PLANS

GROUP 3: Commercial Plan

- Blue Cross of California Partnership Plan (Anthem)
- Blue Shield of California Promise Health Plan
- CHG Foundation, d.b.a. Community Health Group
- Community Health Plan of Imperial Valley
- Health Net Community Solutions, Inc.
- Molina Healthcare of California, Inc.

TOTAL : 6 PLANS

Contract Deliverables: Operational Readiness Review

All MCPs are subject to operational readiness for 2024 which entail a full review of readiness deliverables:

1. MCPs in counties with no changes
2. MCPs in counties subject to county plan model changes
3. MCPs (Commercial) that are directly contracted with DHCS

- Approximately 236 deliverables per MCP
- Of the 236 deliverables, 74 are considered key deliverables that are required to be approved prior to September 1, 2023, as part of the Go/No-Go decision of a MCP going live on January 1, 2024.
- Key deliverables pertain to specific domains including, network adequacy and access, delegation oversight, continuity of care, CalAIM (Enhanced Care Management/Community Supports)

Go-Live Assessment

Conducting deep dive of “high priority” MCPs

- Is the MCP entering a new market?
- Will the MCP take on a substantially new number of members?
- Consideration of other factors that may pose a potential risk to go-live
  - Networks in place to support adequacy and access to care in new markets/ membership
  - Capacity to support new markets/ membership (i.e., member relations)
  - Plans to ensure Continuity of Care policies, procedures, and processes are in place

MCP Transition Principles

DHCS is applying the following principles to guide the planning, implementation and oversight of the 2024 transition:

- Plan for a smooth and effective transition.
- Minimize service interruptions for all members, especially for vulnerable groups most at risk for harm from interruptions in care.
- Provide outreach, education and clear communications to members, providers, MCPs, and other stakeholders
- Proactively monitor MCPs' implementation of transition responsibilities.

Policy Guide Outline

Final guidance published in Policy Guide in June

- **Table of Contents**
- **Updates from Prior Version**
- **Introduction**
  - Context
  - Purpose, Scope, Audience
- **Key Definitions**
- **Protections for American Indian and Alaska Native Members**
- **Member Enrollment**
  - Noticing
  - Enrollment policies for new Medi-Cal members during transition period
  - Enrollment policies for members transitioning from exiting plans
  - Other Kaiser-related enrollment policies
  - Other enrollment policies
- **Continuity of Care** – *Updated to reflect stakeholder feedback*
  - Special populations
  - Continuity of Care for Providers
  - Continuity of Care for Covered Services
  - Continuity of Care Coordination and Management Information
  - Additional Continuity of Care Protections for All Members of Exiting MCPs
  - Transplants
  - Transportation
- **Transition Policy for ECM**
- **Transition Policy for Community Supports**

Published in June with a follow up All Comer webinar on July 10

To be published in Q3 on a rolling basis

- **Data Transfer**
  - From exiting plan to DHCS
  - From DHCS to receiving plans
  - Plan-to-plan
- **Oversight and Monitoring**
- **Education and Communication**
- **Other Policies**, including participation in incentive programs (if needed)

The Policy Guide includes tentative dates for release

Continuity of Care Policy Levers

All members required to transition MCPs January 1, 2024, are eligible for CoC protections using the following policy levers.

- CoC for Providers – The member can keep their provider even if the provider is out of network for the Receiving MCP.
- CoC for Covered Services – The member can continue an active course of treatment and the Receiving MCP must honor prior authorizations from the member's Previous MCP.
- CoC Coordination/Care Management Information – Previous MCP and Receiving MCP work together to transfer additional supportive information (e.g., care plans).
- Additional Continuity of Care Protections for All Transitioning Members - All transitioning members are eligible for additional protections related to Durable Medical Equipment (DME) rentals and medical supplies, non-emergency medical transportation (NEMT) and non-medical transportation (NMT), and scheduled specialist appointments

These levers are currently deployed in policies through the Knox Keene Act,* the 2023 APL on CoC, and the Policy Guides for ECM and Community Supports.

*Knox Keene CoC policy provides protection for some members who will transition to new MCPs in 2024: Members with an acute condition, serious chronic condition, pregnancy and postpartum, care of child between birth and 36 months, terminal illness, and authorized surgery or procedures documented as part of treatment plan to occur within 180 days.
For purposes of the 2024 CoC Policy discussion, the reference to Knox Keene is synonymous with Health and Safety Code 1373.96.

Special Populations

All members required to transition MCPs January 1, 2024, have Continuity of Care protections, but some members – *Special Populations* will have enhanced protections to minimize the risk of harm.

- Special Populations are generally individuals living with complex or chronic conditions. Transitioning members will be identified using DHCS or Previous MCP data, including program enrollment, pharmacy claims, DME claims, screening and diagnostic codes, procedure codes, or aid codes. The Receiving MCP will receive these data in advance of the 2024 Transition.[1]
  - Data guidance, including member identification and transfer responsibility, will be issued in a forthcoming Policy Guide release.
- MCPs will be required to take proactive steps to implement CoC or members of "Special Populations" through MCP outreach to members' providers and data transfer between MCPs.
- DHCS will monitor CoC for Special Populations as part of the monitoring that will happen for all members experiencing a Transition.

Continuity of Care for Providers

All members required to transition MCPs will be eligible to keep their Out-of-Network (OON) providers for 12 months when transitioning to the Receiving MCP. Additional enhanced protections will apply to Special Populations.

- CoC Policy for Providers for <u>all members</u> required to transition MCPs, including Special Populations
  - Members of Previous MCPs may continue seeing their OON Medi-Cal providers[1] for 12 months[2] following the member's Transition if certain requirements are met:
    - Member and provider have a pre-existing relationship
    - Provider is willing to accept the Receiving MCP's contract rates or Medi-Cal FFS rates
    - Provider meets professional standards and there are no quality-of-care issues
    - Provider is CA State Plan approved
- Enhanced Protection for <u>Special Populations</u>
  - MCPs contact providers treating Special Populations to initiate the process for entering a CoC agreement.
  - Extended CoC period for certain populations[3]

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[1]Eligible providers include those providing the following services: primary care, specialists, select ancillary Providers (Dialysis centers, Physical therapists, occupational therapists, respiratory therapists, mental health providers, behavioral health treatment (BHT) providers, speech therapy providers, doulas, and community health workers), Enhanced Care Management providers, Community Supports providers, skilled nursing facilities, ICF-DD facilities, and Community-Based Adult Services providers. Excluded providers providing the following services: transportation and all other ancillary services, including radiology, and laboratory providers, and Non-enrolled Medi-Cal Providers.

[2]With some exceptions to this timeframe per Knox Keene.

[3]In alignment with Knox Keene.

Continuity of Care for Covered Services

The policy for continuing active courses of treatment outside of Knox Keene is new, as is the expectation for MCP outreach to providers treating Special Populations. The policy for continuing authorizations is not new.

Anticipated policy change noted in red, pending final STCs from CMS

» CoC Policy for Services for <u>all members</u> required to transition MCPs, including Special Populations

- Members keep their existing authorizations for Covered Services for ~~90 days~~ six months following the member's Transition to the Receiving MCP from the Previous MCP.
- Members can continue their "active course of treatment" without authorization for ~~90 days~~ six months. Any active course of treatment is expected to be documented prior to January 1, 2024.
- Active Course of Treatment defined as: a course of treatment in which a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.*

» Enhanced Protection for <u>Special Populations</u>

- Following the Transition, members keep their existing authorizations for ~~90 days~~ six months and until the Receiving Plan assesses clinical necessity for ongoing services.
- During the six-month CoC for Services period, the Receiving MCP must examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and must contact those providers to establish any necessary Prior Authorizations.

» Enhanced Protection for <u>Special Population Members Accessing the Transplant Benefit</u>

- The Receiving MCP must start reassessments for clinical necessity no sooner than six months after the transition date (beginning July 1, 2024). The reassessment applies to adults, and children for transplants performed to treat conditions that are not medically eligible for the California Children's Services (CCS) Program.

* CMS proposed Medicare CoC ruling released for public comment on 12/28/22 with a proposed effective date of 7/1/2023

Public Comment

Next Meeting, Next Steps, and Adjourn

Appendix -Behavioral Health Modernization

Modernize the MHSA

- Rename to Behavioral Health Services Act (BHSA).
- Update local categorical funding buckets.
- Broaden the target population to include those with debilitating SUD.
- Focus on the most vulnerable.
- Fiscal accountability, updates to county spending and revise county processes.
- Many components will require a March 2024 ballot initiative .
- Multi-year implementation starting in 2025.

No change to current structure of Mental Health Services Oversight and Accountability Commission.

Update Local Categorical Funding Buckets

- **30% for Housing Interventions** for individuals with serious mental illness/serious emotional disturbance and/or SUD.
  - Counties will manage and direct the funds toward local priorities that meet designated purposes including rental subsidies, operating subsidies, capital investments and nonfederal share for transitional rent.
- **35% for Full Service Partnerships (FSP)** which should be optimized to leverage Medicaid as much as is allowable.
- **30% for Behavioral Health Services and Supports** (Behavioral Health Services and Supports (non-FSP), Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, innovative pilots, and prudent reserve).
  - A majority of the Behavioral Health Services and Supports allocation must be spent on Early Intervention.
- **5% for Population-Based Prevention** for mental health and SUD prevention programming.
- Counties may pilot and test BH models of care programs, community defined practices or promising practices for the programs specified above. The goal is to build the evidence base for the effectiveness of new statewide strategies to implement an equitable behavioral system.

Fiscal Accountability and County Spending

- Require counties to bill Medi-Cal for all reimbursable services in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage BHSA to maximize federal funding for services.
- Require counties to maximize funding from other sources, such as private insurance, and require counties to make a good faith effort to contract with commercial health plans.
- Provide that counties may report to regulators complaints about a health plan's failure to work in good faith and/or failure to timely reimburse.
- Reduce allowable prudent reserve amounts from 33% to 15% for large counties and 20% for small counties. Reassess prudent reserve more frequently from every 5 years to every 3 years.
- Authorize up to 2 percent of local BHSA revenue to be used for administrative resources to assist counties in improving plan operations, quality outcomes, reporting fiscal and programmatic data and monitoring subcontractor compliance for all county BH funding.

Revise County Process

- Create the **Integrated Plan for Behavioral Health Services and Outcomes**.
- Transform the BHSA planning process into a broader county/region BH planning process. Require counties to work with Medi-Cal MCPs in the development of their Population Needs Assessments and with Local Health Jurisdictions in the development of their Community Health Improvement Plans and to ensure strategic alignment.
- Specify state BH goals/outcomes and local goals/outcomes.
- Require counties to identify BH disparities and consider approaches to eliminate disparities, including, but not limited to, promising practices, models of care, community-defined evidence-based practices, workforce diversity, and cultural responsiveness.
- Include workforce strategy for ensuring BH workforce are well supported.
- Specify that counties collaborate with cities, MCPs, and Continuums of Care to outline responsibilities and coordination of services related to Housing Interventions.
- Require plans be approved by county boards of supervisors by June 30th, prior to the year of implementation.

Outcomes, Accountability, and Transparency Report

» Create the **County Behavioral Health Outcomes, Accountability, and Transparency Report**, which includes:

- Annual allocation of BHSA, Realignment, and all federal block grants
- Annual spend on non-federal match payments including BHSA, Realignment or other county sources
- BHSA, Realignment and Block Grant only spend
- Any other BH investments using local General Fund or other funds
- Any unspent BHSA, Realignment or block grant funds for that fiscal year
- Cumulative unspent BHSA, Realignment or block grant funds, inclusive of reserves
- Administrative costs
- Data and information on workforce
- Quality metrics
- Stratified data to identify BH disparities and outcomes
- Information on services provided to persons not covered by Medi-Cal, including commercial insurance, Medicare, and uninsured.

County Accountability and Infrastructure

- Develop outcome measures, not just process measures, to drive toward meaningful and measurable system change.
- Align county BH plans (including mental health plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) and MCP contract requirements when the same requirements exist across programs. This includes:
  - Organization and administration of the plan, including key administrative staffing requirements;
  - Financial information;
  - Information systems;
  - Quality improvement systems;
  - Utilization management;
  - Provider network;
  - Provider compensation arrangements;
  - Provider oversight and monitoring;
  - Access and availability of services, including but not limited to reporting of any waitlists for any BH services or attesting to no waitlists;
  - Care coordination and data sharing;
  - Member services;
  - Member grievances and appeals data;
  - Reporting requirements.
  - Any other contractual requirements determined by DHCS.

Alignment between Medi-Cal and Commercial Coverage of Behavioral Health Services

- Over the next year, the Department of Managed Health Care (DMHC) and DHCS will develop a plan for achieving parity between commercial and Medi-Cal mental health and SUD benefits. This may include phasing in alignment of utilization management, benefit standardization, and covered services.

- DMHC and DHCS will establish a stakeholder process that will include health plans, and other system partners to develop the framework.

Behavioral Health Stakeholder Advisory Committee Hybrid Meeting

July 20, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Recovery Incentives Program

California's Contingency Management Benefit

Ivan Bhardwaj, Division Chief, Medi-Cal Behavioral Health – Policy Division

DHCS

Background

- Contingency management (CM) is an evidence-based, cost-effective treatment for SUDs, and is the only treatment that has demonstrated robust outcomes for individuals living with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment.
- California is the **first** state in the country to receive federal approval of CM as a benefit in the Medicaid program through the CalAIM 1115 Demonstration.
- Twenty-four (24) DMC-ODS counties covering 88% of the Medi-Cal population are participating in the Recovery Incentives Program.
- In March 2023, DHCS approved the first site to offer CM services, and CM service delivery began in Los Angeles County on April 3, 2023.

Recovery Incentives Program

DHCS is piloting Medi-Cal coverage of CM services in DMC-ODS counties that elect and are selected to participate. Medi-Cal members are eligible to:

Participate in a structured **24-week CM Program -**12 weeks with twice weekly testing/incentives and a 12-week continuation with once weekly testing/incentives

Receive incentives for testing **negative for stimulants only,** even if they test positive for other drugs

Earn a **maximum of $599** over the 24-week period in the form of gift cards

Generate incentives and track progress using **Incentive Manager** software

Other Recovery Incentives Program Elements

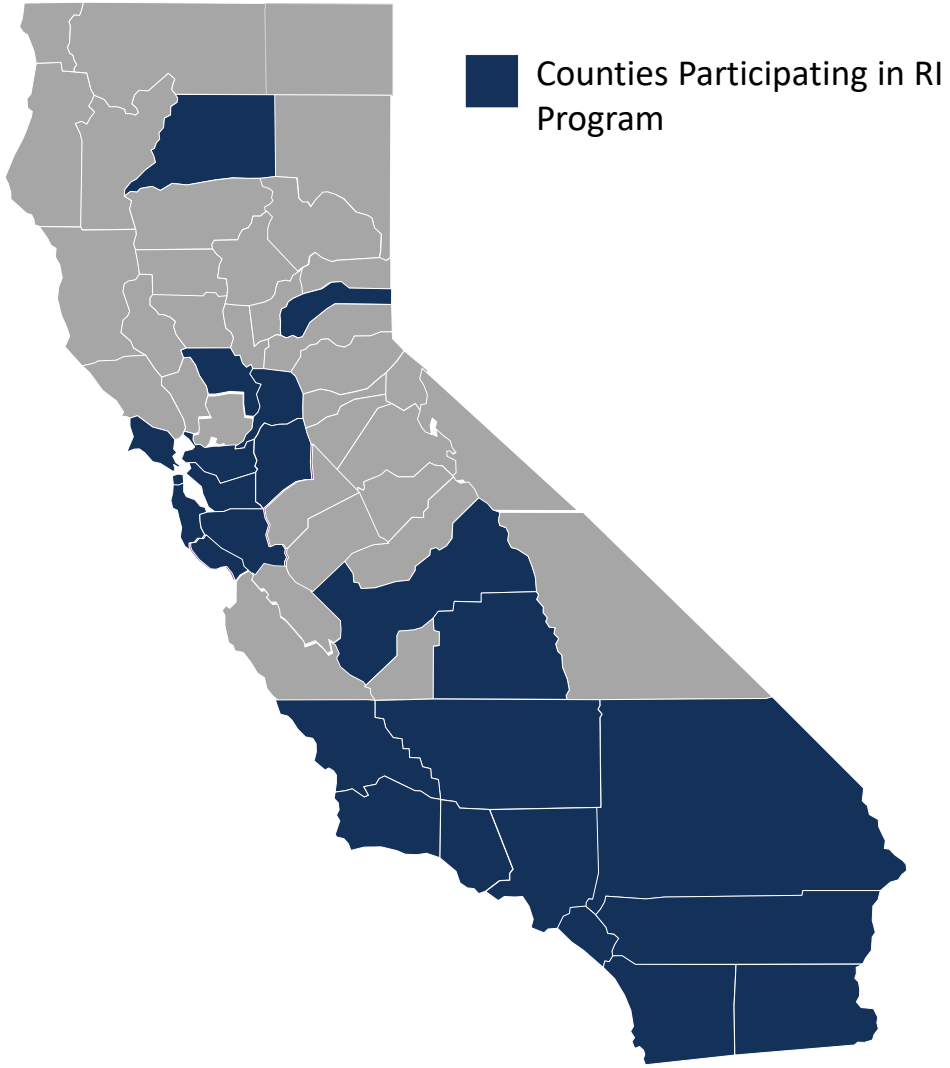
The Recovery Incentives Program will be complemented with ongoing training and technical assistance and a robust evaluation process, while protecting against fraud, waste, and abuse.

Training	Evaluation	Oversight
• Participating counties and SUD providers are required to participate in start-up training and ongoing technical assistance. • Synchronous, live trainings started in February 2023.	• The impact of the pilot program will be measured through a robust evaluation process. • DHCS will release an interim and a final evaluation report, along with quarterly reports to inform future budget decisions.	• Each treatment program must have a policies and procedures manual. • All providers are required to complete readiness reviews. • DHCS and counties will conduct robust monitoring and oversight of CM providers.

24 Participating DMC-ODS Counties

Covers 88% of the Medi-Cal Population

Alameda	San Diego
Contra Costa	San Francisco
Fresno	San Joaquin
Imperial	San Luis Obispo
Kern	San Mateo
Los Angeles	Santa Barbara
Marin	Santa Clara
Nevada	Santa Cruz
Orange	Shasta
Riverside	Tulare
Sacramento	Ventura
San Bernardino	Yolo



Recovery Incentives Program Status Update: June 29, 2023

- Members
  - **188 members** are receiving CM services through the Recovery Incentives Program.
- Sites/Counties
  - **19 sites** have been approved by DHCS to offer CM services.
  - These sites are **in Los Angeles, San Francisco, Kern, Fresno, and Riverside** counties.
- Readiness
  - 47 sites, in 10 additional counties, have completed all training requirements and are working to complete the readiness assessment prior to receiving approval to launch CM services.
  - Implementation trainings are scheduled weekly through August 2023 and will be extended as needed.

Looking Ahead

- DHCS is initially financing the non-federal share of CM services with federal funds received for the DHCS Home and Community-Based Spending Plan, which includes CM services. DHCS must spend the additional federal funds by March 31, 2024.
- If counties elect to participate in the optional benefit 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.

Resources

- **E-mail:** RecoveryIncentives@dhcs.ca.gov
- **Website:** https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx

Behavioral Health Bridge Housing (BHBH)

Ilana Rub, Section Chief, Community Services Division

DHCS

BHBH Program Background

- In 2022, California had an estimated 171,521 individuals experiencing homelessness. (Housing and Urban Development Continuum of Care Point-In-Time Report)
  - 60,905 were individuals experiencing chronic homelessness
  - 39,721 were severely mentally ill
  - 36,096 reported chronic substance use
- The BHBH Program projects 8,000 total beds statewide.

BHBH Program Background

- The BHBH Program was signed into law in September 2022 under Assembly Bill 179 (Ting, Chapter 249, Statutes of 2022), and will provide $1.5 billion in funding through the Department of Health Care Services (DHCS) for county behavioral health agencies and tribal entities through June 30, 2027.
- The primary focus of the BHBH Program is to help people experiencing homelessness who have serious behavioral health conditions that prevent them from accessing help and moving out of homelessness.
- The BHBH Program provides funding for operational and supportive services, not covered under Medi-Cal or other funding sources, to expand bridge housing implementation.

BHBH Program Purpose and Priorities

- The following priorities drive the implementation of the BHBH Program:
  - The need is critical, and the focus is on immediate solutions.
  - Intended to complement long-term/ongoing state, county, and tribal efforts to address homelessness.
  - BHBH Program settings will provide supportive services and housing navigation to assist people who have serious BH conditions and are experiencing homelessness.

BHBH Program Purpose and Priorities

- The following priorities drive the implementation of the BHBH Program:
  - BHBH is identified to be implemented in alignment with the CARE Act, which prioritizes BHBH program resources for CARE Act participants.
  - The proposed reform to the Mental Health Services Act will provide sustainable funding for BH housing.
- Information on "The Next Step to Transform California's Behavioral Health System" is available on: Behavioral Health Reform webpage.

County Behavioral Health Agency (BHA) Request for Application (RFA) Overview

- **Opportunity and Focus:** This initial round of BHBH Program funding is providing a total of $907.6 million to county BHAs for use in the planning and implementation of bridge housing settings for Californians experiencing homelessness who have a serious mental illness and/or SUD.
- **Eligible Entities:** California county BHAs
- **Application Timeline:** Applications were accepted from February 22, 2023, through April 28, 2023
- **Award Announcements:** Award announcements will continue on a rolling basis; the first 39 county BHA awards were announced on June 23, 2023, totaling $777 million. The remaining awards are in process for finalization.
- **Funding must be expended by:** June 30, 2027

BHBH Program Participating Counties

- Alameda
- Amador
- Butte
- Calaveras Colusa
- Contra Costa
- Del Norte
- El Dorado
- Fresno
- Glenn*
- Humboldt
- Imperial
- Inyo
- Kern
- Kings
- Lake
- Lassen
- Los Angeles - DMH*
- Los Angeles - SAPC*
- Madera
- Marin
- Mendocino
- Merced
- Modoc
- Monterey
- Napa
- Nevada
- Orange*
- Placer
- Riverside*
- Sacramento
- San Benito
- San Bernardino
- San Diego*
- San Francisco*
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Siskiyou
- Solano
- Sonoma
- Stanislaus*
- Sutter & Yuba
- Tehama
- Trinity
- Tulare
- Tuolumne*
- Ventura
- Yolo

* CARE Act Cohort 1 counties will be prioritized for follow-up/contract execution

Shelter and Interim Housing

- Tiny homes
- Emergency shelter
- Motel vouchers
- Motel-based sheltering efforts
- Navigation centers
- Peer respite
- Crisis housing
- Transitional housing
- Recovery housing/sober living
- Recuperative care models
- Community-reentry and diversion housing programs

Tribal Entities RFA Overview

- **Opportunity and Focus:** This round of BHBH Program funding is providing $50 million to tribal entities for use in the planning and implementation of bridge housing settings for community members experiencing homelessness who have serious BH conditions (a serious mental illness and/or SUD).
- **Eligible Entities:** California tribal entities
- **Application Timeline:** June 19 – September 15, 2023
- **Award Announcements:** Beginning November 2023

Competitive Funding

- The $500 million remaining of the $1.5 billion in funding will be released in competitive rounds of funding.
- The funding will continue to focus on housing for BH individuals.
- Counties and tribal entities will be the eligible applicants.
- DHCS will release more information on the competitive BHBH grant opportunities in the fall/winter of 2023.

More Information

- **Email: BHBH@dhcs.ca.gov**
- **Website: https://bridgehousing.buildingcalhhs.com/**

Behavioral Health Continuum Infrastructure Program (BHCIP)

Holly Clifton, Section Chief, Community Services Division

DHCS

Behavioral Health Continuum Infrastructure Program (BHCIP) At a Glance

- The BHCIP was signed into law in July 2021 under Assembly Bill 133 (Chapter 143, Statutes of 2021), and will provide $2.2 billion in funding through DHCS to construct, acquire, and expand properties and invest in mobile crisis infrastructure through June 30, 2027.
- DHCS is releasing these funds through six BHCIP grant funding rounds.
- BHCIP provides competitive grants to counties, cities, tribal entities, non-profit and/or for-profit entities.
- Funding is only for new or expanding infrastructure (brick, mortar and mobile crisis) projects and not BH services nor preservation of existing BH infrastructure.

BHCIP Updates

To date, DHCS has awarded a **total of $1.7 billion** through the five rounds of BHCIP grant funding.

- **Round 1 - Crisis Care Mobile Units:** More than $163 million awarded to 49 (county, city, tribal) BH authorities to create or enhance 245 Crisis Care Mobile Units (CCMU) response teams throughout California to expand mobile crisis infrastructure. Awards announced: 1A in November 2021 and 1B in February 2022.
- **Round 2 - Planning Grants:** More than $7 million awarded to 48 county and tribal entities to support activities associated with planning for the construction, acquisition, or rehabilitation of BH facilities. Awards announced: 2A in January 2022 and 2B in April 2022.

BHCIP Updates

The following are updates for infrastructure specific rounds:

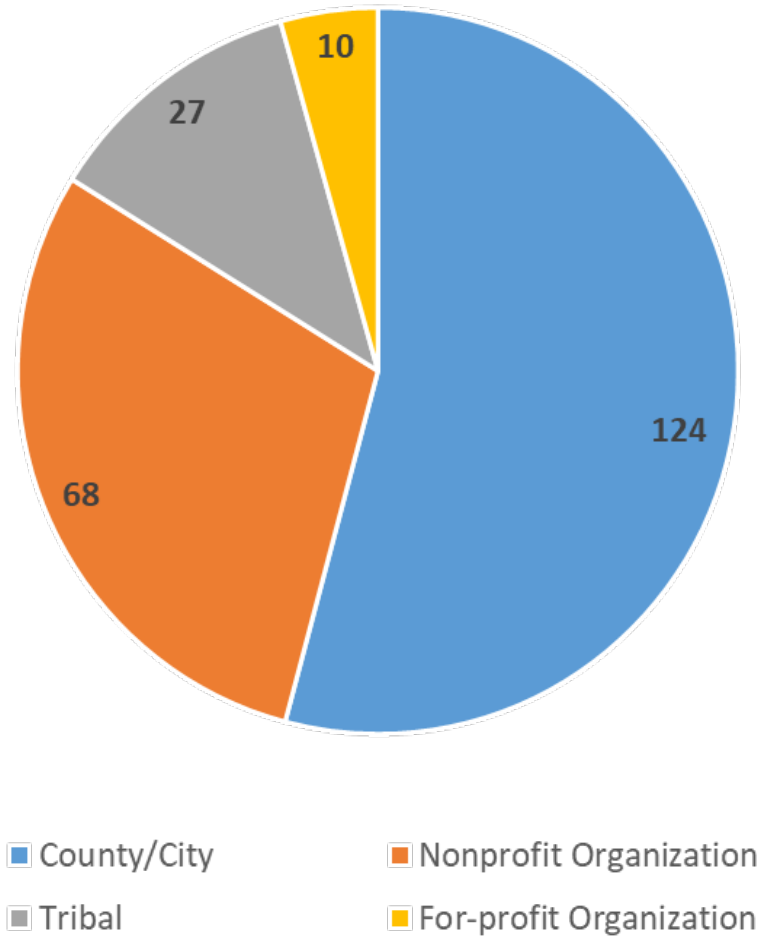
- **Round 3 - Launch Ready:** $518.5 million awarded 45 launch ready projects to build/expand 37 new inpatient and residential facility sites that offer 1,176 new BH treatment beds, and 44 outpatient facilities to offer more than 130,000 new annual BH treatment slots. Awards announced in June 2022.
- **Round 4 - Children and Youth:** $480.5 million awarded 54 children and youth focused projects to support 29 new inpatient and residential facility sites to offer 498 new treatment beds, and 46 outpatient facilities to offer close to 74,000 new annual treatment slots. Awards announced in December 2022.

BHCIP Updates

- **Round 5 - Crisis and BH Continuum:** $430 million awarded to 33 crisis and/or BH focused projects to support the addition of 29 new inpatient/residential facility sites to offer 774 new treatments beds, and 41 outpatient facilities to offer more than 84,000 new annual treatment slots. Awards announced in June 2023.
- **Round 6 - Unmet Needs** (In development)**:** This round of funding will be divided into two parts and totals $480 million. Release of Request for Application for Round 6 Part I is anticipated in January 2024 and award announcements will follow in July 2024. Round 6 Part II is anticipated to follow the same timeframe in 2025.

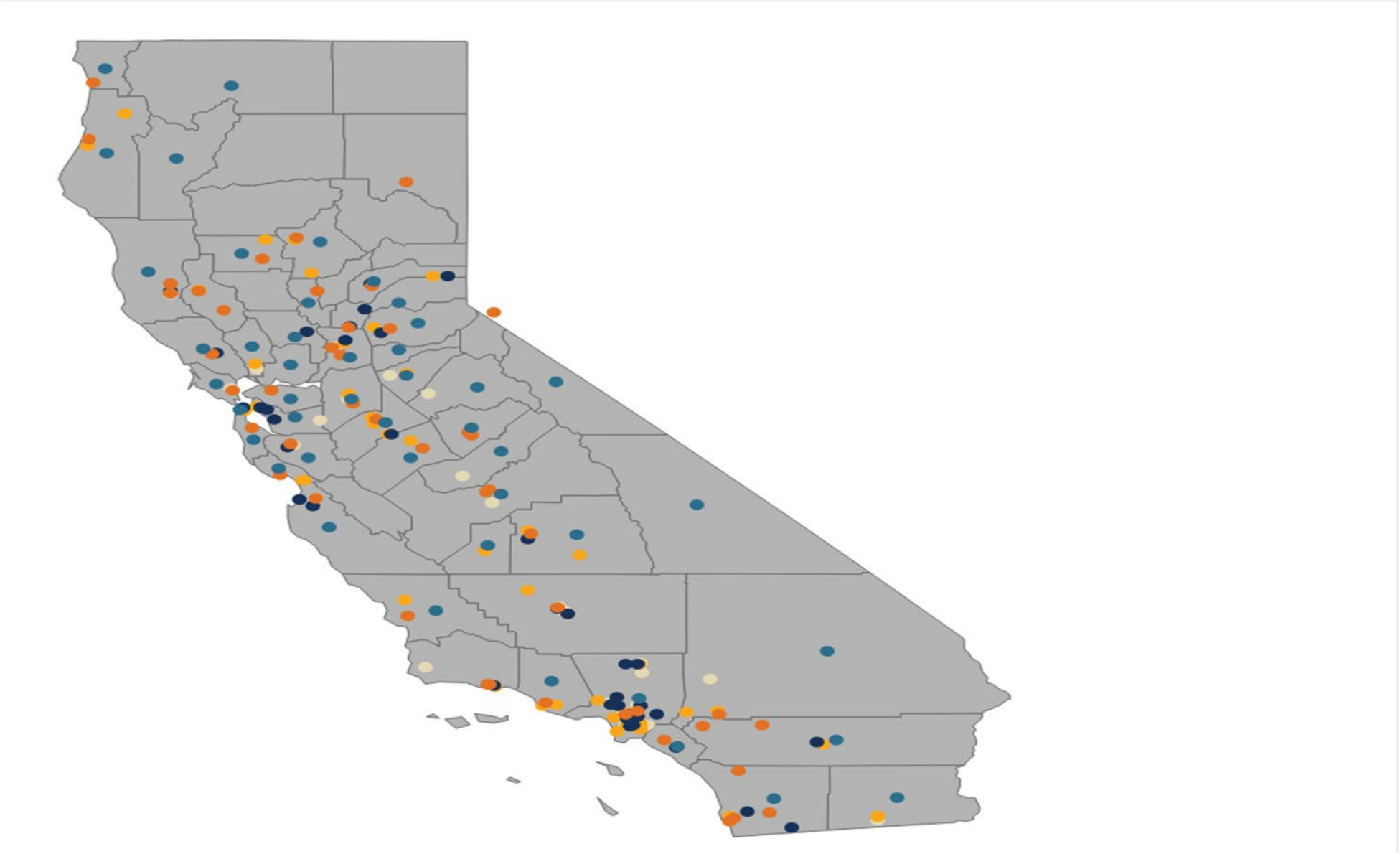
BHCIP Rounds 1 to 5: Awarded Projects by Entity Type

- 124 County/City
- 10 For-profit Organization
- 68 Nonprofit Corporation
- 27 Tribal
- **Total Projects = 229**



Point in time data

BHCIP Rounds 1 through 5 Awards



More Information

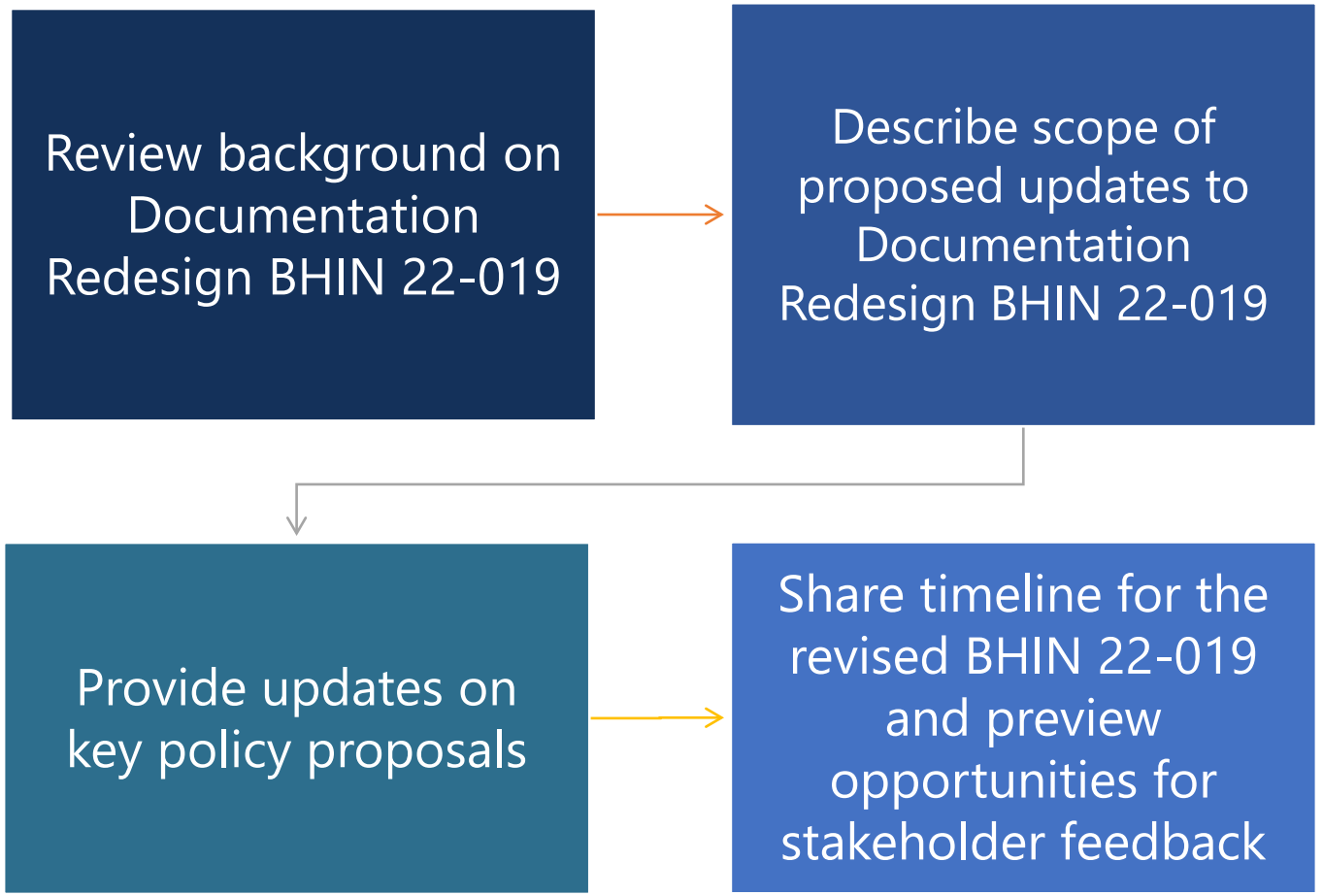
- **Email: BHCIP@dhcs.ca.gov**
- **Website: https://www.infrastructure.buildingcalhhs.com/**

Documentation Redesign

Paula Wilhelm, Assistant Deputy Director, Behavioral Health

DHCS

Documentation Redesign Presentation Objectives



Background: Documentation Redesign

Assembly Bill 133 (2021)

2019 **2021** **Present**

Stakeholder Engagement & Policy Drafting

- CalAIM BH Workgroup [2019 – present]
- Draft BHIN [August 2021]
- Targeted Stakeholder Engagement [January 2022]
- Informational and TA Webinars [2021 – 2022]

April 22, 2022: BHIN 22-019 Published

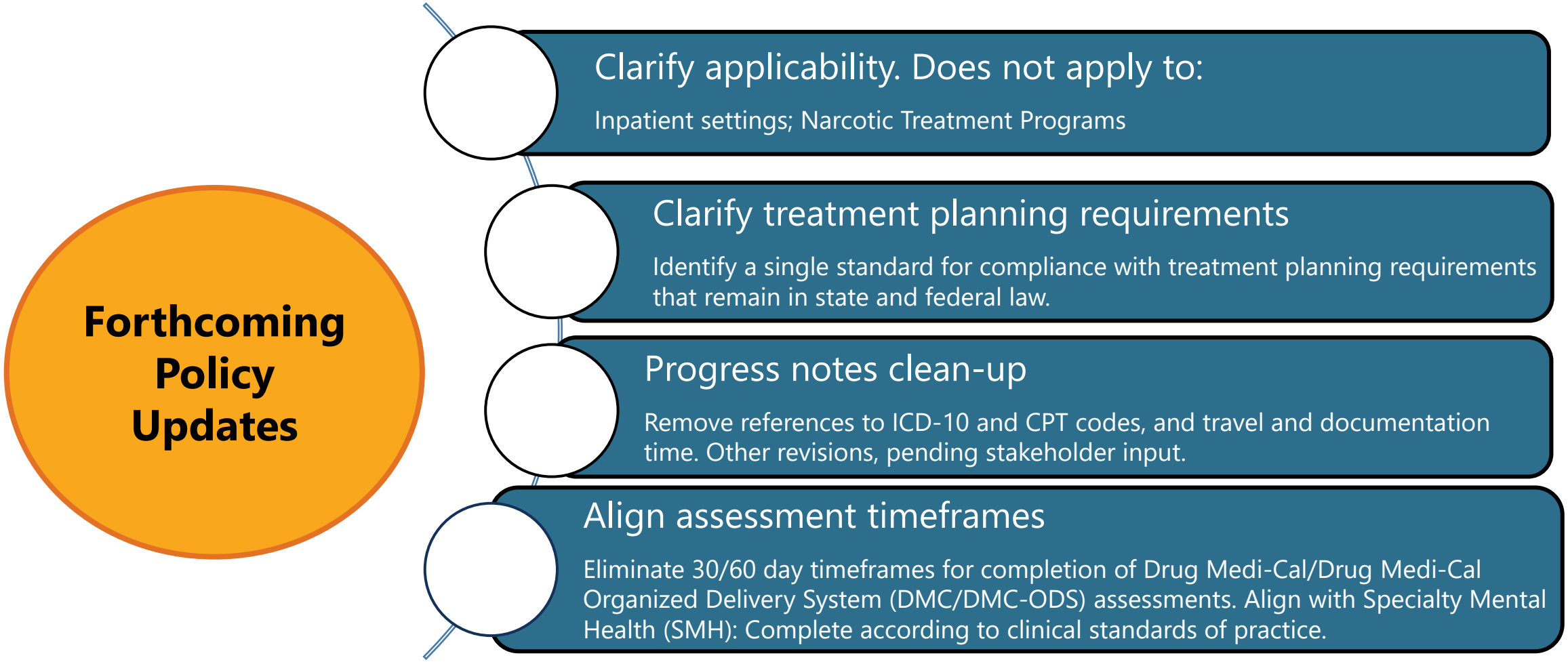
Stakeholder Feedback & Policy Revision

- Targeted Stakeholder Engagement [January & May 2023]
- 1:1 Meetings with stakeholders [Jan-July 2023]
- CalAIM BH Workgroup (June 2023)
- BH-SAC (July 2023)

BHIN 22-019: Key Components

Old Requirements	New Requirements
Static treatment plan	Dynamic problem list and progress notes
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

Forthcoming BHIN 22-019 Updates



Updated Documentation Redesign BHIN, including guidance in response to stakeholder feedback, will be released in fall 2023 and will be effective on January 1, 2024

**This document outlines pre-decisional policy options and questions and does not reflect final DHCS guidance.*

BHIN 22-019 Policy Topic: Treatment Plan

GOAL: Identify a single standard for documenting treatment planning activities to simplify and streamline provider documentation. Where possible, clarify that "standalone" treatment plans are not required.

ISSUE:
Stakeholders are confused about how to document an array of requirements for treatment plans for different programs or services. DHCS may be unable to eliminate or modify all applicable references to treatment planning (or plans) in state and federal law.

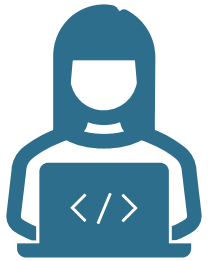
PROPOSED SOLUTION:
Treatment planning requirements (from state and federal law) may be documented flexibly in the clinical record, and plan information must be shared as needed to support care coordination.

**This document outlines pre-decisional policy options and questions and does not reflect final DHCS guidance.*

BHIN 22-019 Policy Topic: Progress Notes

GOAL: Progress notes should capture clinically appropriate and complete information without undue provider burden.

ISSUE:
Per stakeholders, progress notes take too long. Documentation time continues to feel excessive due to requirements for narrative notes.



PROPOSED SOLUTION:
Remove certain progress notes requirements that appear in BHIN 22-019, e.g., requirement to note travel and documentation time. Request feedback on additional changes.

BHIN 22-019 Policy Topic: Eliminate 30 or 60-day Assessment Timeframes for DMC/DMC-ODS

GOAL: Align DMC and DMC-ODS assessment timeframes with SMH assessment requirements.

ISSUE:
Currently, assessments for DMC/DMC-ODS must be completed within 30 or 60 days. This differs from the standard for SMH: assessments must be completed within a reasonable timeframe, consistent with clinical standards of practice.

PROPOSED SOLUTION:
DHCS is considering **eliminating the 30 to 60-day** timeframes and aligning DMC/DMC-ODS assessment standards **with the existing standards for SMH.**

Updated BHIN 22-019 *Tentative* Timeline

Timeline	**Early Summer 2023:** Post FAQs on CalAIM BH FAQ webpage
	Mid-Summer 2023: Posting BHIN for stakeholder review
	Late Summer 2023: Incorporate stakeholder feedback
	Fall 2023: BHIN is posted
	January 2024: BHIN is effective

Discussion Questions

- Please share your feedback and policy recommendations related to:
  - Treatment planning;
  - Progress notes; and
  - Assessment timeframes.
- What is the most important documentation challenge to address in updated guidance?
  - Are there issues or concerns we have not mentioned today?
- What successes has the field experienced in implementing the documentation policy outlined in BHIN 22-019?
  - What is working better today than it was two years ago?

Documentation Redesign Questions

- If you have questions, please email DHCS at BHCalAim@dhcs.ca.gov, subject line "SAC/BH-SAC – July 20, 2023"

Public Comment

Next Meeting, Next Steps, and Adjourn