2024

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

JUNE 2024

The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Addendum Request

Medicaid Section 1115 Addendum

June 2024

CONTENTS

SECTION 1 | INTRODUCTION

The California Department of Health Care Services (DHCS) plans to submit to the Centers for Medicare & Medicaid Services (CMS) an addendum to the pending Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration to further strengthen the continuum of care for Medi-Cal members with significant behavioral health conditions.

In October 2023, California submitted the pending BH-CONNECT demonstration application, which seeks to establish a robust continuum of evidence-based community services for people with significant mental health conditions and/or substance use disorders, with key supports for fidelity monitoring and implementation of treatment interventions. Through ongoing work with stakeholders and individuals with lived experience in late 2023 and through 2024, California identified additional opportunities to expand the continuum of care for Medi-Cal members with significant behavioral health needs who are experiencing long stays in an institutional setting, who are or who are at risk of experiencing homelessness, or who need recovery-oriented residential care. These individuals have historically faced expansive challenges when leaving institutional settings or while experiencing homelessness, and are exactly the members who stand most to gain in terms of recovery and community-stabilization by accessing services provided through BH-CONNNECT, including those envisioned in this addendum.

To address these challenges, California is now seeking to add an addendum to the BH-CONNECT application to further strengthen the continuum of behavioral health care. The addendum will offer two new options for county behavioral health plans to cover the following:

1. **Community Transition In-Reach Services** to support individuals with significant behavioral health conditions who are experiencing long-term stays in institutions in returning to the community; and/or
2. **Room and Board in Enriched Residential Settings** for up to six months for individuals with significant behavioral health conditions and specified risk factors. These settings will be limited in size to 16 beds or less and must be unlocked and voluntary; provide Medi-Cal covered, voluntary, recovery-oriented services; and meet statewide standards established by DHCS in consultation with individuals with lived experience, advocacy groups, stakeholders, and tribal partners.

The two new options were developed in collaboration with individuals with lived experience and are based on the principles of choice, self-determination, purpose, and belonging. The approach aspires to be inclusive and integrated, with services and settings that are voluntary, high quality, accessible, and equity anchored. The two new options contribute to a continuum of sustained, person-centered support to help Medi-Cal members with significant behavioral health needs recover, build resiliency, and reside successfully in the community.

As noted above, the addendum builds out BH-CONNECT and seeks to further strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. Especially with the additions proposed by the addendum, BH-CONNECT will advance California's broader efforts to improve behavioral health care for Medi-Cal beneficiaries. In conjunction with the BH-CONNECT addendum, DHCS is sharing its intent to clarify coverage of High Fidelity Wraparound (HFW) as a Medi-Cal service. HFW is an evidence-based treatment modality for children and adolescents with the most complex and significant mental health conditions. When clinically appropriate, it can be used as an alternative to residential treatment. HFW already is provided to some of the children and youth who meet the clinical criteria for the service, but providers typically must bill for discrete elements of the service; there is no consistent way to bill for the service across the state. While HFW does not require Medicaid 1115 demonstration authority, DHCS views it as an important element of BH-CONNECT like the other child and youth-focused services already mentioned in the original BH-CONNECT application (i.e., Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT)).

Along with BH-CONNECT, California is making unprecedented investments, both one-time and ongoing, to dramatically expand community-based behavioral health care, housing, and social supports for individuals living with mental health conditions and/or substance use disorders. California has invested more than $10 billion into the behavioral health care continuum through initiatives like the Behavioral Health Continuum Infrastructure Program, the Behavioral Health Bridge Housing Program, new behavioral health initiatives under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Bridge Navigator Program, Elevate Youth California, the Behavioral Health Justice Intervention Services Project, the Community Mental Health Equity Project, the Children and Youth Behavioral Health Initiative, Medi-Cal mobile crisis services, 988 expansion, and more.

SECTION 2 | PROGRAM OVERVIEW

BACKGROUND

In California and across the United States, individuals with the most significant behavioral health challenges are often unable to reside stably in their communities of choice due to significant gaps in the care continuum. In California, as in other states, there is an opportunity to expand the array of services and resources dedicated to support individuals in transitioning from long-term stays in institutions into community-based care and housing. There is also an opportunity to expand the array of models and settings that effectively enable these individuals and those leaving incarceration or who are experiencing homelessness to receive effective, voluntary treatment in enriched settings that support access to at least a minimum set of clinically appropriate services. For these populations, the transition to community living after hospitalization, incarceration, or homelessness is often more successful with sustained, person-

centered supports and linkages to evidence-based service models to recover, build resiliency, and address the expansive challenges that they face.[1]

According to the largest representative study of homelessness in the United States since the mid-1990s, nearly half of individuals experiencing homelessness in California live with chronic and complex behavioral health conditions and almost a fifth of these individuals require supports for Activities of Daily Living (ADLs).[2] Data show that individuals with complex behavioral health conditions who are experiencing homelessness are increasingly at risk for premature death due to the instability linked to homelessness, including exposure to extreme temperatures, violence, traffic injuries, and barriers to accessing medical care, among other risk factors.[3] A recovery environment that is responsive to the needs of these individuals with the most chronic and complex behavioral health conditions is necessary to consolidate clinical gains and strengthen and sustain recovery.

Those with a history of incarceration are at grave risk of homelessness as well; a significant portion of individuals enter homelessness from an institutional setting, such as prolonged jail and prison stays, and very few report having received any transition or pre-release services prior to having exited a carceral facility.[4] DHCS is taking significant steps to remedy the lack of pre-release services for individuals dealing with significant behavioral health challenges leaving incarceration through the CalAIM Justice-Involved Initiative. Approved under CMS' Reentry Demonstration Initiative opportunity, the CalAIM Justice-Involved Initiative is an unprecedented step to improve care transitions and health outcomes for individuals re-entering the community from incarceration. The BH-CONNECT addendum request builds on the CalAIM Justice-Involved Initiative by ensuring that individuals with complex behavioral health issues who are transitioning into the community from incarceration (or are transitioning from an institution, or are at risk of or experiencing homelessness) can receive care in a voluntary, enriched residential setting, with direct and facilitated access to Peer Support Services, Assertive Community Treatment (ACT), the Individual Placement and Support (IPS) model of supported employment, and other psychosocial rehabilitation services, therapies, and support with health related social needs (HRSN).

---

[1] UCSF, Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness, June 2023. Available at: https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf.
[2] Ibid.
[3] Fowle, M. and Routhier, G. (2024). *Mortal Systemic Exclusion Yielded Steep Mortality-Rate Increases In People Experiencing Homelessness, 2011–20.* Health Affairs, Vol 43. No. 2. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.01039.
[4] UCSF, Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness, June 2023. Available at: https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf.

Through this BH-CONNECT addendum, California seeks to further expand the care continuum for Medi-Cal members with the most complex behavioral health issues and risk factors. Specifically, California proposes to enable county behavioral health plans to opt into one or both of two new opportunities tailored to the unique needs of Medi-Cal members who live with the most complex and significant behavioral health conditions:

1. **Community Transition In-Reach Services** to support individuals with significant behavioral health conditions who are experiencing long-term stays in institutions in returning to the community;[5] and/or
2. **Room and Board in Enriched Residential Settings** for up to six months for individuals with significant behavioral health conditions and specified risk factors.[6] These settings will be limited in size to 16 beds or less and must be unlocked and voluntary; provide Medi-Cal covered, voluntary, recovery-oriented services; and meet statewide standards established by DHCS in consultation with individuals with lived experience, advocacy groups, stakeholders, and tribal partners.

Co-designed with individuals with lived experience, advocacy groups, and stakeholders, these two new options focus on helping people to achieve person-centered goals and improve self-reported quality of life. These services and settings will provide much-needed support to Medi-Cal members who are experiencing or are at greatest risk of long-term and repeat stays in institutional settings, incarceration, or homelessness. These services and settings will also help individuals with the most significant behavioral health conditions access new services brought forth by BH-CONNECT, such as ACT and the IPS model of Supported Employment.

Even before this addendum, BH-CONNECT was designed to complement and build on California's other major behavioral health initiatives aimed at effectuating a long-term rebalancing of the state's behavioral health care delivery system. The addendum will further ensure resources are focused on community-based settings and supports and that services delivered in inpatient settings are strictly limited to the minimum time period required to address an individual's acute clinical needs. BH-CONNECT, including this proposed addendum, is a key part of California's overarching strategy to implement landmark policy reforms and unprecedented funding investments to strengthen the continuum of community-based behavioral health care and ensure Californians are able to live and thrive in the communities and environments they choose.

---

[5] As described below, Community Transition In-Reach Services will be a Specialty Mental Health Service that county Mental Health Plans (MHPs) can opt in to cover.
[6] As described below, room and board in enriched residential settings will be an allowable Medi-Cal cost that MHPs and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans can opt in to reimburse.

OVERVIEW OF PENDING BH-CONNECT REQUEST

In October 2023, DHCS requested Section 1115 demonstration expenditure and waiver authorities for a discrete set of activities that generally cannot be covered under Medi-Cal State Plan authorities. In this October 2023 submission, California requested authority to expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs, including through:

- Behavioral health workforce investments;
- Activity funds to support children and youth involved in child welfare;
- A cross-sector incentive program to support children and youth involved in child welfare;
- A statewide incentive program to improve behavioral health delivery system performance;
- An evidence-based practice incentive program for opt-in counties to support community-based services implementation;
- Transitional rent services for up to six months for eligible high-need members; and
- Federal match for some short-term stays in a limited set of Institutions for Mental Diseases (IMDs) for individuals with serious mental illness or serious emotional disturbance consistent with applicable federal guidance.

As part of the broader BH-CONNECT initiative (i.e., beyond the authorities requested in the BH-CONNECT 1115 waiver application), DHCS is also seeking State Plan authority to make ACT, Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), the IPS model of Supported Employment, Community Health Worker services, and Clubhouse Model services available at county option in the Specialty Mental Health (SMH), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) delivery systems. As a condition of receiving federal financial participation for services provided during short-term stays in IMDs consistent with applicable requirements described in federal guidance, a county must agree to cover a full array of enhanced community-based services, 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. More information about these requests can be found in the BH-CONNECT demonstration application.

BH-CONNECT ADDENDUM GOALS

Through the BH-CONNECT addendum, California seeks to advance the goals of Medicaid by:

- Advancing BH-CONNECT's goals of strengthening the continuum of community-based behavioral health services and improving health outcomes for Medi-Cal members with the most complex and significant behavioral health conditions;

- Ensuring members are served in the least restrictive settings possible, on a voluntary basis;
- Shortening lengths of stay in, and reducing the need for, care in institutional settings, incarceration, and homelessness;
- Supporting successful transitions to community-based care settings and community reintegration; and
- Reducing utilization of acute care or crisis related services following successful, stable transition to a community-based care setting.

In alignment with the goals of BH-CONNECT, this addendum seeks to support Californians experiencing inequity as a result of their behavioral health needs to live with dignity and integrity in the communities of their choice and access care in the least restrictive, appropriate settings. A foundational priority for DHCS is to ensure the addendum and its implementation is shaped by peers with lived experience with mental health and substance use disorder conditions. In designing the BH-CONNECT addendum, California collaborated with stakeholders, including individuals with lived experience, peer-run organizations, disability rights advocates, and health rights organizations. To further develop, implement, and evaluate the addendum, California will continue to collaborate with individuals with lived experience and stakeholders, including through workgroups, focus groups, and one-on-one interviews.

SECTION 3 | BH-CONNECT ADDENDUM REQUEST

The BH-CONNECT addendum requests authority to test the provision of two opportunities available at county option that are tailored to the unique needs of Medi-Cal members who live with the most complex needs and significant behavioral health conditions.

COUNTY PARTICIPATION

As with other services established through BH-CONNECT, all counties may opt in to offer one or both of the two new components.

SERVICES AND SETTINGS

DHCS is seeking expenditure authority for two county options that will be part of the continuum of care established by BH-CONNECT:

1. Community Transition In-Reach Services, and
2. Room and Board in Enriched Residential Settings.

Community Transition In-Reach Services

County Mental Health Plans (MHPs) will have the option to establish community-based, multi-disciplinary care transition teams that provide intensive pre- and post-discharge

care planning and transitional care management services to support individuals with significant behavioral health conditions who are experiencing long-term stays in institutional settings in returning to the community. They will deploy an in-reach model for individuals who are experiencing or at risk of experiencing extended lengths of stay (LOS) (120 days or more) in inpatient, residential, or subacute settings (including IMDs) to support reintegration into the community. The Community Transition In-Reach Services will be Specialty Mental Health services (SMHS) that county MHPs can opt in to cover.

Eligibility Criteria

Medi-Cal members who reside in an opt-in county, meet access criteria for SMHS, are aged 18 years or older or are an emancipated minor,[7] and who are experiencing or at risk of experiencing extended LOS (120 days or more) in inpatient, residential, or subacute settings (including IMDs) will qualify for Community Transition In-Reach Services for up to 180 days prior to discharge and for a transitional period upon discharge.

Service Description

The Community Transition In-Reach Service will provide person-centered, pre-discharge care planning and transitional care management to support reentry and successful integration into the community, including following discharge from the facility. MHPs that opt-in will be able to use demonstration funding to leverage community-based, multi-disciplinary care teams that provide services for up to 180 days before an individual is discharged from inpatient, residential, subacute, or non-carceral behavioral health institutional settings. Community transition teams will provide in-reach services and foster connections to community-based providers.

Community transition teams will be multi-disciplinary and, at a minimum, they must include at least the following practitioners for purposes of providing in-reach and post-discharge care planning, transitional care management, and community re-integration services:

- A licensed mental health professional as a team lead;
- A certified Peer Support Specialist or other Specialty Mental Health Services practitioner with lived experience of recovery from a significant behavioral health condition;
- An occupational therapist (if not serving as team lead);
- At least one additional Specialty Mental Health Services practitioner.

---

[7] California defines emancipated minor as a person under the age of 18 years that meetings any of the following criteria: (a) has entered a valid marriage; (b) is on active duty with US armed forces; or (c) has received a declaration of emancipation pursuant to §7122. (Div. 11, Part 6, Ch. 1, §7002).

Additionally, community transition teams must provide access to a prescriber for the purpose of coordinating medication management throughout the care transition.

The teams providing Community Transition In-Reach Services will:

- Connect with and establish trusted relationships with the individual.
- Develop comprehensive individualized care transition plans that support the member's transition to a community-based, home-like setting with supports; these settings may include Enriched Residential Settings described below, or other community-based settings (e.g., independent community living and supportive housing). Transition plans will include medical and specialized behavioral health care services and may include approaches for addressing:
    - Peer support and other evidence-based therapies to assist people struggling with trauma and maladaptive coping mechanisms, and behaviors that can be caused by prolonged stays in institutions and stigma;
    - Psychosocial rehabilitation;
    - Social drivers of health, including housing, transportation, nutrition, and public assistance, with a core emphasis on providing navigation and tenancy support services to facilitate the direct transition to community living, including supportive housing;
    - Activities of daily living as necessary; and
    - Supported employment and educational goals.
- Contact significant support persons, including family members, friends/social supports, or conservators, as appropriate, to assess needs and inform the individualized care transition plan.
- Facilitate warm hand-offs to community-based providers, including peer providers who can support recovery planning and evidence-based peer practices, as indicated in the care transition plan through closed loop referrals and multiple touch points following the referral to ensure ongoing engagement.
- Facilitate linkages to housing services and supports, including housing navigation services, housing deposits, tenancy supports, and rental assistance.
- Provide intensive assistance in applications for available benefits, public programs and key resources.
- Facilitate assessments, referrals, and enrollment assistance as needed for home and community-based services, including but not limited to In-Home Supportive Services and the Home and Community-Based Alternatives Waiver.
- Coordinate access to existing Medi-Cal benefits (as described below), including but not limited to Enhanced Care Management (ECM) and Community Supports available through CalAIM Peer Support Services, and expanded, community-based behavioral health care available through BH-CONNECT initiatives including ACT, ACT, IPS model of Supported Employment, and Clubhouse Model services.
- Identify and address other system barriers, including social and financial issues, to support successful reintegration of Medi-Cal members into their communities.

Eligible members may also receive Medi-Cal covered services necessary during the 180-day period prior to discharge, including in IMDs, when they are part of a re-integration plan to support their transition to the community, as clinically appropriate and desired by the Medi-Cal member, including but not limited to:

- Peer Support Services;
- Clubhouse Model services;
- Supported Employment and Supported Education;
- ACT and FACT; and
- Occupational therapy, including Specialty Mental Health Services delivered by occupational therapists.

The expenditure authority for Community Transition In-Reach Services would comprise a limited exception to the federal claiming prohibition for facilities that meet the definition of an IMD. Under no circumstances will the requested expenditure authority for federal financial participation for the Community Transition In-Reach Services be used for services provided by the institution in which the eligible individual resides. The Community Transition In-Reach Services will only be provided by community-based providers that are administratively distinct from the IMD facility, such as county Mental Health Plan (MHP)-operated and MHP-contracted community-based outpatient behavioral health provider organizations that travel to the IMD facility (or provide services via telehealth to supplement Community Transition In-Reach Services they provide in-person when they travel to the IMD facility).

Room and Board in Enriched Residential Settings

DHCS is seeking authority to provide Room and Board in Enriched Residential Settings for up to six months for individuals with significant behavioral health conditions and specified risk factors (e.g., experiencing or at risk of homelessness, transitioning out of institutional settings, or transitioning from carceral settings). These settings will be limited in size to 16 beds or fewer and must be unlocked and voluntary. DHCS is seeking federal reimbursement for room and board, inclusive of transportation, as it is key to therapeutic treatment.[8] The Enriched Residential Settings will provide Medi-Cal covered, voluntary, recovery-oriented services. Enriched Residential Settings must meet statewide standards established by DHCS in consultation with stakeholders, as described below.

Eligibility Criteria

Medi-Cal members with significant behavioral health conditions who are 18 years or older or emancipated minors for whom Enriched Residential Settings are clinically appropriate will be eligible for Room and Board in Enriched Residential Settings, if they:

[8] Approach would be in line with California's Whole Person Care Pilots, which included coverage of transportation to community activities as part of the room and board rate.

- 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 defined in 24 CFR part 91.5, with two modifications:
    - 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 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days.[9] OR
- Are transitioning out of an institutional care or institutional 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. OR
- Are transitioning out of a state prison, county jail, or youth correctional facility.

In operationalizing these eligibility standards for the Room and Board in Enriched Residential Settings, DHCS may leverage California's ECM Populations of Focus (POF), as outlined in California's CalAIM ECM Policy Guide, to facilitate alignment with the existing CalAIM initiative and care coordination resources. Specifically, California may align the eligibility criteria for Room and Board in Enriched Residential Settings with the ECM POFs such that Room and Board in Enriched Residential Settings is eligible for:

- Adults who meet SMHS or DMC/DMC-ODS access criteria and also meet the ECM POF of adults experiencing homelessness (ECM POF 1a);
- Adults who meet SMHS or DMC/DMC-ODS access criteria and also meet the ECM POF of adults transitioning from incarceration (ECM POF 4); and
- Adults who meet SMHS or DMC/DMC-ODS access criteria and are transitioning directly from an inpatient or residential BH facility.

Scope

MHPs and DMC-ODS Plans can opt in to provide eligible Medi-Cal members with Room and Board in Enriched Residential Settings for up to six months as medically necessary. To qualify as a Enriched Residential Setting, a facility must have no more than 16 beds and be voluntary and unlocked. Enriched settings must also meet the following statewide standards:

[9] In alignment with the definition of homelessness and at risk of homelessness used for Community Support services authorized through CalAIM and proposed for transitional rent services under BH-CONNECT and CalAIM.

- Reflect core principles of choice, self-determination, purpose, belonging, and inclusivity by ensuring services and settings are voluntary, high quality, accessible, and equity anchored.
- Provide a physical environment consistent with therapeutic goals, including through furnishings, decorations, and physical spaces that provide a welcoming environment and promote healing and recovery, community integration, safety, dignity, privacy, choice, and freedom of movement. Members must be able to decorate their spaces in a way that reflects their personal choices.
- Promote coordinated access to a minimum set of evidence-based, recovery-oriented services that support self-determination, recovery, and community integration during the members' stay in the residential setting. The Enriched Residential Settings can promote coordinated access to the minimum set of services by either providing them directly, by arranging for them to be provided onsite by community-based providers that travel to the Enriched Residential Setting, or by arranging for transportation to community providers for members to access them during their stay in the Enriched Residential Setting. Minimum services must include, as clinically appropriate for the Medi-Cal member:
    - Core clinical services, including care coordination, individual and group therapy, crisis intervention, crisis stabilization, medication support services including medications for addiction therapy, treatment for co-occurring disorders, and occupational therapy; AND
    - Psychosocial and rehabilitation services, including peer support services, recovery-oriented practices, community integration skills, referrals to and engagement with ACT and FACT teams, supported employment and supported education, support for ADLs and instrumental activities of daily living (IADLs), and Illness Management and Recovery (IMR) or Wellness Recovery Action Plan (WRAP) or other wellness curriculum; AND
    - Social supports, including transportation, referrals through MCPs to Community Supports (i.e., housing-related and Medically Tailored Meals/Medically-Supportive Food), and referral through MCPs to ECM; AND
    - Meet any additional standards established by DHCS to ensure that Enriched Residential Settings can deliver appropriate clinical care in a manner consistent with the goals of person-centered, voluntary care.

Peer-run peer respite models are important alternatives to hospitalizations or more clinical residential settings. The Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and the National Association of State Mental Health Program Directors (NASMHPD) all recognize peer respite settings and/or peer support services as vital components of effective crisis relief and stabilization approaches. As such, peer-run peer respite settings can be considered Enriched Residential Settings if they meet the core principles and physical environment minimum standards described

above and have services that align with Living Room Model standards[10] or another minimum set of standards that align with national best practices[11] and research,[12] as determined by DHCS.

MHPs and DMC-ODS Plans that seek to opt-in to this opportunity will demonstrate how participating Enriched Residential Settings meet the requirements described above through a county-specific readiness plan. Participating MHPs and DMC-ODS Plans will be responsible for directly overseeing Enriched Residential Settings and ensuring they meet minimum statewide standards and comply with all DHCS policy guidance. Counties can add their own standards that go above and beyond the state's minimum standards subject to DHCS approval in the implementation plan/approval process. Settings will adhere to reporting requirements to support evaluation of this component.

DHCS anticipates that most Enriched Residential Settings will be clinical facilities or peer respite settings that treat people with serious mental illness or emotional disturbance. However, residential SUD treatment facilities can be considered Enriched Residential Facilities if they meet all other standards and provide incidental medical services. Ideally the facilities will also offer Co-Occurring Enhanced (COE) Programs that serve patients with more complex mental health issues, but that is not part of the minimum set of requirements.

MEDI-CAL ELIGIBILITY, DELIVERY SYSTEM, BENEFITS, AND COST SHARING

ELIGIBILITY
The BH-CONNECT Addendum will not modify the parameters for Medi-Cal eligibility.

DELIVERY SYSTEM AND BENEFITS
As described in detail above, the BH-CONNECT Addendum will modify Medi-Cal benefits and Med-Cal behavioral health delivery systems by permitting counties to provide two options tailored to the unique needs of Medi-Cal members who live with the most complex and significant behavioral health conditions.

COST SHARING
There is no cost sharing in the proposed BH-CONNECT Addendum.

---

[10] SMI Adviser. What is the Living Room model for people experiencing a mental health crisis? August 2020. Available at: https://smiadviser.org/knowledge_post_fp/what-is-the-living-room-model-for-people-experiencing-a-mental-health-crisis.
[11] SAMHSA Advisory. Peer Support Services in Crisis Care. June 2022. Available at: https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf.
[12] Croft B, İsvan N. Impact of the 2nd story peer respite program on use of inpatient and emergency services. Psychiatr Serv. 2015 Jun;66(6):632-7. doi: 10.1176/appi.ps.201400266. Epub 2015 Mar 1. PMID: 25726982.

SECTION 4 | ENROLLMENT

The State is not proposing any changes to Medi-Cal eligibility requirements in this Section 1115 addendum request. As such, the BH-CONNECT addendum is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes and economic conditions. Even though this Section 1115 request does not propose to otherwise expand eligibility, the BH-CONNECT addendum is expected to improve care for Medi-Cal members in participating counties who meet the eligibility criteria for the demonstration components. The State anticipates the BH-CONNECT Addendum will serve a subset of the approximately 606,000 Medi-Cal members that utilize the SMH delivery system and 113,000 Medi-Cal members that utilize the DMC-ODS delivery system each year.

Table 1 provides information about projected enrollment in each of the major eligibility categories over the course of the demonstration period.

Table 1. 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 | FINANCING AND BUDGET NEUTRALITY

Based on the programmatic details described above, California has estimated projected spending for the BH-CONNECT addendum. Consistent with CMS' budget neutrality approach for pre-release in-reach services in justice-involved settings, California is seeking hypothetical budget neutrality treatment for the Community Transition In-Reach Services in inpatient, residential, and subacute settings. Consistent with CMS' budget neutrality framework for HRSN services and the approved budget neutrality approach

for recuperative care and short-term post hospitalization housing, California is seeking capped hypothetical budget neutrality treatment for Room and Board in Enriched Residential Settings. The following table shows the with waiver expenditures across the five Demonstration Years (DYs).

Table 2. Projected Expenditures for BH-CONNECT Addendum Components

Projected Expenditures (millions)	Type	DY 1	DY 2	DY 3	DY 4	DY 5
		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
Community Transition In-Reach Services	Per Capita Cap	$3,876	$4,077	$4,289	$4,512	$4,747
Room and Board in Enriched Residential Settings	Agg.	$280,463,000	$372,691,000	$392,071,000	$412,459,000	$433,907,000

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 addendum. 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 addendum.

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 3. Waiver Authority Requests

Waiver Authority	Use for Waiver
Section 1902(a)(1) Statewideness	To enable the State to operate Community Transition In-Reach Services and Room and Board in Enriched Settings on a county-by-county basis.
Sections 1902(a)(10)(B) and 1902(a)(17) Amount, Duration, and Scope and Comparability	To enable the State to provide Community Transition In-Reach Services and Room and Board in Enriched Settings to qualifying Medi-Cal members

Waiver Authority	Use for Waiver
	with significant behavioral health needs 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 4 below) promotes the goals of Title XIX by shortening lengths of stay in, and reducing the need for, care in institutional settings for Medi-Cal members, supporting successful transitions to community-based care and housing settings, supporting community reintegration for Medi-Cal members with significant behavioral health conditions in institutional settings, and improving health outcomes for Medi-Cal members with complex behavioral health conditions.
2. Expenditure authority 2 promotes the goals of Title XIX by ensuring members are served in the least restrictive settings possible on a voluntary basis, supporting successful transitions to community-based care and housing settings, supporting community reintegration for Medi-Cal members with significant behavioral health conditions and risk factors, and improving health outcomes for Medi-Cal members with complex behavioral health conditions.

Table 4. Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority
1. Expenditures related to Community Transition In-Reach Services	Expenditure authority for Community Transition Team services, as described in the resulting STCs, for qualifying Medi-Cal members experiencing or at risk of experiencing extended LOS (120 days or more) in inpatient, residential, or subacute settings (including IMDs) who reside in participating counties for up to 180 days prior to and on a temporary basis following discharge.
2. Expenditures related to Room and Board in Enriched Residential Settings	Expenditures for Room and Board in Enriched Residential Settings, as outlined in the resulting STCs, to qualifying Medi-Cal members in participating counties.

SECTION 7 | HYPOTHESES AND EVALUATION PLAN

The table below provides a preliminary plan to evaluate the BH-CONNECT addendum and its achievement of the proposed goals:

- Advancing BH-CONNECT's goals of strengthening the continuum of community-based behavioral health services and improving health outcomes for Medi-Cal members with the most complex and significant behavioral health conditions;
- Ensuring members are served in the least restrictive settings possible, on a voluntary basis;
- Shortening lengths of stay in, and reducing the need for, care in institutional settings, incarceration, and homelessness;
- Supporting successful transitions to community-based care settings and community reintegration; and
- Reducing utilization of acute care or crisis related services following successful, stable transition to a community-based care setting.

These hypotheses and plan are subject to change and will be further defined as California works with an independent evaluator and CMS to develop an evaluation design consistent with the resulting STCs and CMS policy.

Table 5. Preliminary Evaluation Plan for BH-CONNECT Addendum

#	Hypothesis	Evaluation Approach	Data Sources
1	Demonstration will improve health outcomes among Medi-Cal members in opt-in counties with complex and significant behavioral health conditions who are eligible for addendum services	The State will compare the following metrics across Pilot enrollees and a comparison group: • Patient reported outcomes (PRO) • Experience of care • Quality of care metrics • Morbidity and mortality metrics • State of chronic non-behavioral health diseases (e.g., diabetes, hypertension)	• Pre- and post-implementation surveys to track changes and progress over time • Focus groups /interviews of Medi-Cal members receiving addendum services on their experience with care • CMS Core Set Measures and other clinical outcomes metrics
2	Demonstration will help Medi-Cal members in opt-in	The State will analyze:	• Pre- and post-implementation

#	Hypothesis	Evaluation Approach	Data Sources
	counties with significant health needs and who are eligible for addendum services avert health care expenditures in more costly and restrictive settings	• Retention rate of community living • Utilization of institutional settings • Rates of incarceration	surveys to track changes and progress over time • Claims data • California Department of Corrections and Rehabilitation data and public record data
3	Demonstration will help Medi-Cal members with significant health needs who are eligible for addendum services to improve quality of life over the course of the demonstration	The State will analyze: • Improvement in life satisfaction while in an institutional setting/homeless/ incarcerated vs. in community living • Level of community integration • Reductions in, returns to, and length of homelessness	• Pre- and post-implementation surveys to track changes and progress over time • Focus groups /interviews of Medi-Cal members experience with community living • Homeless Management Information System (HMIS) data
4	Community Transition In-Reach Services will reduce LOS in inpatient, subacute, and residential facilities	The State will compare the LOS and percentage of successful discharges from inpatient, subacute, and residential settings among eligible individuals with complex behavioral health conditions served by Community Care Teams over a period of time (e.g., 3 months/6 months) against the LOS and percentages of successful discharges among similar Medi-Cal members	• Claims data

#	Hypothesis	Evaluation Approach	Data Sources
		who are not eligible for in-reach services (e.g., who reside in non-participating counties)	
5	Room and Board in Enriched Residential Settings will enable successful discharges of Medi-Cal members eligible for the services with complex behavioral health conditions leaving incarceration, institutional care, or homelessness.	The State will analyze the: • Number of individuals who have successfully entered into a community-based living arrangement of the person's choice after leaving the Enriched Residential Settings	• County reporting

SECTION 8 | PUBLIC COMMENT PROCESS

On June 14, 2024, DHCS released the requisite notices for the BH-CONNECT addendum and launched a state public comment period from June 14, 2024 through July 14, 2024. DHCS will present and discuss the BH-CONNECT addendum during two public hearings, the first on Tuesday, June 25, 2024 from 3:30 – 4:30 PM PT and the second on Tuesday, July 2, 2024 from 3:30 – 4:30 PM PT.

DHCS released a Tribal Public Notice to Tribal Chairpersons, Designees of Indian Health Programs, and Urban Indian Organizations on May 31, 2024 that described the provisions of the BH-CONNECT addendum and implications for Tribal Health Programs, Federally Qualified Health Centers, and Indian Medi-Cal Beneficiaries. Tribal Chairpersons, Designees of Indian Health Programs, and Urban Indian Organizations were invited to share feedback on the Tribal Notice and proposal by June 30, 2024 and are invited to participate in the 30-day State Public Comment Period from June 14, 2024 through July 14, 2024. DHCS will also host a webinar to solicit Tribal and Indian Health Program stakeholder comments on Wednesday, July 17, 2024 from 10:00 to 11:00 AM PT. Comments received during the Tribal and Indian Health Program webinar will be considered as part of the public comment period summary and responses described below.

Following completion of the public comment period and public hearing, and prior to submission to CMS, DHCS will summarize key themes of the comments received and provide DHCS' responses, including feedback related to the goals, member eligibility criteria, scope, and implementation approach for the BH-CONNECT addendum components, Community Transition In-Reach Services and Room and Board in Enriched Residential Settings.

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: State Medicaid Director

Agency: Department of Health Care Services

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