2023

The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration

DRAFT FOR PUBLIC COMMENT

AUGUST 2023

DHCS

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration

Medicaid Section 1115 Demonstration Application

DRAFT FOR PUBLIC COMMENT – August 1, 2023

CONTENTS

SECTION 1 | INTRODUCTION

OVERVIEW

The California Department of Health Care Services (DHCS) is requesting a new Section 1115 demonstration, effective January 1, 2025, to expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED). The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration will amplify the state's ongoing behavioral health initiatives, and is informed by the findings from DHCS' comprehensive 2022 assessment of California's behavioral health landscape *Assessing the Continuum of Care for Behavioral Health Services in California*.

The proposed BH-CONNECT demonstration will leverage the 2018 guidance from the Centers for Medicare & Medicaid Services (CMS) that describes how states can use Section 1115 demonstration authority to secure federal financial participation (FFP) for care provided during short-term stays in Institutions for Mental Diseases (IMDs), as long as they meet certain standards.[1] The demonstration also includes elements designed particularly for children and youth who have high needs, some of which are tailored specifically to children and youth involved in child welfare; individuals and families who are experiencing or at risk of homelessness; and those who are justice-involved.

The BH-CONNECT demonstration is integral to the state's broader efforts to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. Building upon CMS' approval of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration in December 2021, the BH-CONNECT demonstration will directly address the need to expand and strengthen the continuum of care specifically for Medi-Cal members living with SMI and SED.

The BH-CONNECT demonstration will also build upon California's historic commitment to creating a full continuum of care for substance use disorder (SUD) treatment and recovery services. In 2015, California launched the Drug Medi-Cal Organized Delivery System (DMC-ODS), a first-in-the-nation Section 1115 SUD demonstration model that has been emulated in over 30 other states. Like the DMC-ODS, this opportunity allows DHCS to make historic investments in building out the full continuum of care for behavioral health, working in collaboration with county behavioral health plans, responding to members' needs and priorities, and paying particular attention to populations most at risk.

---

[1] CMS, "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," November 13, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

In parallel with the expenditure and waiver authority requests outlined in this application, DHCS will implement additional delivery system reforms and policy innovations to strengthen services for Medi-Cal members living with SMI and SED. Although these changes do not require Section 1115 demonstration authority, they are described briefly in this application to provide CMS and stakeholders with a comprehensive overview of DHCS' approach to improving care and outcomes for members living with SMI and SED.

GOALS AND APPROACH

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

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

Specifically, the demonstration aims to:

- Expand the continuum of community-based services and evidence-based practices (EBPs) available through Medi-Cal;
- Strengthen family-based services and supports for children and youth living with or at risk of SED;

- Connect members living with SMI/SED to employment, housing, and social services and supports;
- Invest in statewide practice transformations to better enable county behavioral health plans and providers to support Medi-Cal members living with behavioral health conditions;
- Strengthen the workforce needed to delivery community-based behavioral health services and EBPs to members living with SMI/SED;
- Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness;
- Incentivize outcome and performance improvements for children and youth involved in child welfare that receive care from multiple service systems; and
- Reduce use of institutional care by those individuals most significantly affected by SMI/SED.

The BH-CONNECT demonstration reflects the state's ongoing commitment to ensuring that services are provided in the least restrictive setting appropriate for a member's needs. DHCS recognizes that a robust, comprehensive continuum of community-based care for Medi-Cal members living with SMI/SED, inclusive of housing supports and other community supports, helps to ensure that residential care and inpatient care are used only when medically necessary and clinically needed to stabilize and transition adults, children and youth to community-based care. The approach to the BH-CONNECT demonstration is also informed by the findings from data and stakeholder perspectives described in the 2022 report *Assessing the Continuum of Care for Behavioral Health Services in California*. Box 1 below summarizes the key issues and opportunities identified in the 2022 assessment.

Box 1: Key Issues and Opportunities Identified in California's 2022 Report *Assessing the Continuum of Care for Behavioral Health Services in California*[2]

- **Community-based treatment, including crisis care.** It is critical to have a comprehensive approach to behavioral health treatment that includes a robust continuum of crisis services (e.g., CalHOPE, 988 Crisis Line, Medi-Cal funded qualifying community-based mobile crisis intervention services[3] and crisis stabilization services) and emphasizes community-based treatment and supports (e.g., Supported Employment and linkages to Community Supports, rental assistance and other housing services and supports), and prevention/early intervention and wellness initiatives (e.g., Children and Youth Behavioral Health Initiative (CYBHI)).
- **Children and youth.** More treatment options (e.g., Multisystemic Therapy (MST)) are vital for children and youth living with or at risk for significant mental illness

[2] DHCS, "Assessing the Continuum of Care for Behavioral Health Services in California; Data, Stakeholder Perspectives, and Implications," January 10, 2022. Available at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.
[3] 42 U.S.C. § 1396w–6, subd.(c).

and SUDs, including key supports for those involved in child welfare and juvenile justice (e.g., activity stipends).

- **Evidence-based practices (EBPs).** More can be done to ensure that evidence-based and community-defined practices (e.g., Assertive Community Treatment (ACT)) are used consistently and with fidelity.
- **At-risk populations.** Building a system to effectively address the behavioral health needs – and related housing, economic and physical health issues – of the most vulnerable, including individuals who are justice-involved (e.g., Forensic Assertive Community Treatment (FACT)), at risk of or experiencing homelessness (e.g., transitional rent), and severely impaired (e.g., Community Assistance, Recovery and Empowerment (CARE) Act) is critical.

KEY COMPONENTS

To accomplish the goals for the BH-CONNECT demonstration outlined above, DHCS is requesting Section 1115 demonstration expenditure and waiver authorities for specific features of the BH-CONNECT demonstration. In parallel with the expenditure and waiver authorities requested in this application, DHCS will work with CMS to implement other features of the BH-CONNECT demonstration that do not require Section 1115 demonstration authority. Specifically, several features of the BH-CONNECT demonstration will require a State Plan Amendment (SPA) or an update to the Public Assistance Cost Allocation Plan. Other features of the BH-CONNECT demonstration do not require any new federal Medicaid authorities and can be implemented with state-level guidance.

For example, one particularly notable feature that will be implemented using Medicaid administrative funds will be Centers of Excellence to offer training and technical assistance to behavioral health delivery systems and providers to support implementation of the BH-CONNECT proposal. Centers of Excellence will support fidelity implementation and delivery of EBPs to improve outcomes for Medi-Cal members living with SMI/SED and/or a SUD, expand dissemination of community-defined practices when appropriate, and strengthen the ability of Medi-Cal behavioral health providers to offer culturally-sensitive care.

Table 1 below illustrates the key components of the BH-CONNECT demonstration, including:

- Features for which DHCS is requesting Section 1115 demonstration expenditure and waiver authorities;
- Features for which DHCS will pursue a SPA; and
- Other features that will be implemented through state-level guidance using existing federal Medicaid authorities.

Some features of the BH-CONNECT demonstration will be implemented statewide, while others will be available at county option. Under the BH-CONNECT demonstration, county mental health plans can “opt in” to receive FFP for care provided during short-term stays in IMDs if they meet a robust set of requirements consistent with applicable

CMS guidance, including providing a full array of enhanced community-based services and EBPs available through the BH-CONNECT demonstration, meeting key CMS requirements related to accreditation and emergency department (ED) strategies, and meeting robust accountability requirements to ensure care provided in residential and inpatient settings is short-term and high-quality.

Features that will be implemented statewide are indicated in Table 1 with an "*". All other features will be available at county option.

Table 1. Components of the BH-CONNECT Demonstration

Requesting Section 1115 Demonstration Authority[4]
• Workforce initiative to invest in a robust, diverse behavioral health workforce to support Medi-Cal members living with SMI/SED and/or a SUD* • Activity Stipends to ensure children and youth involved in child welfare have access to extracurricular activities that support health and wellbeing* • Cross-sector incentive program to support children and youth involved in child welfare who are also receiving specialty mental health services* • Statewide incentive program to support behavioral health delivery systems in strengthening quality infrastructure, improving performance on quality measures, and reducing disparities in behavioral health access and outcomes* • Incentive program for opt-in counties to support and reward counties in implementing community-based services and EBPs for Medi-Cal members living with SMI/SED and/or a SUD • Transitional rent services for up to six months for eligible high-need members who are experiencing or at risk of homelessness • FFP for care provided during short-term stays in IMDs
Forthcoming State Plan Amendment[5]
• Assertive Community Treatment (ACT) • Forensic ACT (FACT) • Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

[4] To the extent that CMS advises the state that additional authorities are necessary to implement the programmatic vision and operational details described above, the state is requesting such waiver or expenditure authority, as applicable. California's negotiations with the federal government, as well as state legislative and/or budget changes, could lead to refinements in these lists as the state works with CMS to establish Special Terms and Conditions for the BH-CONNECT demonstration.

[5] To make ACT, FACT, CSC for FEP, IPS Supported Employment, community health worker services, and clubhouse services available at county option, DHCS will leverage California's waivers of statewideness and comparability authorized in the CalAIM 1915(b) waiver, which apply to benefits offered under both the SMHS and DMC-ODS delivery systems. To make IPS Supported Employment and community health worker services available at county option in the DMC delivery system, DHCS is seeking waivers of statewideness and comparability as part of the BH-CONNECT demonstration.

- Individual Placement and Support (IPS) model of Supported Employment[6]
- Community health worker services[7]
- Clubhouse services

Existing Federal Medicaid Authorities

- Clarification of coverage requirements for evidence-based practices for children and youth under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), including:*
    - Multisystemic Therapy (MST)
    - Functional Family Therapy (FFT)
    - Parent-Child Interaction Therapy (PCIT)
    - Potentially additional therapeutic modalities
- Inclusion of a management-level Foster Care Liaison within Managed Care Plans (MCPs) to enable effective oversight and delivery of Enhanced Care Management (ECM), attend Child and Family Team meetings, ensure managed care services are coordinated with other services, and serve as a point of escalation for care managers if they face operational obstacles*
- Establishment of an initial child welfare/specialty mental health assessment at entry point into child welfare*
- Centers of Excellence to offer training and technical assistance to behavioral health delivery systems and providers to support fidelity implementation and delivery of EBPs and community-defined evidence practices for Medi-Cal members living with SMI/SED and/or a SUD*[8]
- Implementation of specific requirements for counties that opt-in to receive FFP for short-term stays in IMDs, such as enhanced review of utilization of community-based mental health services
- Implementation of county and mental health facility requirements related to employing a utilization review process to ensure access to appropriate levels of care and appropriate inpatient/residential admissions and length of stay, conducting intensive predischarge care coordination, incorporating housing needs during discharge planning and making referrals to community services before discharge, and following up with beneficiaries within 72 hours of discharge.

[6] The IPS model of Supported Employment is an evidence-based practice that helps individuals living with serious behavioral health conditions obtain and maintain paid competitive jobs through vocational assessment, job-finding assistance and job skills training. It has been shown to reduce health care costs and hospitalizations among individuals living with SMI, and to help keep individuals stably housed by ensuring they have access to a regular income.

[7] To support county behavioral health outreach and engagement.

[8] Centers of Excellence will offer dedicated training, technical assistance and fidelity implementation support to providers on EBPs such as ACT/FACT, CSC for FEP, IPS Supported Employment, EBPs for children and youth, including MST, FFT, PCIT, High-Fidelity Wraparound, and other culturally tailored and/or community-defined practices. Centers of Excellence will support the delivery and statewide dissemination of EBPs to improve outcomes for Medi-Cal members living with SMI/SED and/or a SUD, expand dissemination of community-defined practices when appropriate, and strengthen the ability of Medi-Cal behavioral health providers to offer culturally-sensitive care. DHCS intends to update its cost allocation plan to include expenditures for Centers of Excellence as an administrative cost.

SECTION 2 | PROGRAM OVERVIEW

BACKGROUND

System Overview

Medi-Cal—California's Medicaid and Children's Health Insurance Program (CHIP)—provides comprehensive health care coverage, including behavioral health services, for 15.9 million low-income individuals,[9] about one in three Californians. Medi-Cal covers a continuum of behavioral health services ranging from early intervention services to crisis intervention, outpatient, and inpatient and residential treatment for Medi-Cal members with behavioral health needs. Medi-Cal behavioral health services, inclusive of mental health and SUD treatment services, are provided in multiple delivery systems, including:

- Non-Specialty Mental Health Services (NSMHS) delivered via the Medi-Cal fee-for-service (FFS) system and Medi-Cal Managed Care (MCMC) via MCPs;
- SMHS delivered via county MHPs;
- SUD Services delivered via the fee-for-service DMC program; and
- Expanded SUD Services delivered via county DMC-ODS plans.

The state's Medi-Cal managed care delivery systems, including MCMC, dental managed care, SMHS, and DMC-ODS, are authorized under a Section 1915(b) waiver that will run concurrently with this Demonstration.

SMHS are currently provided by 56 MHPs, which cover all 58 counties in the state, including two joint-county arrangements in Sutter/Yuba and Placer/Sierra counties. MHPs are responsible for covering SMHS for Medi-Cal members who meet specified access criteria, which differ for adult members and for members under age 21. SMHS are covered under the California Medicaid State Plan, defined and detailed in the MHP contract, and include a comprehensive array of services including mental health services, medication support services, day treatment intensive services, day rehabilitation, targeted case management, and a range of crisis services and inpatient and residential psychiatric services. Consistent with the EPSDT mandate, MHPs are responsible for providing all medically necessary SMHS for members under the age of 21.

In most counties, SUD services are provided through the DMC-ODS, a section 1115 SUD initiative operated at county discretion to provide extended SUD services to Medi-Cal members. DMC-ODS was established under the state's Medi-Cal 2020 Section 1115 demonstration and reauthorized under the CalAIM Section 1115 demonstration and 1915(b) waiver in December 2021. Participation in the DMC-ODS is voluntary for counties, and requires that counties provide access to all levels of care along the continuum defined in The American Society of Addiction Medicine (ASAM) Criteria.

---

[9] As of April 2023. DHCS, "Medi-Cal Enrollment Update," Available at https://www.dhcs.ca.gov/dataandstats/Documents/Medi-Cal-Enrollment-April2023.pdf.

These include, for example, multiple levels of residential SUD treatment, withdrawal management, recovery services, clinician consultation, and the option to provide partial hospitalization, inpatient residential treatment, and additional levels of withdrawal management.[10] Currently, 37 counties participate in DMC-ODS, representing approximately 96 percent of Medi-Cal members. In addition, Mariposa County is in the process of opting into DMC-ODS, which will expand DMC-ODS coverage to 97 percent of Medi-Cal members. Members who reside in counties that have not opted into DMC-ODS receive their SUD services through the DMC program. The DMC program covers fewer SUD services for individuals ages 21 and older than DMC-ODS, and relies on a fee-for-service delivery system.

Mental Health Challenges

As highlighted in DHCS' 2022 report *Assessing the Continuum of Care for Behavioral Health Services in California*, California faces a growing crisis exacerbated by the COVID-19 pandemic.[11] Prior to the pandemic, the rate of SMI in California increased by 50 percent from 2008 to 2019.[12] As of 2019, nearly one in 20 (4.5 percent) adults in California was living with a SMI, a rate expected to grow as more mid-to-post pandemic data becomes available.[13] At the same time, one in 13 children in California was living with a SED, with rates of depression and suicide higher among youth who are low-income, Black, American Indian and Alaska Native, Latino, and LGBTQ.[14,15,16] Of particular concern is the approximately 25 percent of California residents with SMI who are experiencing homelessness and, therefore, at higher risk of justice involvement. Among incarcerated individuals, data suggest that close to one in three are living with an SMI.[17]

---

[10] Under EPSDT, youth under age 21 who are enrolled in Medi-Cal receive comprehensive and preventive health care services, including all appropriate mental health and substance use disorder treatment.
[11] CDC, Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24-30, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm; CDC, National and State Trends in Anxiety and Depression Severity Scores Among Adults During the COVID-19 Pandemic — United States, 2020-2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7040e3.htm; CDC Drug Overdose Deaths in the U.S. Top 100,000 Annually, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.
[12] SAMHSA, California Behavioral Health Barometer Volume 6. https://www.samhsa.gov/data/sites/default/files/reports/rpt32821/California-BH-Barometer_Volume6.pdf.
[13] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.
[14] Holzer C and Nguyen H, "Estimation of Need for Mental Health Services." Accessed October 2021. Available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Joint%20Health%2002_26_19%20Teare%20to%20Ctte.pdf.
[15] "Native American Youth Depression and Suicide," Child Welfare Information Gateway, Department of Health & Human Services. Available at https://www.childwelfare.gov/topics/systemwide/diverse-populations/americanindian/wellbeing/depression/.
[16] Chapin Hall, Missed Opportunities: LGBTQ Youth Homelessness in America, https://voicesofyouthcount.org/wp-content/uploads/2018/05/VoYC-LGBTQ-Brief-Chapin-Hall-2018.pdf, April 2018.
[17] "Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding," Californian Budget and Policy Center, March 2020. Available at https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf .

In the aftermath of the COVID-19 pandemic, even more people are living with serious mental health or SUDs related to social isolation, economic hardship, loss of family members and other disruptions.[18] For children and youth, in particular, the pandemic has exacerbated mental health and SUD issues, prompting the American Academy of Pediatrics and other leading national associations to declare a public health emergency. Nationally, suicide rates among youth between the ages of 10 and 18 have increased, as has the rate for Black and Hispanic youth between the ages of 10 and 24.[19] In California, hospitals have reported a significant increase in the number of families seeking psychiatric treatment for adolescents in EDs since the beginning of the pandemic.[20]

In response, DHCS has made strengthening California's behavioral health system a top priority, particularly for individuals with the greatest needs. DHCS is making unprecedented investments in expanding behavioral health services, housing, and social supports for individuals living with a SED, mental illness and/or a SUD. For Medi-Cal members, initiatives include CalAIM and other efforts to strengthen the Medi-Cal program. Find a comprehensive list of ongoing and new initiatives to strengthen behavioral health care services detailed in Appendix 1.

However, significant gaps remain in the current continuum of care available to Medi-Cal members living with SMI/SED and/or a SUD, particularly among children and youth (including those involved in child welfare), individuals who are experiencing or at risk of homelessness, and those who are justice-involved. To help address these gaps, DHCS is requesting the necessary federal Medicaid authorities to implement the BH-CONNECT demonstration to expand access to and strengthen the continuum of behavioral health services for Medi-Cal members living with SMI/SED and/or a SUD, particularly for populations experiencing disparities in access to behavioral health services and outcomes. The BH-CONNECT demonstration is designed to complement and build on California's other major behavioral health initiatives. Figure 1 below is a diagram of the ecosystem of behavioral health care in California, and illustrates how the BH-CONNECT proposal complements and will further build out the continuum of care for individuals living with SMI/SED and/or a SUD.

---

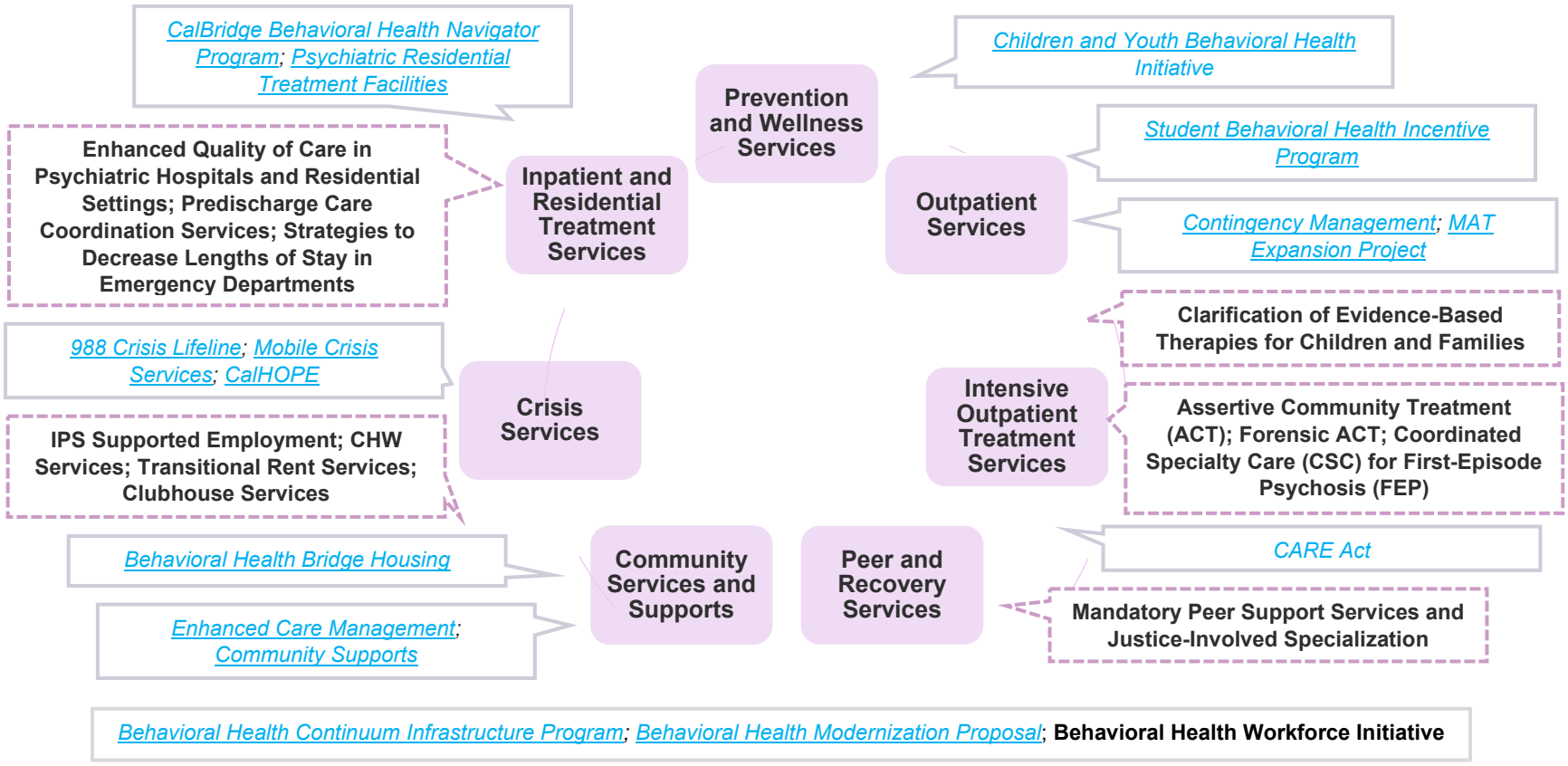
[18] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. Available at https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

[19] CDPH, "Suicide in California – Data Trends in 2020, COVID Impact, and Prevention Strategies," July 2021. Available at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/SuicideAndSelfHarmIn2020-DataBrief-ADA.pdf

[20] Wiener, Jocelyn. "Stranded in the ER: Can California change its treatment of kids in crisis?" Cal Matters, September 27, 2021. Available at https://calmatters.org/health/2021/09/children-suicide-residential-treatment-crisis-california/.

Figure 1. Building Out the Continuum of Care for Individuals Living with SMI/SED and/or a SUD

Key: Proposed BH-CONNECT demonstration initiatives are in **bold with purple outline.** *Existing initiatives are italicized.*



Note: This depiction does not identify all ongoing initiatives; additional details about California's other initiatives and investments in behavioral health are detailed in Section II. Some of the proposed BH-CONNECT demonstration features are specific to counties that opt in to receive FFP for care provided during short-term stays in IMDs or are otherwise optional for counties.

DEMONSTRATION GOALS AND OBJECTIVES

California's goal for the BH-CONNECT demonstration is to strengthen the state's continuum of community-based behavioral health services to better meet the needs of Medi Cal members living with SMI/SED and/or a SUD across the state, and to improve access, quality, and outcomes for populations experiencing disparities in particular. California's proposed goals for the BH-CONNECT demonstration aligns with the specific goals for SMI/SED demonstrations outlined in State Medicaid Director Letter (SMDL) #18-011, including:

1. Reduced utilization and lengths of stay in EDs among Medicaid members with SMI or SED while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
3. Improved 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. Improved access to community-based services to address the chronic mental health care needs of members with SMI or SED including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in EDs, hospitals and residential treatment facilities.

Building upon the goals identified in SMDL #18-011, California has identified additional state-specific goals for the BH-CONNECT demonstration, including:

6. Improved availability in Medi-Cal of high-quality community-based behavioral health services, EBPs, and community-defined evidence practices, including ACT, FACT, CSC for FEP, IPS Supported Employment, community health worker services, clubhouse services, and transitional rent services;
7. Improved outcomes for members living with SMI/SED and/or SUD, particularly for those who historically have experienced healthcare disparities, including individuals who are involved in child welfare, justice-involved, and homeless or at-risk of homelessness;
8. Improved availability of training, technical assistance and incentives for providers and counties to implement high-quality community-based behavioral health services and improve outcomes for high-risk populations;
9. Expanded behavioral health workforce to ensure that clinicians and other staff are available to treat Medi-Cal members living with SMI/SED and/or SUD.

HYPOTHESES AND EVALUATION PLAN

The BH-CONNECT demonstration will test whether the granted waiver and expenditure authorities increase access to community-based behavioral health services and improve outcomes for Medi-Cal members living with SMI/SED and/or a SUD.

California has developed a set of preliminary hypotheses and evaluation approaches to assess progress on the goals identified in SMDL #18-011 and California's state-specific goals outlined above. California will contract with an independent evaluator to conduct a critical and thorough evaluation of the Demonstration. The evaluator will develop a comprehensive evaluation design that is consistent with CMS guidance and the requirements of the Special Terms and Conditions for the Demonstration. To the maximum extent possible, the BH-CONNECT demonstration evaluation will be coordinated with other existing evaluations that DHCS already is conducting for CMS for CalAIM and other initiatives.

Based on the goals identified above, the state has developed a preliminary evaluation plan that delineates potential hypotheses, a potential evaluation approach for each hypothesis, and the expected source(s) of data that can be used in the evaluation, summarized in Table 2.[21] All components of the preliminary evaluation plan are subject to change as the program is implemented and an evaluator is identified.

Table 2. Preliminary Evaluation Plan for BH-CONNECT Demonstration

Hypothesis	Evaluation Approach	Data Sources
ED utilization and lengths of stay among Medicaid members with SMI/SED will decrease over the course of the demonstration.	The state will analyze the: • Number and proportion of Medicaid members[22] with a SMI/SED diagnosis with an emergency department (ED) visit related to SMI/SED, and characteristics of ED service utilization (e.g., length of stay pending available data) to be described in the formal evaluation design.	• Claims data
SMI/SED-related readmissions to acute care hospitals and residential settings will decrease over the course of the demonstration.	The state will analyze the: • Number and proportion of Medicaid members with a SMI/SED diagnosis with an acute care hospital, psychiatric inpatient hospital, or Medicaid-funded residential mental health treatment readmission related to SMI/SED.	• Claims data

[21] In addition to the hypotheses summarized in Table 2, DHCS will ensure transitional rent services are evaluated in an integrated evaluation that is inclusive of the MCMC and behavioral health delivery systems.
[22] For some proposed metrics, DHCS will only review data among Medicaid members residing in counties that opt-in to participate in the BH-CONNECT demonstration. Other proposed metrics will be evaluated statewide.

Hypothesis	Evaluation Approach	Data Sources
Utilization of community-based crisis services will increase over the course of the demonstration.	The state will analyze the: • Number and proportion of Medicaid members with a SMI/SED diagnosis utilizing community-based crisis services.	• Claims data
Availability and utilization of community-based behavioral health services will increase over the course of the demonstration.	The state will analyze the: • Number and proportion of Medicaid members with a SMI/SED diagnosis accessing community-based behavioral health services (e.g., ACT, FACT, Peer Support Services, including those delivered by Peer Support Specialists with a forensic specialization, IPS Supported Employment, clubhouse services, transitional rent services). • Number of Medicaid provider sites offering these community-based behavioral health services.	• Claims data
Care coordination for members living with SMI/SED will improve over the course of the demonstration.	The state will analyze the: • Rates of follow-up after an ED visit for mental illness. • Rates of follow-up after hospitalization for mental illness. • Number and proportion of Medicaid members with a SMI/SED diagnosis who are utilizing Enhanced Care Management and/or Community Support services. • Number and proportion of Medicaid members with a SMI/SED diagnosis who are utilizing physical health services, including primary care.	• Claims data
Outcomes for individuals who are justice-involved and those who are homeless or at-risk of homelessness will improve over the course	The state will analyze the: • Number and proportion of members with a SMI/SED diagnosis who have experienced one or more days of homelessness in the past year. • Number and proportion of Medicaid members with a SMI/SED diagnosis who have experienced one or more incidences of incarceration in the past year.	• Claims data • HMIS data • Incentive program data • CDCR data • Data on Medi-Cal members who enter and

Hypothesis	Evaluation Approach	Data Sources
of the demonstration.		exit incarceration[23]
Outcomes for children and youth involved with child welfare will improve over the course of the demonstration.	The state will analyze the: • Number and proportion of children and youth involved with child welfare with an ED visit related to SMI/SED. • Number and proportion of children and youth involved with child welfare with an SED utilizing residential behavioral health treatment services, including short-term residential therapeutic programs (STRTPs). • Number and proportion of children and youth involved with child welfare with an SED utilizing community-based services and EBPs (e.g., intensive in-home services, MST, FFT, PCIT, Activity Stipends). • Ratio of children and youth involved with child welfare with an ED visit related to SMI/SED to children and youth involved with child welfare utilizing community-based services and EBPs (e.g., intensive in-home services, MST, FFT, PCIT, Activity Stipends).	• Claims data • Cross-sector incentive program data
Availability of trainings, technical assistance and incentives to strengthen the provision of community-based care and improve outcomes will increase over the course of the demonstration.	The state will analyze the: • Number of trainings delivered by Centers of Excellence. • Number of fidelity reviews conducted by Centers of Excellence. • Participation rate among eligible Medicaid providers and county behavioral health plans in trainings offered by Centers of Excellence. • Participation rate among eligible Medicaid providers in fidelity reviews offered by Centers of Excellence. • Provider feedback surveys on effectiveness of trainings and fidelity reviews provided by Centers of Excellence.	• Centers of Excellence data • Incentive program data

[23] By April 2024, DHCS expects to have access to data on Medi-Cal members who enter and exit incarceration. Currently, data are available via the eligibility system for Medi-Cal members incarcerated for a period of 28 days or longer because they are re-classified under a special aid code that limits their benefits to hospitalizations in community facilities of 24 hours or more. Even if it is harder to secure incarceration data than hoped, DHCS and its evaluator can modify the hypotheses and the data sources after the waiver is approved via the formal evaluation design that must be submitted to CMS.

Hypothesis	Evaluation Approach	Data Sources
	• Participation rate among counties in statewide and opt-in county incentive programs. • Incentive dollars earned through statewide and opt-in county incentive programs. • Performance improvements as reported through statewide and opt-in county incentive programs.	
Availability of behavioral health providers will increase over the course of the demonstration.	• Number of providers expanding clinical capacity attributable to the behavioral health workforce initiative. • Number of new college/university slots funded through behavioral health workforce initiative.	• Workforce initiative data

SECTION 3 | BH-CONNECT DEMONSTRATION REQUEST

KEY FEATURES

DHCS is requesting new authorities, effective January 1, 2025, to strengthen the continuum of community-based care for Medi-Cal members living with SMI/SED, including children and youth involved in the child welfare system, individuals and families experiencing or at risk of homelessness, and those who are justice-involved. As detailed in Table 1 above, the BH-CONNECT demonstration includes new statewide initiatives, as well as features available at county option. While DHCS is requesting approval of the requested authorities effective January 1, 2025, the BH-CONNECT demonstration will be implemented through a phased approach as described in the "Demonstration Implementation" section below.

Below, find additional details about each of the statewide initiatives requested as part of the BH-CONNECT demonstration. The following section reviews the Section 1115 demonstration requests for initiatives that will be available at county option.

BH-CONNECT Features Available Statewide

DHCS is requesting expenditure authority to make targeted improvements statewide. These include new investments in a robust, diverse behavioral health workforce and programs to support children and youth who are involved in child welfare and who have, or are at risk of developing, significant behavioral health conditions. In addition, DHCS is requesting expenditure authority to implement an incentive program for county behavioral health delivery systems to enhance quality infrastructure and improve performance on key outcomes among Medi-Cal members living with SMI/SED and/or SUD.

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

Like the rest of the nation, California is facing an acute behavioral health workforce shortage. Expanding the supply, diversity and cultural competency of the behavioral health care workforce is a key priority that California shares with the Biden Administration.[24] In California, county behavioral health departments, providers and consumer advocacy groups have highlighted that the workforce crisis will be the most significant challenge to implementing the proposed components of the BH-CONNECT demonstration. One county behavioral health director requested targeted workforce funding to support their participation in the BH-CONNECT demonstration. Advocacy

[24] The White House, "Fact Sheet: Biden-Harris Administration Announces New Actions to Tackle Nation's Mental Health Crisis," May 2023. Available at https://www.whitehouse.gov/briefing-room/statements-releases/2023/05/18/fact-sheet-biden-harris-administration-announces-new-actions-to-tackle-nations-mental-health-crisis/

groups highlighted recruitment, retention and bandwidth as significant concerns to implementing new services as part of the BH-CONNECT demonstration.

In addition, a recent analysis of California's behavioral health workforce authored by researchers from Healthforce Center at the University of California, San Francisco for the California Behavioral Health Directors Association[25] found that:

- 90 percent or more of county behavioral health agencies reported difficulty recruiting LCSWs, psychiatrists, and LMFTs. Between 70 percent and 90 percent had difficulty recruiting registered nurses (RNs), LPCCs, and psychologists.
- Most county behavioral health agencies had difficulty recruiting sufficient numbers of Native American, Asian, Black, Latino(a), and Native Hawaiian/Pacific Islander behavioral health professionals to match clients' race/ethnicity.
- The three top barriers reported by county behavioral health agencies in recruiting behavioral health providers were the inability to offer competitive pay; lengthy hiring processes; and location.

To meet this need, DHCS has made building a diverse and equitable workforce a top priority and is making significant state-level investments in California's behavioral health workforce. As noted above, the state has embarked on massive investments totaling more than $10 billion in resources to strengthen the behavioral health care continuum. Further, Governor Newsom's recent proposal to transform California's behavioral health system would authorize an additional $4.7 billion to expand access to behavioral health care and permanent supportive housing for individuals with behavioral health conditions.[26] In tandem with unprecedented state funding investments in behavioral health care infrastructure and capacity development, California is implementing significant delivery system transformations to reshape how behavioral health care is administered and reimbursed in Medi-Cal with the goal of better meeting the needs of Medi-Cal members living with the most significant mental health and substance use disorder needs. These system transformations are described in further detail in Appendix 1.

To build upon work already underway in California, and consistent with the Biden Administration's prior[27] and current[28] budget proposals for historic investments in the behavioral health workforce, DHCS is requesting expenditure authority for a behavioral

---

[25] Healthforce Center at UCSF, "Building the Future Behavioral Health Workforce: Needs Assessment," February 2023. Available at https://static1.squarespace.com/static/5b1065c375f9ee699734d898/t/63e695d3ce73ca3e44824cf8/1676056025905/CBHDA_Needs_Assessment_FINAL_Report_2-23.pdf.

[26] CalHHS, "The Next Step to Transform California's Behavioral Health System." Available at https://www.chhs.ca.gov/behavioral-health-reform/

[27] The White House, "Fact Sheet: President Biden's Budget Advances A Bipartisan Unity Agenda, " March 2022. Available at https://www.whitehouse.gov/omb/briefing-room/2022/03/28/fact-sheet-president-bidens-budget-advances-a-bipartisan-unity-agenda/

[28] The White House, "Fact Sheet: The President's Budget for Fiscal Year 2024," March 2023. Available at https://www.whitehouse.gov/omb/briefing-room/2023/03/09/fact-sheet-the-presidents-budget-for-fiscal-year-2024/

health workforce initiative needed to support the identification, training and retention of the people who will be providing services across the full continuum of care for Medi-Cal members living with SMI/SED and/or a SUD. The investments are critical to expand access to behavioral health care for Medi-Cal members and ensure the sustainability of new Medi-Cal community-based services and EBPs implemented through the BH-CONNECT demonstration. Key areas of focus will be on ensuring that the workforce is equipped to provide culturally and linguistically-appropriate care; engaging individuals with lived experience in the professional workforce; and, addressing the particularly acute shortages in behavioral health professionals who work with children and youth, and justice-involved individuals.

Demonstration Request

DHCS requests expenditure authority totaling $2,400,000,000 for long- and short-term investments in a robust, diverse behavioral health workforce required for Medi-Cal members living with SMI/SED and/or a SUD. DHCS proposes to fund 85% of the non-federal share of the workforce investments by drawing down federal Medicaid matching dollars for Designated State Health Programs (DSHP) and the remaining 15% of the non-federal share using state or local funds. In total, DHCS is requesting expenditure authority totaling $1,020,000 for DSHP to finance the workforce investments required to implement the BH-CONNECT demonstration.

Scope of Program

The workforce initiative will be used by DHCS for both long- and short-term investments in the behavioral health workforce required to provide Medi-Cal benefits, which may include:

- Long-term investments to expand the pipeline of behavioral health professionals who can work with Medi-Cal members living with SMI/SED and/or a SUD, such as partnerships with community colleges and public universities to expand allied professional and graduate programs in social work, psychology, and other related programs, and to build upon recent investments to augment the pipeline of Peer Support Specialists, Community Health Workers, SUD counselors, and other practitioners; and
- Short-term investments to support recruitment efforts for key community-based Medi-Cal behavioral health services, such as hiring and retention bonuses, scholarship and loan repayment programs, certification costs for community health workers and peer support specialists, and other stipends determined by DHCS to be needed to implement BH-CONNECT.

DHCS will ensure all new investments made through the workforce initiative will build upon, not duplicate, existing behavioral health workforce initiatives in the state and that they will be directed toward the workforce required to provide care to Medi-Cal members living with SMI/SED and/or SUD.

Activity Stipends

Children and youth involved in the child welfare system often do not have access to extracurricular activities that support physical health, mental wellness, healthy attachment and social connections – all protective factors that support social and emotional development, promote enhance long-term mental health and prevent substance use. After-school and extracurricular activities can be an effective way to improve outcomes and mitigate the impact of poverty, trauma and poor health.[29] They expose children to others in different socioeconomic groups, different cultures, healthy and functional family systems, and give them a chance to try activities that might turn into meaningful passions. They help to prevent attachment to negative peer culture with potential implications for substance use disorders and/or risk of involvement with the juvenile justice system. Physical activities for certain at-risk children (e.g., those suffering from attention deficit hyperactivity disorder) can help to prevent the need for or limit the use of medication. Finally, these activities can help children and youth who are involved in child welfare to feel "normal," which is critical to helping children and youth to heal and recover from their experiences. Indeed, the lack of the ability to do normal developmental activities is something that former foster children emphasize is one of the hardest parts of receiving foster care.[30] This proposal is consistent with California's 2009 law AB81 which, while primarily focusing on the education system, also explicitly states that foster youth have a statutory right to participate in extracurricular activities. In addition, California youth advocacy groups have raised that young people have repeatedly elevated the importance of non-traditional therapeutic interventions in supporting children and youth involved in child welfare and/or juvenile justice systems.[31]

It is in this context that DHCS proposes to develop a new support for children aged three and older involved with the child welfare system to be used for activities and supports to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful physical and mental health effects of trauma.

Demonstration Request

DHCS requests expenditure authority totaling $214,335,000 over the demonstration period for Activity Stipends. Coverage of Activity Stipends will enable DHCS to support

---

[29] Polihronakis, Tina, "Information Packet: Mental Health Care Issues of Children and Youth in Foster Care," April 2008. Available at http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/Mental_Health.pdf.
[30] The Annie E. Casey Foundation, "What Young People Need to Thrive," 2015. Available at https://assets.aecf.org/m/resourcedoc/aecf-whatyoungpeopleneedtothrive-2015.pdf
[31] Klitsch, Stephanie, "Beyond the Basics: How Extracurricular Activities Can Benefit Foster Youth," National Center for Youth Law, 2011. Available at https://youthlaw.org/news/beyond-basics-how-extracurricular-activities-can-benefit-foster-youth#:~:text=The%20law%20prohibits%20any%20other,from%20participating%20in%20extracurricular%20activities.&text=The%20law%20requires%20private%20agencies,promote%20participation%20in%20extracurricular%20activities

the social and emotional well-being of children and youth in the child welfare system, resulting in improved physical and behavioral health outcomes.

Eligibility Criteria

Children and youth ages three and older enrolled in Medi-Cal may be eligible for Activity Stipends if they:

- Are under age 21 and are currently involved in the child welfare system in California;[32]
- Are under age 21 and previously received care through the child welfare system in California or another state within the past 12 months;
- Have aged out of the child welfare system up to age 26 (having been in foster care on their 18th birthday or later) in California or another state;
- Are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or
- Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

Scope of Services

Activity Stipends would support activities not otherwise reimbursable in Medi-Cal, such as:

- Movement activities;
- Sports;
- Leadership activities;
- Excursion and nature activities;
- Music and art programs; and
- Other activities to support healthy relationships with peers and supportive adults.

DHCS will be responsible for oversight of Activity Stipends, but will work with California Department of Social Services (CDSS), county child welfare agencies, and Tribal child welfare programs as applicable on distribution as part of promoting cross-agency accountability and coordination.

Cross-Sector Incentive Program for Children Involved in Child Welfare

It is important that children and youth involved in child welfare have access to well-coordinated and managed health care. Separation from parents – even in cases of abuse or neglect – is traumatizing, and the experience of trauma increases the risk of mental illness, SUDs, and poor physical health outcomes, which can hinder development and have a lasting impact. Children involved in child welfare frequently require coordination across multiple systems to meet their needs.

[32] As defined in BHIN 21-073, "Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements." December 2021. Available at https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf.

To address these challenges, DHCS plans to establish a cross-sector incentive program to facilitate innovation and drive member outcome improvements through cross-agency collaboration to address the needs of children and youth involved in child welfare who are living with or at high-risk for SED. The program will provide fiscal incentives for three key systems – MCPs, county behavioral health delivery systems, and county child welfare systems – to work together and share responsibility for improvement in behavioral health outcomes among children and youth involved in child welfare.[33] The cross-sector incentive program for children in child welfare will incentivize activities such as cross-sector collaboration, implementation of child- and youth-related components of the BH-CONNECT demonstration, and improved outcomes for children and youth with behavioral health conditions involved in child welfare, among others. DHCS has received valuable feedback on potential measures for this incentive program and is working closely with stakeholders on the framework and measure set for the cross-sector incentive program to ensure it is designed in a way to best support children and youth involved in child welfare who are living with behavioral health needs.

Demonstration Request

DHCS requests expenditure authority totaling $250,000,000 over the demonstration period for the cross-sector incentive program for children in child welfare. This program will incentivize MCPs, MHPs and county child welfare systems to work together to address the physical, behavioral health, and health-related social needs of children and youth involved with the foster care system in their communities, and address concerns about cross-sector accountability.

Based on the initial implementation experience with children and youth involved in child welfare, in future years DHCS will assess opportunities to expand this incentive program to promote improved outcomes and accountability for children and youth involved with juvenile justice, the Department of Developmental Disabilities, and/or the Department of Education. If DHCS determines it is appropriate to extend the cross-sector incentive program to additional children and youth and/or other domains, it will pursue an amendment to this demonstration.

Statewide Incentive Program

To complement the training, coaching and fidelity supports offered directly to providers through Centers of Excellence, DHCS proposes to make new investments in county MHPs and DMC-ODS counties so that they are equipped to provide the robust set of community-based services described in BH-CONNECT. These investments will directly build on initial work done as part of the CalAIM Behavioral Health Quality Improvement Program (BHQIP) to strengthen counties' quality monitoring infrastructure and ensure

[33] Based on the initial implementation experience with children and youth involved in child welfare, DHCS may submit an amendment to the BH-CONNECT demonstration to expand this program to support children and youth involved with juvenile justice, the Department of Developmental Disabilities, and the Department of Education.

counties are equipped to track and report on key measures and demonstrate improved outcomes among Medi-Cal members.

Demonstration Request

DHCS requests expenditure authority totaling $1,512,720,000 over the demonstration period to establish a statewide incentive program that will incentivize MHPs and DMC-ODS counties to improve performance on quality measures and reduce disparities in behavioral health access and outcomes. The initiative is focused on supporting counties in providing the Medi-Cal benefits most critical to individuals living with SMI/SED and/or a SUD who otherwise are at-risk of hospitalization or other significant adverse health outcomes.

Scope of Program

Specific measures for the statewide incentive program will be determined through a robust stakeholder process, but may include measures that are aligned with National Committee for Quality Assurance (NCQA) standards and other core set measures such as:

- Effective transitions of care;
- Cultural and Race, Ethnicity and Language (REAL) responsiveness;
- Follow-up after ED visit for mental illness;
- Follow-up after hospitalization for mental illness;
- Antidepressant medication management;
- Use of first-line psychosocial care for children and adolescents on antipsychotics; and
- Adherence to antipsychotic medications for individuals with schizophrenia.

In initial years, counties will be eligible for incentives if they demonstrate consistent reporting on key measures. Over time, counties will also be incentivized for improved performance on key measures.

Incentive program measures will build upon the quality measures included in the DHCS Comprehensive Quality Strategy (CQS) Section 1915(b) Special Terms and Conditions and Section 1115 SMI/SED Monitoring Protocol (DHCS' SMI/SED Monitoring Protocol, which must be developed by DHCS and approved by CMS in advance of demonstration implementation). Quality performance measures will also include rates specific to populations experiencing disparities in behavioral health care access and outcomes regardless of whether they have received services from MHPs or DMC-ODS counties.

Counties that participate in the statewide incentive program will be required to reinvest the FFP received through earned incentives into Medi-Cal behavioral health service provision or capacity expansion.

BH-CONNECT Features Available at County Option

Option to Cover Enhanced Community-Based Services

The core objective of the BH-CONNECT demonstration is to strengthen the continuum of community-based services available to Medi-Cal members living with SMI/SED and/or a SUD. To reach this goal, DHCS proposes to provide counties with the option to cover additional evidence-based, community-based services that reduce the need for institutional inpatient and residential care and improve outcomes among individuals living with SMI/SED.[34] Through the development of DHCS' 2022 report *Assessing the Continuum of Care for Behavioral Health Services in California* and robust stakeholder engagement, DHCS has identified key EBPs that improve outcomes for Medi-Cal members living with SMI/SED and/or a SUD. In particular, these services have demonstrated effectiveness in supporting recovery for populations most in need of enhanced behavioral health services and supports, including those who are justice-involved and members who are homeless or at risk of homelessness.[35]

As part of the BH-CONNECT demonstration, DHCS requests expenditure authority to fund transitional rent services for eligible members who are homeless or at-risk of homelessness at county option. DHCS also intends to submit a SPA authorizing county behavioral health delivery systems to deliver:

- ACT;
- FACT;
- CSC for FEP;
- IPS Supported Employment;
- Community health worker services; and
- Clubhouse services.

Table 3 below describes which community-based services and EBPs authorized through the BH-CONNECT demonstration will be available in each behavioral health delivery system.

Table 3. Community-Based Services and EBPs by Behavioral Health Delivery System

SMHS	DMC	DMC-ODS
• Transitional rent services • ACT	• Transitional rent services	• Transitional rent services

[34] As always, children and youth under 21 are already eligible for these services to the extent they are required to be covered by EPSDT; the new options do not overturn or modify in any way the existing obligation to meet EPSDT requirements.

[35] "Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration," Judge David L. Bazelon Center for Mental Health Law, September 2019. Available at http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf.

• FACT • CSC for FEP • IPS Supported Employment • Community health worker services • Clubhouse services	• IPS Supported Employment • Community health worker services	• IPS Supported Employment • Community health worker services

To make ACT, FACT, CSC for FEP, IPS Supported Employment, community health worker services, and clubhouse services available at county option in the SMHS and DMC-ODS delivery systems, DHCS will leverage California's waivers of statewideness and comparability authorized in the CalAIM 1915(b) waiver, which apply to benefits offered under both delivery systems. To make IPS Supported Employment and community health worker services available at county option in the DMC delivery system, DHCS is seeking waivers of statewideness and comparability as part of the BH-CONNECT demonstration.

Transitional Rent Services

Housing supports, including services that help individuals find, move into and retain housing, are essential to the treatment and recovery of individuals living with serious behavioral health conditions. Housing supports are particularly critical for high-need members who are homeless and living with SMI/SED and/or SUD, especially those transitioning out of institutional care or congregate settings, correctional facilities, or the child welfare system.

To meet this need, DHCS proposes to cover transitional rent services for up to 6 months for eligible Medi-Cal members who are homeless or at risk of homelessness and who meet other specified criteria. DHCS also intends to request authority to cover transitional rent services through MCMC as an amendment to the CalAIM Section 1115 demonstration. DHCS will establish processes to avoid duplication of services across delivery systems. Transitional rent services will be closely coordinated across delivery systems, with other housing-related supports offered as Medi-Cal Community Support services, and with other non-Medi-Cal funded housing services. DHCS is requesting authority to implement transitional rent services in BH-CONNECT on a phase-in basis, if necessary.

Demonstration Request

DHCS is requesting expenditure authority totaling $565,741,000 over the demonstration period to cover transitional rent services for eligible individuals in the SMHS, DMC, and DMC-ODS delivery systems. DHCS is also seeking waivers of statewideness, comparability and amount, duration and scope to allow for counties to determine whether they will offer transitional rent services and, if necessary, to phase in implementation of the transitional rent service.

Eligibility Criteria

Medi-Cal members may be eligible for up to 6 months of transitional rent services through the BH-CONNECT demonstration in participating counties if they:

- Meet the access criteria for SMHS, DMC and/or DMC-ODS services; and
- Meet the US Department of Housing and Urban Development's (HUD's) current definition of homeless or the definition of individuals who are at-risk of homelessness as codified at 24 CFR part 91.5, with two modifications:[36]
    - If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization; and
    - The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the current HUD definition to thirty (30) days; and
- Meet at least one of the following:
    - 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 disorder treatment or recovery facility, an inpatient or residential mental health treatment facility, or nursing facility;
    - Are transitioning out of a correctional facility;
    - Are transitioning out of the child welfare system;
    - Are transitioning out of a recuperative care facility or short-term post-hospitalization housing;
    - Are transitioning out of transitional housing;
    - Are transitioning out of a homeless shelter/interim housing;
    - Meet the criteria of unsheltered homelessness described at 24 CFR part 91.5; [37] or
    - Meet eligibility criteria for a Full Service Partnership (FSP) program.[38]

Scope of Services

Transitional rent will be available for a period of no more than six months and will be provided only if it is determined to be medically appropriate. Transitional rent services may be subject to a population or geographic phase-in, as determined by DHCS.

---

[36] In alignment with the definition of homelessness and at-risk of homelessness used for Community Supports services authorizes through CalAIM.

[37] Specifically, "An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground."

[38] FSP is a comprehensive and intensive mental health program for individuals with persistent mental illness that have demonstrated a need for an intensive FSP program, including individuals who are experiencing or at risk of homelessness, those who are justice-involved, and high-utilizers of emergency or high-acuity mental health services. An estimated 71,000 individuals are currently enrolled FSP programs (.5% of the Medi-Cal population).

Short-Term Residential and Inpatient Psychiatric Stays in IMDs

As part of the BH-CONNECT demonstration, DHCS proposes that counties that agree to certain conditions ("opt-in counties") will receive FFP for services provided during short-term stays in IMDs consistent with applicable requirements described in federal guidance. To participate, a county must agree to cover a full array of enhanced community-based services and EBPs described above,[39] reinvest dollars generated by the demonstration into community-based care, and meet accountability requirements to ensure that IMDs are used only when there is a clinical need and that they meet quality standards. In addition to the expenditure authority for FFP for services provided during short-term stays in IMDs consistent with applicable requirements described in federal guidance, DHCS is also requesting expenditure authority to establish an incentive program for opt-in counties to prepare for participation in the BH-CONNECT demonstration, focusing on building out enhanced community-based services and EBPs and ensuring effective use of short-term IMD stays.

DHCS is committed to ensuring that Medi-Cal members have access to a comprehensive continuum of care that allows members who require residential and inpatient services to receive them when necessary. DHCS is also committed to ensuring that individuals are served in inpatient and residential settings only when clinically indicated and for no longer than necessary for them to receive the most appropriate care. DHCS recognizes that behavioral health care needs to be tailored to an individual's circumstances; an individualized, person-centered approach to behavioral health means that some individuals may need a longer course of treatment when clinically indicated; DHCS, however, is not requesting FFP for any stays in excess of 60 days in any circumstances.

Demonstration Request

To support access to necessary care for Medi-Cal members who require inpatient or residential treatment, DHCS is requesting expenditure authority totaling $958,834,000 over the demonstration period for otherwise covered Medi-Cal services furnished to Medi-Cal members who are receiving short-term residential or inpatient psychiatric care in IMDs consistent with all applicable federal guidance, including stays in STRTPs for youth. DHCS also requests to exercise the flexibility CMS has provided to waive the length-of-stay requirements under the Section 1115 SMI/SED guidance for foster children residing in STRTPs that are Qualified Residential Treatment Programs in certain circumstances.[40],[41] Finally, DHCS is seeking waivers of statewideness,

---

[39] With the exception of clubhouse services. Opt-in counties must offer ACT, FACT, CSC for FEP, IPS Supported Employment, transitional rent services, and community health worker services.
[40] CMS, "Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements Q&A," October 2021. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf
[41] While the number of children residing in such facilities is minimal, DHCS has determined that a small number of STRTP facilities remain essential for now in order to provide care to children and youth who require more extended treatment and who cannot safely be treated in alternative settings.

comparability and amount, duration and scope to allow for use of Medi-Cal funding for short-term stays in IMDs only in counties that meet specified conditions.

Incentive Program for Opt-In Counties

Counties that "opt-in" to the BH-CONNECT demonstration will need to make significant investments to meet the requirements for receiving FFP for care provided during short-term stays in IMDs, including building networks to deliver newly required, enhanced community-based services, conducting oversight of participating IMDs, and meeting other state and federal requirements not applicable in other counties.

Demonstration Request

DHCS requests expenditure authority totaling $1,078,717,000 over the demonstration period to establish an incentive program for opt-in counties.

Scope of Program

The incentive program will support and reward counties in implementing community-based care options that enable Medi-Cal members living with SMI/SED to remain in the community rather than in inpatient or residential settings.

Specific measures will be determined through a robust stakeholder process, but may include:

- Start-up and capacity development, such as:
    - Receive DHCS approval of BH-CONNECT county implementation plan
- Process and structural milestones, such as:
    - Submit baseline reporting on outcome measures related to BH-CONNECT programs
    - Ensure provider organizations participate in fidelity review for specific EBPs, such as ACT, FACT, CSC for FEP, and IPS Supported Employment
- Performance and outcomes, such as:
    - Demonstrate improved outcomes related to BH-CONNECT programs (e.g., reduction in homelessness and incarceration)
    - Demonstrate increased utilization rates of community-based services and EBPs available through the BH-CONNECT demonstration
    - Demonstrate improvement on specified quality of life measures

While the incentive program for opt-in counties will support counties and providers in launching their participation in the demonstration, most of its resources are focused on outcomes associated with effective implementation of community-based services such as ACT/FACT, IPS Supported Employment, CSC for FEP, community health worker services, clubhouse services, and transitional rent for eligible members experiencing or at risk of homelessness.

Counties that participate in the incentive program for opt-in counties will be required to reinvest the FFP received through earned incentives into Medi-Cal behavioral health service provision or capacity expansion.

PROPOSED BENEFIT CHANGES

Delivery System

There are no proposed changes to the structure of California's Medicaid delivery systems as part of this demonstration request. MCPs will remain responsible for providing covered NSMHS and some SUD services (e.g., smoking cessation) to adult and youth members, and MHPs will continue covering SMHS for Medi-Cal members who meet specified criteria for services. SUD services will continue to be administered primarily by the counties through the DMC program and DMC-ODS.

Cost Sharing

There is no cost sharing in the proposed BH-CONNECT demonstration.

SECTION 4 | DEMONSTRATION ELIGIBILITY AND ENROLLMENT

ELIGIBILITY REQUIREMENTS

There are no proposed changes to California's Medicaid eligibility requirements as part of this demonstration request.

ENROLLMENT

The State is not proposing any changes to Medicaid eligibility requirements in the Section 1115 demonstration request. As such, the demonstration is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes and economic conditions. Even though this demonstration request does not propose to otherwise expand eligibility, the BH-CONNECT demonstration is expected to improve care for Medi-Cal members living with behavioral health needs, including the estimated 640,000 adults living with SMI and 127,000 children and youth living with SED across the state.

Table 4 provides information about projected enrollment in each of the major eligibility categories over the course of the Demonstration.

Table 4. Projected Enrollment by Category of Aid

Category of Aid	Projected Enrollment (in Thousands)				
	DY1	DY2	DY3	DY4	DY5
	1/1/25-12/31/25	1/1/26-12/31/26	1/1/27-12/31/27	1/1/28-12/31/28	1/1/29-12/31/29
Families and Children (not CHIP)	5,721,771	5,721,771	5,721,771	5,721,771	5,721,771
CHIP	1,282,063	1,282,063	1,282,063	1,282,063	1,282,063
Seniors and Persons with Disabilities	2,191,022	2,191,022	2,191,022	2,191,022	2,191,022
ACA Expansion	4,371,622	4,371,622	4,371,622	4,371,622	4,371,622
Other	954,319	954,319	954,319	954,319	954,319
Total	14,525,797	14,525,797	14,525,797	14,525,797	14,525,797

SECTION 5 | DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

COST ESTIMATES

Table 5. Total Projected Expenditures

Expenditure Authorities	Total Projected Expenditures (in Thousands)				
	DY1	DY2	DY3	DY4	DY5
	1/1/25-12/31/25	1/1/26-12/31/26	1/1/27-12/31/27	1/1/28-12/31/28	1/1/29-12/31/29
Workforce Initiative	480,000	480,000	480,000	480,000	480,000
Activity Stipends	23,815	47,630	47,630	47,630	47,630
Cross-Sector Incentive Program		62,500	62,500	62,500	62,500
Statewide Incentive Program	302,544	302,544	302,544	302,544	302,544
Opt-In County Incentive Program	182,175	198,001	208,540	245,000	245,000
Transitional Rent Services	36,001	85,258	119,874	153,087	171,521
IMDs	161,929	175,997	185,364	217,772	217,772
Total	**1,186,464**	**1,351,930**	**1,406,452**	**1,508,533**	**1,526,967**

Table 6. Projected Federal Expenditures for DSHPs to Support BH-CONNECT Workforce Initiative

Federal Funding	Projected Federal Expenditures for DSHPs to Support Workforce Initiative (in Thousands)[42]				
	DY1	DY2	DY3	DY4	DY5
	1/1/25-12/31/25	1/1/26-12/31/26	1/1/27-12/31/27	1/1/28-12/31/28	1/1/29-12/31/29
DSHP	204,000	204,000	204,000	204,000	204,000
Total	**204,000**	**204,000**	**204,000**	**204,000**	**204,000**

[42] DHCS anticipates expenditures for the workforce initiative would total $480,000,000 annually. Of that total, DSHP would cover 85% of the non-federal share, totaling $204,000,000 annually, and the state would cover the remaining 15%, totaling $36,000,000 annually.

MAINTENANCE OF EFFORT

California has summarized the outpatient community-based mental health expenditures for state fiscal year 2022 distributed by population and stratified according to federal share, state share general funds and state share county-level funding in Table 7 below. California attests it will meet CMS's maintenance-of-effort requirements for SMI/SED demonstrations and is committed to maintaining or improving access to community-based mental health services throughout the course of this Demonstration.

Table 7. Maintenance of Effort

	Federal	State–General Funds (Matchable)	State-County Funds	Total
Families and Children (not CHIP)	$890,492,443.30	$27,455,348.78	$692,870,128.16	$1,610,817,920.24
CHIP	$209,986,171.92	$6,944,153.20	$92,829,157.52	$309,759,482.64
Seniors and Persons with Disabilities	$700,317,395.58	$282,426.49	$545,557,014.15	$1,246,156,836.22
ACA Expansion	$712,659,294.10	$100,545,474.09		$813,204,768.19
Other	$11,095,293.57	$359,216.54	$6,147,818.25	$17,602,328.36
Total	**$2,524,550,598.47**	**$135,586,619.10**	**$1,337,404,118.08**	**$3,997,541,335.65**

SECTION 6 | WAIVER AND EXPENDITURE AUTHORITIES

California is requesting a waiver of the following sections of the Social Security Act, to the extent necessary, to support implementation of the BH-CONNECT demonstration. To the extent that CMS advises the state that additional authorities are necessary to implement the programmatic vision and operational details described above, the state is requesting such waiver or expenditure authority, as applicable. California's negotiations with the federal government could lead to refinements in these lists as the state works with CMS to establish Special Terms and Conditions for the BH-CONNECT demonstration.

To make ACT, FACT, CSC for FEP, IPS Supported Employment, community health worker services, and clubhouse services available at county option, DHCS will leverage California's waivers of statewideness and comparability authorized in the CalAIM 1915(b) waiver, which apply to benefits offered under the both delivery systems. To make IPS Supported Employment and community health worker services available at county option in DMC, DHCS is seeking waivers of statewideness and comparability as part of BH-CONNECT.

WAIVER AUTHORITIES

Under the authority of Section 1115(a)(1) of the act, the following waivers shall enable California to implement this Section 1115 demonstration from January 1, 2025 through December 31, 2029.

Table 8. Waiver Authority Requests

Waiver Authority	Use for Waiver
§ 1902(a)(1) Statewideness	To enable the State to operate components of the Demonstration on a county-by-county basis. To enable the State to provide short-term inpatient and residential treatment services to individuals in IMDs on a geographically limited basis. To enable the State to provide IPS Supported Employment (DMC only), community health worker services (DMC only), and transitional rent services on a geographically limited basis.
§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability	To enable the State to provide short-term inpatient and residential treatment services in IMDs to individuals with SMI/SED that are otherwise not available to all members in the same eligibility group. To enable the State to provide IPS Supported Employment (DMC only), community health worker services (DMC only), and transitional rent services to

	qualifying individuals with SMI/SED and/or SUD that are otherwise not available to all members in the same eligibility group.

EXPENDITURE AUTHORITIES

Under the authority of Section 1115(a)(2) of the act, California is requesting expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the act, shall, through December 31, 2029, be regarded as expenditures under the state's Title XIX plan.

These expenditure authorities promote the objectives of Title XIX in the following ways:

1. Expenditure authority 1 (Table 9 below) promotes the objectives of title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the State.
2. Expenditure authorities 1, 2, 3 and 4 promote the objectives of title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks to support better integration, improved health outcomes, and increased access to health care services.
3. Expenditure authorities 5, 6, 7 and 8 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the State.

Table 9. Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority
1. Expenditures Related to the Workforce Initiative	Expenditure authority for funding as described in the STCs to strengthen the capacity of the behavioral health workforce and long-term pipeline of behavioral health professionals to support BH-CONNECT implementation and operations.
2. Expenditures Related to Activity Stipends	Expenditure authority to provide Activity Stipends to qualifying individuals with behavioral health needs.
3. Expenditures Related to the Cross-Sector Incentive Program	Expenditure authority to support improved health outcomes and accountability for children and youth involved in child welfare through incentive payments to qualified MCPs, MHPs and child welfare agencies described in the STCs.
4. Expenditures Related to the Statewide Incentive Program	Expenditure authority for payments to MHPs and DMC-ODS counties as described in the STCs to strengthen service delivery, improve health outcomes for members with SMI/SED, reduce health disparities and promote health equity and achieve practice transformation.

Expenditure Authority	Use for Expenditure Authority
5. Expenditures Related to Incentive Program for Opt-in Counties	Expenditure authority to support BH-CONNECT implementation and support quality outcomes in BH-CONNECT demonstration counties that opt to provide an enhanced continuum of care and receive FFP for short-term stays in IMDs.
6. Expenditures Related to Transitional Rent Services	Expenditure authority to provide transitional rent services to qualifying individuals who are homeless or at risk of homelessness who meet specified standards.
7. Expenditures Related to IMDs	Expenditures for otherwise-covered services furnished to otherwise-eligible individuals who are short-term residents/inpatients in facilities that meet the definition of an IMD.
8. Expenditures Related to Designated State Health Programs	Expenditures for Designated State Health Programs, identified in these STCs, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs.

SECTION 7 | DEMONSTRATION IMPLEMENTATION

DHCS is requesting approval of the proposed BH-CONNECT demonstration effective January 1, 2025 through December 31, 2029. The BH-CONNECT demonstration will be implemented through a phased approach, as outlined in Table 10 below. Counties may opt-in to receive FFP for services provided during short-term stays in IMDs on a rolling basis over the course of the demonstration period, insofar as they meet all requirements for opt-in counties described above. The implementation timeline includes all proposed components of the BH-CONNECT demonstration, including features that do not require Section 1115 demonstration authority, and is subject to change depending on implementation progress. See Table 1 above for a review of which features of the BH-CONNECT demonstration require Section 1115 demonstration authorities, which require a new SPA, and which California intends to implement through state-level guidance under existing federal Medicaid authorities.

Table 10. BH-CONNECT Demonstration Implementation Timeline

Statewide Features	
Demonstration Year 0	• Inclusion of a management-level Foster Care Liaison within MCPs to enable effective oversight and delivery of ECM, attend Child and Family Team meetings, ensure managed care services are coordinated with other services, and serve as a point of escalation for care managers if they face operational obstacles (effective January 1, 2024)

Demonstration Year 1	• Workforce initiative
	• Centers of Excellence
	• Statewide incentive program
	• Clarification of coverage requirements for EBPs for children and youth under EPSDT:
	  ○ MST
	  ○ FFT
	  ○ PCIT
	  ○ Potentially additional therapeutic modalities
	• Activity Stipends for children and youth involved in child welfare
	• Initial child welfare/specialty mental health behavioral health assessment at entry point into child welfare

Demonstration Year 2	• Cross-sector incentive program to support children and youth involved in child welfare also receiving specialty mental health services • Evidence-based tools to connect members living with SMI/SED to appropriate care
Features Available at County Option	
Rolling Basis	• County option to enhance community-based services:

	○ Transitional rent services ○ IPS Supported Employment ○ Community health worker services ○ ACT ○ FACT ○ CSC for FEP ○ Clubhouse services
Upon IMD Opt-In County Go-Live (*rolling basis*)	• Participate in incentive program for opt-in counties • Meet county accountability requirements • Begin providing: ○ Peer support services with a forensic specialization ○ Community health worker services • Begin participating in training and technical assistance for ACT/FACT through Center of Excellence, including completion of preliminary fidelity assessment
Within 1 Year of Go-Live	• Fully implement ACT • Begin providing transitional rent services
Within 2 Years of Go-Live	• Begin providing: ○ FACT ○ CSC for FEP
Within 3 Years of Go-Live	• Begin providing: ○ IPS Supported Employment

SECTION 8 | PUBLIC REVIEW AND COMMENT PROCESS

On August 1, 2023, DHCS released the requisite notices for the BH-CONNECT demonstration and launched a state public comment period from August 1, 2023 through August 31, 2023. DHCS will present and discuss the BH-CONNECT proposal and implementation during two public hearings, the first on August 11, 2023 from 10:00 to 11:30 AM PT and the second on August 24, 2023 from 9:30 to 11:30 AM PT. DHCS will also host a webinar to solicit Tribal and Indian Health Program stakeholder comments on August 30, 2023.

SECTION 9 | DEMONSTRATION ADMINISTRATION

Pleases see below for contact information for the State's point of contact for this demonstration application:

Name: Tyler Sadwith

Title: Deputy Director, Behavioral Health

Agency: Department of Health Care Services

Email Address: tyler.sadwith@dhcs.ca.gov

APPENDIX 1 | CURRENT INITIATIVES TO EXPAND COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES IN CALIFORNIA

Children- and Youth-Focused Initiatives

- **Children and Youth Behavioral Health Initiative (CYBHI).**[43] CYBHI is a $4.4 billion investment to enhance, expand and redesign the systems that support behavioral health for children and youth. The goal of CYBHI is to reimagine mental health and emotional well-being for all children, youth and families in California by delivering equitable, appropriate, timely and accessible behavioral health services and supports.
- **Student Behavioral Health Incentive Program (SBHIP)**.[44] SBHIP includes a designated $389 million over a three-year period from January 1, 2022, to December 31, 2024 for incentive payments, to break down silos and improve coordination of child and adolescent student behavioral health services through increased communication with schools, school affiliated programs, managed care providers, counties, and mental health providers. The program will distribute incentives to MCPs that meet predefined goals and metrics associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools.
- **Complex Care Capacity Building.**[45] Assembly Bill 153 provided $43.3 million in one-time funding to both county welfare agencies and probation departments to support counties with establishing a high-quality continuum of care designed to support foster children and nonminor dependents (NMDs) in the least restrictive setting, consistent with the child/NMD's permanency plan.

Enhanced Supports for Populations of Focus

- **Justice-Involved Initiative.**[46] On January 26, 2023, through the Justice-Involved Initiative, California became the first state in the country to receive federal approval to offer a targeted set of Medicaid services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. The goals of the initiative include increasing and continuing Medi-Cal coverage, improving coordination and communication among correctional systems, Medicaid systems, and community-based providers, and providing appropriate health care interventions at earlier opportunities. The state

[43] CalHHS, "Children and Youth Behavioral Health Initiative," May Revision 2021-22. Available at https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.

[44] DHCS, "Student Behavioral Health Incentive Program (SBHIP) Application, Assessment, Milestones, Metrics." Available at https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SBHIP-Overview-and-Requirements-2-1LR.pdf.

[45] CDSS, All County Letter No. 21-143, November 2021. Available at https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2021/21-143.pdf?ver=2021-11-17-115026-727.

[46] DHCS, "Justice Involved Initiative."Available at https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx

is establishing Medi-Cal enrollment processes, providing targeted Medi-Cal services to eligible individuals while they are incarcerated immediately prior to their release, and ensuring continuity of coverage and services after incarceration as part of re-entry planning.

- **Behavioral Health Bridge Housing (BHBH).**[47] The BHBH Program will provide a total of $1.5 billion in funding to county behavioral health agencies and Tribal entities to operate bridge housing settings to address the immediate and sustainable housing needs of people experiencing homelessness who have serious behavioral health conditions, including a SMI and/or SUD. The program, which was signed into law in September 2022 under Assembly Bill 179 (Ting, Chapter 249, Statutes of 2022), provides funding through June 30, 2027. .
- **Felony Incompetent to Stand Trial (IST) Waitlist Solutions.**[48] The 2022-23 California State Budget includes $535.5 million in general fund spending in 2022-23, increasing to $638 million per year in 2025-26 and ongoing at the Department of State Hospitals for solutions focusing on Early Stabilization and Community Care Coordination and Expanding Diversion and Community-Based Restoration Capacity for the IST population. This proposal will establish 5,000 beds over four years to support felony ISTs.
- **Housing and Homelessness Incentive Program (HHIP).**[49] As a means of addressing social determinants of health and health disparities, HHIP allows MCPs to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. MCPs and the local homeless continuum of care, in partnership with local public health jurisdictions, county behavioral health, Public Hospitals, county social services and local housing departments, must submit a homelessness plan to DHCS.
- **Community Assistance, Recovery and Empowerment (CARE) Act.**[50] CARE Act is a new framework to get people with mental health and substance use disorders the support and care they need. It is aimed at helping the thousands of Californians who are suffering from untreated mental health and substance use disorders leading to homelessness, incarceration or worse. California is taking a new approach to act early and get people the support they need and address underlying needs - without taking away people's rights. CARE Act includes accountability for everyone – on the individual and on local governments – with court orders for services.

Other Initiatives to Strengthen the Continuum of Care

---

[47] "California State Budget Summary – 2022-23," Health and Human Services. Available at https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.
[48] Ibid.
[49] DHCS, "Housing and Homelessness Incentive Program," March 2022. Available at https://www.dhcs.ca.gov/services/Pages/Housing-and-Homelessness-Incentive-Program.aspx.
[50] "Governor Newsom's New Plan to Get Californians in Crisis Off the Streets and into Housing, Treatment, and Care," March 2022. Available at https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf.

- **CalAIM Enhanced Care Management (ECM).**[51] As a key part of CalAIM, ECM is a statewide Medi-Cal benefit available to select populations of focus that will address clinical and nonclinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet members wherever they are – on the street, in a shelter, in their doctor's office or at home. Members will have a single Lead Care Manager who will coordinate care and services among the physical, behavioral, dental, developmental and social services delivery systems, making it easier for them to get the right care at the right time. Effective July 1, 2023, the ECM benefit will launch statewide for the Children and Youth Involved in Child Welfare population of focus. The Children and Youth Involved in Child Welfare population of focus includes children and youth who meet one or more of the following conditions:
    a. Are under age 21 and are currently receiving foster care in California
    b. Are under age 21 and previously received foster care in California or another state within the past 12 months
    c. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
    d. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program
    e. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months
- **CalAIM Community Supports.**[52] Community Supports are services provided by MCPs as cost-effective alternatives to traditional medical services or settings. Community supports are designed to address social drivers of health (factors in people's lives that influence their health). All MCPs are encouraged to offer as many of the 14 pre-approved Community Supports as possible, which are available to eligible Medi-Cal members regardless of whether they qualify for ECM services.
- **Recovery Incentives: California's Contingency Management (CM) Program.**[53] CM is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests that are negative for stimulants. CM 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.. While CM has been tested using other sources of funding, California is the first state in the country to receive federal approval to offer CM as a Medicaid benefit through the CalAIM Section 1115 demonstration.

---

[51] DHCS, "CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program." Available at https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices.
[52] Ibid.
[53] DHCS, "DMC-ODS Contingency Management." Available at https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx.

- **Medication-Assisted Treatment (MAT) Expansion Program.**[54] The California MAT Expansion Project increases access to MAT, reduces unmet treatment need, and reduces opioid overdose-related deaths through the provision of prevention, harm reduction, treatment and recovery activities. The California MAT Expansion Project supports more than 30 projects across the state and has expanded access to MAT to 206 hospitals/emergency departments, 37 county jail systems, 12 Indian Health Programs, 10 mental health/SUD clinics, 22 sites specifically for youth, and 270 Community Access Points.
- **Behavioral Health Continuum Infrastructure Program (BHCIP).**[55] BHCIP awards competitive grants ($2.2 billion in total) to qualified entities to construct, acquire and rehabilitate real estate assets, or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. DHCS is releasing BHCIP grant funds through six rounds that target various gaps in the state's behavioral health facility infrastructure.
- **CalBridge Behavioral Health Navigator Pilot Program.**[56] The CalBridge Behavioral Health Navigator Pilot Program supports EDs to become primary access points for the treatment of substance use disorders and co-occurring mental health conditions. Hospitals participating in the Bridge Navigator Program will SUD as a treatable medical emergency, utilizing trained navigators to identify patients who would benefit from initiating MAT or mental health services. Through this program, DHCS aims to make treatment of substance use and mental health conditions the standard of care in all California EDs. The Bridge Navigator Program provides all participating hospitals with access to materials, training, and technical assistance for navigators, clinicians, nurses, and other hospital staff and stakeholders. .
- **988 Crisis Call Hotline.**[57] DHCS invested $20 million in California's network of emergency call centers to support the launch of the new national 988 hotline for people seeking help during a behavioral health crisis.
- **Medi-Cal Community-Based Mobile Crisis Intervention Services .**[58] Mobile crisis services are a community-based intervention designed to provide de-escalation and relief to individuals experiencing a behavioral health crisis wherever they are, including at home, work, school, or in the community. Mobile crisis services are provided by a multidisciplinary team of trained behavioral health professionals in the least restrictive setting. Mobile crisis services include

---

[54] DHCS, "The California MAT Expansion Project Overview." Available at https://www.dhcs.ca.gov/individuals/Pages/MAT-Expansion-Project.aspx.
[55] DHCS, "The Behavioral Health Continuum Infrastructure Program." Available at https://www.dhcs.ca.gov/services/MH/Pages/BHCIP-Home.aspx#:~:text=The%20Behavioral%20Health%20Continuum%20Infrastructure%20Program%20(BHCIP)%20provides%20the%20Department,expand%20the%20community%20continuum%20of.
[56] DHCS, "Medicaid Home- and Community-Based Services (HCBS) Spending Plan: Quarterly Reporting for Federal Fiscal Year 2021-2022," October 2021. Available at https://www.dhcs.ca.gov/Documents/HCBS-Spending-Plan-Q2-Final-Report.pdf.
[57] DHCS, "California Dedicates $20 Million to Support New Mental Health '988' Crisis Hotline," September 2021. Available at https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2021/21-06-988-Line.pdf.
[58] "California State Budget Summary – 2022-23," Health and Human Services. Available at https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

screening, assessment, stabilization, de-escalation, follow-up, and coordination with healthcare services and other supports. Mobile crisis services are intended to provide community-based crisis resolution and reduce unnecessary law enforcement involvement and emergency department utilization. The mobile crisis services benefit will ensure that Medi-Cal members have access to coordinated crisis care 24 hours a day, 7 days a week, 365 days per year. In October 2022, DHCS submitted SPA 22-0043 to add qualifying mobile crisis services as a new Medi-Cal benefit, effective January 2023.

- **CalHOPE.**[59] CalHOPE delivers crisis support for communities impacted by a national disaster. CalHOPE is a Crisis Counseling Assistance and Training Program funded by the Federal Emergency Management Agency (FEMA) and operated by DHCS. . Services include individual and group crisis counseling and support, individual and public education, community networking and support, connection to resources, and media and public service announcements..[60]

Behavioral Health Delivery System Reforms

- **CalAIM Behavioral Health Payment Reform.**[61] DHCS seeks to move counties away from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal members. Payment reform will transition counties from cost-based reimbursement funded via CPEs to FFS reimbursement funded via IGTs, eliminating the need for reconciliation to actual costs. As part of payment reform, SMHS and SUD services will transition from existing HCPCS Level II coding to Level I coding, known as CPT coding, when possible.
- **CalAIM No Wrong Door.**[62] DHCS implemented a “no wrong door" policy to ensure members receive mental health services regardless of the delivery system where they seek care (via County Behavioral Health, MCP, or the FFS delivery system). This policy allows members who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services by their contracted plan, even if the member is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, members may receive coordinated, non-duplicative services in multiple delivery systems, such as when a member has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

---

[59] “CalHOPE.” Available at https://www.calhope.org/Pages/default.aspx.
[60] CalHHS, “Children and Youth Behavioral Health Initiative,” May Revision 2021-22. Available at https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.
[61] DHCS, “CalAIM Behavioral Health Workgroup.” Available at https://www.dhcs.ca.gov/provgovpart/Pages/bhworkgroup.aspx.
[62] DHCS, “Behavioral Health Stakeholder Advisory Committee (BH-SAC) meeting,” October 21, 2021. Available at https://www.dhcs.ca.gov/services/Documents/102121-BH-SAC-presentation.pdf.

- **CalAIM Screening and Transition Tools.**[63] DHCS conducted a robust stakeholder process to develop standardized screening and transition tools for both adults and individuals under 21 years old for use by MHPs and MCPs. DHCS developed the tools to determine the appropriate delivery system(s) for members who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. In addition, DHCS developed a standardized Transition of Care Tool to ensure that Medi-Cal members receive timely and coordinated care when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment. .
- **CalAIM Updated Specialty Mental Health Services (SMHS)**[64] **and DMC/DMC-ODS Criteria.** As of January 1, 2022, DHCS updated and clarified the responsibilities of MHPs, including updates to the criteria for access to SMHS, both for adults and members under age 21 through BHIN 21-073. These criteria were developed and improved based on significant feedback from stakeholders. The goal of these changes is to improve members' access to services and reduce provider administrative burdens. Additionally, as of January 1, 2022, DHCS made updates to DMC-ODS, based on experience from the first several years of implementation, in order to improve member care and administrative efficiency through BHIN 21-075. DHCS also issued guidance through BHIN 21-071 establishing that ASAM Criteria be used to determine the appropriate level of care for covered SUD treatment services in both DMC-ODS counties and DMC State Plan counties.
- **CalAIM Documentation Redesign.**[65] As of July 1, 2022, DHCS streamlined behavioral health documentation requirements for SUD and SMHS to align more closely with national standards. DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, except for specifically noted requirements in attachment 1 of BHIN 22-019. The new documentation requirements include the use of an active and ongoing problem list with progress notes reflecting the care given, aligning with the appropriate billing codes.
- **Behavioral Health Integration (BHI) Incentives Program.**[66] As authorized under Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care, the objective of the BHI Incentives Program is to incentivize improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in an MCP network.

[63] DHCS, "CalAIM Behavioral Health Initiative." Available at https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx.
[64] DHCS, "CalAIM Behavioral Health Initiative." Available at https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx.
[65] DHCS, "CalAIM Behavioral Health Initiative." Available at https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx.
[66] DHCS, "Behavioral Health Integration Incentive Program Application." Available at https://www.dhcs.ca.gov/provgovpart/Pages/VBP_BHI_IncProApp.aspx.