

September 25, 2026

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

Dear Director Sadwith:

The Centers for Medicare & Medicaid Services (CMS) is clarifying the applicability of recent changes to the Medicaid and Children's Health Insurance Program (CHIP) statutes and related regulation and policy for California's Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration (Project Numbers 11-W-00472/9 and 21-W-00080/9).

Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, made changes to the Medicaid and CHIP provisions of the Social Security Act (the Act), including eligibility and financing changes. CMS has issued regulations and guidance implementing and interpreting many of the Medicaid and CHIP provisions of the WFTC legislation. Some of these statutory and related regulatory changes will affect this demonstration. Therefore, in this action, CMS is clarifying the applicability of certain of these new requirements to the BH-CONNECT section 1115 demonstration during this demonstration period.

Specifically, in this action:

- We are clarifying the applicability of section 1903(v)(5) of the Act (added by section 71109 of the WFTC legislation) and guidance related to these sections of the Act; these changes are effective October 1, 2026, through December 31, 2029.

Unless renewed or otherwise amended, all authorities granted to operate this demonstration will expire on December 31, 2029.

The clarification is authorized under STC 3.2, which specifies that all requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents, apply to the demonstration.

CMS has determined that this action for the BH-CONNECT demonstration is likely to assist in promoting the objectives of the Medicaid and CHIP statutes by aligning this section 1115 demonstration with new statutory requirements applicable to the Medicaid and CHIP programs

and with how CMS has interpreted and implemented those requirements in regulations and guidance. The effective date of this action is intended to align with the implementation timeline of this new statutory requirement.

Program Integrity

As part of this action, CMS would like to remind the state about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid and CHIP laws and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity, including processes to identify, investigate, and refer suspected fraud and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement, when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Changes

Section 71109 – Alien Medicaid eligibility

Beginning October 1, 2026, sections 1903(v)(5) and 2107(e)(1)(R) of the Act, as added and amended, respectively, by section 71109 of the WFTC legislation, generally limit federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP), with limited exceptions, to U.S. citizens and U.S. nationals, lawful permanent residents (LPRs), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants.

Section 1903(v)(5) of the Act describes three exceptions to these FFP limitations: (1) care and services necessary for the treatment of an emergency medical condition as described in section 1903(v)(3) of the Act, (often referred to as “emergency Medicaid”), per section 1903(v)(2) of the Act; (2) full Medicaid and CHIP coverage provided to lawfully residing children and pregnant women under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option, per section 1903(v)(4) of the Act, applicable to CHIP through a cross reference at

section 2107(e)(1)(Q) of the Act; and (3) Health Services Initiatives (HSIs), which are programs that are designed to improve the health of low-income children, authorized under section 2105(a)(1)(D)(ii) of the Act. California elected the CHIPRA 214 option for Medicaid coverage of lawfully residing children and pregnant women and CHIP coverage of lawfully residing children.

On April 8, 2026, CMS issued State Health Official (SHO) letter #26-001, which provides policy and operational guidance to states related to implementation of the changes made by section 71109 of the WFTC legislation.¹ On August 17, 2026, CMS issued a letter to California describing CMS's determination that continuing previously approved policies in section 1115 demonstrations that authorize federal matching funds for expenditures for services furnished to individuals who will be subject to the FFP limitations in sections 1903(v)(5) and 2107(e)(1)(R) of the Act would not be likely to promote the objectives of the Medicaid or CHIP statutes, as applicable and as modified by the WFTC legislation.² In this action, CMS is clarifying the applicability of section 1903(v)(5) of the Act to the STCs of the demonstration. This clarification is expected to protect program integrity and ensure proper claiming of FFP.

Aligning Designated State Health Programs authority with section 71109 changes

CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide federal matching funds for state expenditures for Designated State Health Programs (DSHP). On April 10, 2025, CMS sent states a letter explaining that CMS does not anticipate approving new state proposals or renewing existing expenditure authority for section 1115 demonstration expenditure authority for DSHP.³ In this letter, CMS is clarifying that the time-limited authority in the BH-CONNECT demonstration for DSHP must align with new statutory limitations for FFP in section 1903(v)(5) of the Act that apply beginning October 1, 2026. This includes ensuring that DSHP expenditures are restricted to expenditures for individuals who are U.S. citizens and U.S. nationals, LPRs, Cuban/Haitian entrants, and COFA migrants, unless a limited exception applies such as expenditures for lawfully residing children or pregnant women in accordance with the state's election of the CHIPRA 214 option as described in the state plan.

This letter is clarifying required compliance with the WFTC legislation and does not change current CMS guidance that section 1115 demonstration expenditure authority for DSHP in the BH-CONNECT demonstration is not expected to be extended beyond the currently approved demonstration period.

Budget Neutrality

There are no changes to budget neutrality or allotment neutrality for this action.

¹ <https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf>

² <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-cms-ltr-08172026.pdf>

³ <https://www.medicaid.gov/resources-for-states/downloads/dshp-dsnp.pdf>

Monitoring and Evaluation

The state is required to conduct systematic monitoring and evaluation in accordance with the demonstration STCs and to incorporate, as appropriate, the clarification specified in this letter into these activities. Monitoring and evaluation should identify and describe any observed changes in metrics or outcome measures, including relevant context, as well as associated operational updates. In addition to other required content, these activities—including required deliverables and monitoring calls—should address any anticipated or actual challenges, risks, and program integrity considerations related to implementation of the clarification in this letter.

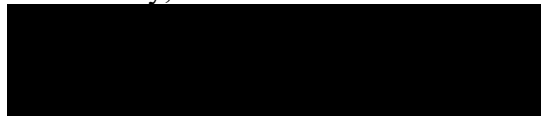
Other Information

This action for the demonstration project is conditioned upon compliance with the previously approved waivers, expenditure authorities and STCs which set forth in detail the nature, character and extent of anticipated federal involvement in the project. Your project officer is Diona Kristian, who is available to answer any questions concerning your section 1115 demonstration. Ms. Kristian's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Diona.Kristian@cms.hhs.gov

If you have questions regarding this action, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,



Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

cc: Nicole Lemmon, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00472/9 and 21-W-00080/9

TITLE: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration

AWARDEE: California Department of Health Care Services

Under the authority of the Section 1115(a)(1) of the Social Security Act (“the Act”), the following waivers are granted to enable the California Department of Health Care Services (referred to herein as the state or the State) to operate the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration. These waivers are effective beginning January 1, 2025 through December 31, 2029 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services’ (CMS) approval letter, the Secretary of Health and Human Services has determined that the BH-CONNECT Section 1115(a) Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program and Children’s Health Insurance Program (CHIP) expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 1, 2025 through December 31, 2029.

1. Statewide Operation

Section 1902(a)(1)

To enable the state to operate the demonstration on a county-by-county basis.

To enable the state to provide services to individuals who are primarily receiving treatment for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD) on a geographically limited basis.

To enable the state to cover Community Transition In-Reach Services only for those members receiving services through participating Behavioral Health Plans (BHPs).

To enable the state to provide peer support services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis.

To enable the state to provide supported employment within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis. This authority is effective the date SPA 24-0051 is implemented.

To enable the state to provide enhanced community health worker services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis. This authority is effective the date SPA 24-0052 is implemented.

2. Comparability/Amount, Duration, and Scope Section 1902(a)(10)(B) and 1902(a)(17)

To enable the state to provide services to individuals who are primarily receiving treatment for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD) that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the State to cover Community Transition In-Reach Services for qualifying Medi-Cal members with significant behavioral health needs that are otherwise not available to all members in the same eligibility group.

To enable the state to provide peer support services within electing Drug Medi-Cal State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide supported employment within electing Drug Medi-Cal State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group. This authority is effective the date SPA 24-0051 is implemented.

To enable the state to provide enhanced community health worker services within electing Drug Medi-Cal State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group. This authority is effective the date SPA 24-0052 is implemented.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00472/9 and 21-W-00080/9

TITLE: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration

AWARDEE: California Department of Health Care Services

Under the authority of section 1115(a)(2) of the Social Security Act (“the Act”), expenditures made by California for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from January 1, 2025 through December 31, 2029, unless otherwise specified, be regarded as expenditures under the state’s title XIX and XXI plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable California to operate the above-identified section 1115(a) demonstration.

1. **Access, Reform and Outcomes Incentive Program.** Expenditures for incentive payments to BHPs that meet defined criteria as outlined in Section 5 of the STCs to strengthen access to behavioral health services and improve health outcomes among Medi-Cal members living with significant behavioral health needs.
 - a. Time limited expenditure authority is granted until two years following the conclusion of the approval period for the Access, Reform and Outcomes Incentive Program, in order for the state to pay close-out costs of operating the program, and incentive payments associated with periods of performance within the approval period for the Access, Reform and Outcomes Incentive Program.
 - b. This expenditure authority does not entitle uninsured individuals to any benefits under the demonstration.
2. **Workforce Initiatives.** Expenditures for workforce initiatives that meet the criteria specified in Section 6 of the STCs.
 - a. Time limited expenditure authority is granted until four years following the end of the demonstration (December 31, 2033), in order for the state to pay close-out administrative costs of operating the programs and monitoring service commitments.
3. **Activity Funds Initiative.** Expenditures for payments to organizations for specified services or items for children and youth enrolled in Medi-Cal that meet the criteria in Section 7 of the

STCs with a behavioral health condition or at high risk of a behavioral health condition who are involved in the child welfare system. The services or items will be prescribed in an individual's clinical record, resulting in improved behavioral health outcomes.

4. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
5. **Community Transition In-Reach Services.** Expenditure authority for Community Transition In-Reach Services, provided by community-based transition teams, as described in these STCs, for qualifying Medi-Cal members with significant behavioral health needs experiencing or at risk of experiencing extended lengths of stay of 120 days or more in inpatient, subacute, and residential facilities, including in facilities that meet the definition of an Institution for Mental Diseases (IMD), for up to 180 days prior to discharge. Payments will not be made to facilities where the beneficiary resides.
6. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, described in these STCs (Section 11), which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. This authority is contingent upon adherence to the requirements within STC Section 12 Provider Rate Increase, as well as all other applicable STCs.
7. **Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 10. This expenditure authority is contingent upon compliance with Section 12, as well as all other applicable STCs.

Title XIX Requirements Not Applicable to the HRSN Expenditure Authorities

Statewideness

Section 1902(a)(1)

To enable the state to provide short-term rental assistance services only in certain geographic areas where Medi-Cal managed care plans elect to offer these services, unless and until the state requires all Medi-Cal managed care plans to cover short-term rental assistance.

Comparability; Amount, Duration and Scope; Provision of Medical Assistance

Section 1902(a)(10)(B), and Section 1902(a)(17)

To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section 10 of the STCs.

Title XXI Expenditure Authority:

8. **Activity Funds Initiative.** Expenditures for payments to organizations for specified services or items for children and youth enrolled in CHIP that meet the criteria in Section 7 of the STCs with a behavioral health condition or at high risk of a behavioral health condition who are involved in the child welfare system. The services or items will be prescribed in an individual's clinical record, resulting in improved behavioral health outcomes.
9. **Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 10. This expenditure authority is contingent upon compliance with Section 12, as well as all other applicable STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00472/9 and 21-W-00080/9

TITLE: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration

AWARDEE: California Department of Health Care Services

1. PREFACE

The following are the Special Terms and Conditions (STC) for the “Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment” (BH-CONNECT) section 1115(a) Medicaid demonstration (hereinafter “demonstration”), to enable the California Department of Health Care Services (hereinafter “state”) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The periods for each Demonstration Year (DY) will be as follows:

- DY 1: January 1, 2025 through December 31, 2025
- DY 2: January 1, 2026 through December 31, 2026
- DY 3: January 1, 2027 through December 31, 2027
- DY 4: January 1, 2028 through December 31, 2028
- DY 5: January 1, 2029 through December 31, 2029

The STCs related to the programs for those populations affected by the demonstration are effective from January 1, 2025 through December 31, 2029, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility and Enrollment
5	Access, Reform, and Outcomes Incentive Program
6	Workforce Initiatives
7	Activity Funds
8	Serious Mental Illness (SMI) Program and Benefits
9	Community Transition In-Reach Services

10	Health-Related Social Needs (HRSN) Services
11	DSHP
12	Provider Rate Requirements
13	State Commitments to Provider Rates
14	Monitoring and Reporting Requirements
15	Evaluation of the Demonstration
16	General Financial Requirements
17	Monitoring Budget Neutrality for the Demonstration
18	Monitoring Allotment Neutrality
19	Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	Access, Reform and Outcomes Incentive Program Protocol
Attachment D	Reserved for SMI Implementation Plan and Financing Plan
Attachment E	Reserved for Monitoring Protocol
Attachment F	Evaluation Design
Attachment G	HRSN Services Protocol
Attachment H	HRSN Services Matrix
Attachment I	HRSN Implementation Plan
Attachment J	DSHP List
Attachment K	Provider Rate Increase Attestation Table

2. PROGRAM DESCRIPTION AND OBJECTIVES

The BH-CONNECT demonstration aims to strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs, inclusive of mental health conditions and substance use disorders (SUDs). The demonstration builds on the success of California's previous section 1115 demonstrations and 1915(b) waiver to improve health outcomes and reduce health disparities for the Medi-Cal population in the state.

The BH-CONNECT section 1115 demonstration authorizes:

- A Workforce Initiative to invest in a highly qualified, diverse behavioral health workforce to support Medi-Cal members and uninsured populations living with behavioral health needs.
- Federal funding for Designated State Health Programs (DSHP), which California will use to support the Workforce Initiative.
- Activity Funds to ensure children and youth involved in child welfare have access to activities that support health and wellbeing.
- The Access, Reform and Outcomes Incentive Program to incentivize county behavioral health delivery systems to improve access to behavioral health services; improve

outcomes among Medi-Cal members living with significant behavioral health needs; and make targeted behavioral health delivery system reforms.

- Services for eligible individuals with a serious mental illness during short-term stays in Institutions for Mental Diseases (IMDs), consistent with the requirements outlined in SMDL #18-011.
- 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.
- Short-term rental assistance for a limited time-period for eligible beneficiaries.

Through the BH-CONNECT demonstration, California aims to:

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

Throughout these STCs, the term behavioral health plans (BHPs) is defined as including three types of Prepaid Inpatient Health Plans regulated under 42 CFR Part 438: (1) mental health plans (MHPs) that are responsible for Specialty Mental Health Services (SMHS), (2) Drug Medi-Cal Organized Delivery Systems (DMC-ODS) that are responsible for providing specialty substance use disorder (SUD) services, and (3) Integrated Prepaid Inpatient Health Plans that are responsible for providing both SMHS and DMC-ODS.

3. GENERAL PROGRAM REQUIREMENTS

- 3.1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

- 3.2. **Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.
 - b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
- 3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.
- 3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either

through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

- 3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
 - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - d. An up-to-date CHIP allotment worksheet, if necessary;
 - e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
- 3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.
- 3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
- b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
- c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d. **Transition and Phase-out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.
- e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

- f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
 - g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.
- 3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.
- 3.11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.
- 3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other

contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

- 3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

- 4.1. **Eligibility Groups Affected by the Demonstration.** There is no change to Medicaid or CHIP eligibility and the standards and methodologies for eligibility remain set forth under the Medicaid or CHIP state plans and are subject to all applicable Medicaid and CHIP laws and regulations.

5. ACCESS, REFORM, AND OUTCOMES INCENTIVE PROGRAM

A key goal of this section 1115 demonstration is to improve access and quality for Medi-Cal members living with significant behavioral health needs. The state is eligible to receive \$1,900,000,000 total computable over 5 years contingent on it meeting the requirements below. Under this demonstration, the state is providing incentive payments to participating behavioral health plans that demonstrate improvements in access to behavioral health services and outcomes among Medi-Cal members living with behavioral health needs.

- 5.1. **Description.** The state will implement the Access, Reform and Outcomes Incentive Program as a pilot in a select number of counties where funding is most needed to improve performance in this program's focus areas of access, outcomes and delivery system reform. Within participating counties, BHPs will receive incentive payments for demonstrated improvements in access to behavioral health services and outcomes among Medi-Cal members living with behavioral health needs. Additional program criteria and measurement areas will be further specified in the Access, Reform and Outcomes Incentive Program Protocol, hereafter referred to as the Incentive Program Protocol.
- a. In this program, the state will pay BHPs solely based on achieving goals and the corresponding progress as measured by performance on identified measures as further described in these STCs and the Incentive Program Protocol.

- b. DHCS will administer the Access, Reform and Outcomes Incentive Program and distribute incentive payments to BHPs that meet participation requirements described in STC 5.2 and meet performance targets on the measures outlined in these STCs and the Incentive Program Protocol.
- c. DHCS will determine the amount of funding that each BHP can earn in each demonstration year using the methodology described in these STCs and the Incentive Program Protocol.
- d. Access, Reform and Outcomes Incentive Program funding will not supplant funding provided by other Federal, state or local funding sources for behavioral health services. Incentive payments will not be used to reduce payment amounts otherwise payable to and by BHPs for Medi-Cal activities.
- e. Access, Reform and Outcomes Incentive Program funding will not reward BHPs for improvements that are already being incentivized by another state program.
- f. BHPs must use any earned incentive payments to support and expand Medi-Cal services and activities that benefit Medi-Cal members served by the behavioral health delivery system. However, this funding will not be used to supplant funding for existing benefits.

5.2. Participation Requirements.

- a. The Access, Reform and Incentive Program is limited to a pilot of up to 80 percent of counties as specified in the Incentive Program Protocol. The state will select counties where the funding is most needed to improve performance on the access, outcomes and delivery system reform measures specified in the Incentive Program Protocol described in STC 5.13. Within participating counties, BHPs will be eligible to earn incentive payments if they meet the following participation requirements:
 - i. BHPs must complete a self-directed assessment with the National Committee for Quality Assurance (NCQA) on NCQA's Managed Behavioral Healthcare Organization (MBHO) standards on a timeline specified by DHCS. The assessment will evaluate BHPs' performance on managed care, quality improvement, and care coordination capabilities.
 - ii. To be eligible to earn incentive payments for selected measures related to the implementation of key evidence-based practices (EBPs), BHPs must complete the assessment described in STC 5.2(a), and cover and implement Assertive Community Treatment (ACT), Forensic ACT, Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), the Individual Placement and Support model of Supported Employment, Clubhouse Services, Enhanced Community Health Worker Services, and/or Peer Support Services, including a forensic specialization, as specified by DHCS.
 - iii. On at least an annual basis, BHPs must submit reports and data to DHCS to allow the state to determine whether the county BHP is meeting reporting or

performance requirements. Failure to adequately report on milestones and performance metrics may preclude receipt of future Access, Reform and Outcomes Incentive Program funding.

- b. The state has the discretion to remove a county from participation in the Access, Reform and Outcomes Incentive Program due to poor performance or non-compliance with program requirements.

5.3. **Program Areas of Focus.** Progress towards achieving the goals specified above will be assessed by specific measures in three focus areas as outlined below. Both these measures, as well as the methodology for determining whether the goals and targets associated with these measures are being met, will be specified in the Incentive Program Protocol described in STC 5.13. Measures must have the potential to demonstrate improvements over the demonstration period, and measures submitted for each calendar year should reflect data from that calendar year; any exceptions must be documented and approved in the Incentive Program Protocol. Participating BHPs will be eligible to earn incentive payments in the following areas of focus:

- a. **Focus Area 1.** Improve Access to Behavioral Health Services: Up to \$850,000,000 total computable will be available for incentive payments related to improved access to behavioral health services.
- b. **Focus Area 2.** Improve Health Outcomes and Quality of Life: Up to \$800,000,000 total computable will be available for incentive payments related to improved health outcomes and member-reported quality of life among Medi-Cal members with behavioral health needs.
- c. **Focus Area 3.** Targeted Behavioral Health Delivery System Reforms: Up to \$250,000,000 total computable will be available for incentive payments related to targeted behavioral health delivery system reforms.
- d. The Incentive Program Protocol will outline the measures for which participating BHPs must meet specified performance targets to earn incentive payments in the Access, Reform and Outcomes Incentive Program. For participating BHPs that do not have adequate sample size to report on select measures, funding may be re-distributed to other measures or Areas of Focus. To the extent sample sizes are sufficiently large, participating BHPs will be required to stratify data based on the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

5.4. **Baseline data.** Where possible, the state must use existing plan data accumulated prior to implementation to identify performance goals for participating BHPs. If data prior to implementation is not available, the state will establish baseline data in initial demonstration years. The state's plan for baseline data for each metric will be provided in the Incentive Program Protocol.

5.5. **Additional Terms and Operations of the Access, Reform and Outcomes Incentive Program.** The following will apply:

- a. DHCS will distribute incentive payments earned in the measure areas described in STC 5.3 to BHPs based on its review and assessment of data on BHP performance. Payments will be made on at least an annual basis. The distribution methodology for the incentive payments will be outlined in the Incentive Program Protocol.
- b. DHCS will submit summaries of BHP performance annually to CMS in the Monitoring Reports. The summaries should include an assessment of progress towards each of the focus areas, the relevant measurement periods, and any mid-course corrections the state may be considering.
- c. DHCS will monitor BHP participation in the Access, Reform and Outcomes Incentive Program and related payments to ensure compliance with program requirements and applicable statutory and regulatory requirements, and to prevent fraud, waste and abuse.

5.6. Federal Financial Participation (FFP) for the Access, Reform and Outcomes Incentive Program.

The state may claim, as authorized expenditures under the demonstration, up to \$1,900,000,000 total computable over 5 years, for performance-based incentive payments to BHPs participating in the Access, Reform and Outcomes Incentive Program across three areas of focus, as specified in Table 1 below. Payments are an incentive for successfully meeting specified targets on measures associated with access to care, quality of care, and health outcomes rather than payment of claims for the provision of behavioral health care.

- a. Access, Reform and Outcomes Incentive Program payments are not direct reimbursement for expenditures of payments for services. Such payments are intended to support and reward BHPs for strengthening access to behavioral health services and improving health outcomes among Medi-Cal members living with significant behavioral health needs. Such payments are not considered patient care revenue.
- b. The state may claim FFP for Access, Reform and Outcomes Incentive Program payments for one measure in Demonstration Year 1 as described in STC 5.12.
- c. With the exception of the measure described in STC 5.12, the state may not claim FFP for Access, Reform and Outcomes Incentive Program payments until after CMS has approved the Incentive Program Protocol. Once approved, the state may receive FFP for expenditures beginning January 1, 2026.
- d. The state may not claim FFP for Access, Reform and Outcomes Incentive Program payments in each year until the state has concluded whether or not the BHPs have met the performance standard for each payment. BHPs must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to approved Access, Reform and Outcomes Incentive Program activities.

- e. The state must inform CMS of the funding of all Access, Reform and Outcomes Incentive Program payments to BHPs annually through Monitoring Reports submitted to CMS as required by STC 14.6.

Table 1. Access, Reform and Outcomes Incentive Program Funding by Demonstration Year (\$ in thousands)

Area of Focus	DY 1	DY 2	DY 3	DY 4	DY 5
Maximum Incentive Program Expenditure Authority	\$210,000	\$285,000	\$ 385,000	\$ 510,000	\$ 510,000
Program Accountability Percent	0%	0%	5%	10%	20%
Program Accountability Dollars	N/A	N/A	\$19,250	\$51,000	\$102,000
Maximum Funds Net Program Accountability	\$210,000	\$285,000	\$365,750	\$459,000	\$408,000
Improved Access to Behavioral Health Services	\$60,000	\$185,000	\$176,338	\$187,050	\$164,100
Improved Health Outcomes and Quality of Life	\$60,000	\$60,000	\$151,915	\$238,580	\$217,160
Targeted Behavioral Health Delivery System Reforms	\$90,000	\$40,000	\$37,498	\$33,370	\$26,740

- f. Within each area of focus, DHCS will determine the initial allocation of incentive funds available to be potentially earned by each participating BHP for each demonstration year in accordance with a methodology, to be detailed in the Incentive Program Protocol, that may be based on the following factors:
- i. Total number of participating BHPs;
 - ii. Total Medi-Cal member enrollment in the county;
 - iii. County-level indicators of social and health-related risk based on data such as the Healthy Places Index (HPI) percentile data; and
 - iv. Minimum and maximum allocation limits per county.

- g. Authorized expenditure amounts for one demonstration year cannot be carried, shifted or otherwise transferred across demonstration years in any circumstances; however, earned incentive payment based on one demonstration year may be paid in a subsequent demonstration year against the expenditure limit for the demonstration year on which the incentive payment is based, as necessary pursuant to operational processes to determine the final incentive payment amount.
- 5.7. **High-Performance Pool.** The state will create a high-performance pool to redistribute incentive funds that are unearned by BHPs in DY 1 – DY 5. To the extent unearned incentives remain after the annual performance period, any remaining funds will be used for incentive payments for BHPs meeting higher standards of access and outcome improvements in the same performance period, based on a subset of measures to be defined in Incentive Program Protocol. The high-performance pool will be made up only with unearned incentives for the BHPs and the state will not withhold any amounts to increase it. The parameters to earn this funding will be outlined in the Incentive Program Protocol. Unearned funding for Incentive Program Accountability, described in STC 5.11, is not available for the high-performance pool.
- a. To be eligible to participate in the high-performance pool, the BHP must achieve prerequisite targets on a set of measures from the three focus areas as specified in the Incentive Program Protocol. These targets should be based on national data from the same year, if available, and otherwise compared to data submitted by all participating BHPs during that year. These targets will be specified in the Incentive Program Protocol.
 - b. A BHP which has met the above prerequisites may receive a high-performance payment based on tiered measure performance on a set of measures from the three focus areas, where plans which achieve higher percentile performance receive relatively higher incentive payments, in accordance with the High-Performance Pool earning and funding methodology described in the Incentive Program Protocol.
- 5.8. **Budget Neutrality Treatment for Access, Reform and Outcomes Incentive Program.** The expenditure authority for the Incentive Program must be supported out of budget neutrality savings.
- 5.9. **Federal Matching Rate for Access, Reform and Outcomes Incentive Program.** All expenditures for the Access, Reform and Outcomes Incentive Program must be claimed as administrative on the applicable CMS 64.10 waiver forms(s). The state must ensure that Access, Reform and Outcomes Incentive Program expenditures described in STC 5 (this STC) are not factored into payment rates, and that there is no duplication of funds.
- 5.10. **Claiming Process.** The state is required to report expenditures for the program on the CMS-64 as prescribed within these STCs and follow applicable timely filing rules.
- a. The state will incur administrative costs related to implementing and overseeing the Access, Reform and Outcomes Incentive Program for the entirety of the

demonstration period, but also related administrative closeout costs that may be claimed for up to two years following the conclusion of Demonstration Year 5.

- b. The state may only distribute incentive payments associated with Demonstration Years 1-5.

5.11. **Incentive Program Accountability.** A share of total Access, Reform and Outcomes Incentive Program funding will be at risk if the participating BHPs fail to demonstrate progress toward meeting a set of accountability measures, to be defined and approved by CMS in the Incentive Program Protocol. The percentage at risk will gradually increase from 5 percent in DY 3 to 20 percent in DY 5. The state must propose 3-5 accountability measures with at least one measure pertaining to each focus area of the incentive program. These measures must be able to be calculated and aggregated across all participating counties and have the potential to demonstrate improvement over the demonstration period.

- a. Program accountability is applied prior to calculation of individual plan performance, so any reductions from program accountability apply to the global amount of funding from which BHP payments may be made, described in STC 5.3 above.
- b. The accountability measures submitted for each calendar year should reflect data from that calendar year; any exceptions must be documented and approved in the Incentive Program Protocol. Where possible, the state must use data from before demonstration implementation as a baseline to inform the program accountability calculation. If data prior to implementation is not available, the state will establish baseline data in DY1.
- c. The program accountability calculation will be based on achievement of or improvement towards performance goals across all BHPs participating in the Access, Reform and Outcomes Incentive Program. The targets for each measure used in the program accountability calculation, as well as the methodology for determining progress towards those targets (including relevant baseline data), will be specified in the Incentive Program Protocol.
- d. Each accountability measure will be assigned a weight for each performance year. Aggregated participating BHP performance in each component will be multiplied by the associated weight, and then summed together to create an aggregate score, which will be the state's Accountability Score. The state will report its Accountability Score to CMS in the Monitoring Report once it is available, with supporting documentation showing the calculation of the score. If the state is unable to provide this in the Monitoring Report, it should indicate in the Incentive Program Protocol its preferred submission timeline for CMS's approval. The score will then be used by the State and CMS to determine whether the state's Access, Reform and Outcomes Incentive Program expenditure authority will be reduced for the relevant demonstration year. The maximum amount of funding at risk for program accountability is described in Table 1, and the actual amount of any reduction for a

year will be determined according to the methodology agreed upon by the state and CMS in the Incentive Program Protocol.

- e. Participating BHP performance is assessed individually by BHP and by measure to determine whether the BHP has met the established targets for incentive payments.
- f. Expenditure limit reductions for the state are forfeited and cannot be earned back in subsequent demonstration years. However, an earned incentive payment based on one demonstration year may be paid in a subsequent demonstration year against the expenditure limit for the demonstration year on which the incentive payment is based, as necessary to determine the final earned incentive payment amount.

5.12. **Requirements for Demonstration Year 1.** In the first year of the demonstration, the state may receive FFP for a measure related to Focus Area 3: Targeted Behavioral Health Delivery System Reforms. The state shall include narrative documentation in its first Annual Monitoring Report showing that it met this requirement. Additionally, the state will submit in the Monitoring Report baseline data for the accountability metrics, as appropriate.

5.13. **Access, Reform and Outcomes Incentive Program Protocol (Incentive Program Protocol).** The state must submit a proposed Incentive Program Protocol for CMS approval. With the exception of the measure described in STC 5.12, the state is at risk for all incentive payments until the Incentive Program Protocol is approved. FFP will be available retroactively to the beginning of DY 2 for approved elements of the Incentive Program Protocol, should the state make qualifying expenditures prior to the Protocol's approval. The Incentive Program Protocol will be appended to these STCs as Attachment C. The Incentive Program Protocol must include the following information (in addition to what is described elsewhere in these STCs):

- a. Description of the statewide approach to improve access to behavioral health services and outcomes among Medi-Cal members living with behavioral health needs, including the relationship between the accountability measures and the interventions at the health system level.
- b. Description of how its analysis (including the NCQA MBHO assessments) identified areas for improvement across the Focus Areas and led to the selection of the proposed measures for the three focus areas as well as the program accountability measures and interventions.
- c. Description of how the state will select which counties participate in the Access, Reform and Outcomes Incentive Program based on identifying counties with the greatest need, including how it will consider both the NCQA MBHO assessments as well as other factors in its selection process.
- d. Selected measures, both at the individual BHP level as described in STC 5.3 and the aggregated accountability level as described in STC 5.7, and their technical specifications for the Access, Reform and Outcomes Incentive Program. The state must have written permission from measure stewards to use their measures prior to

program implementation, as applicable. Validated and tested measures from nationally recognized measure stewards should be prioritized for selection; if such measures do not address certain program goals, additional measures may be selected or developed as specified in the Incentive Program Protocol. In the event that a measure is retired by a measure steward for any reason, the state must replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within California (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the finding from analysis and/or NCQA MBHO assessment.

- e. Goals/targets for the above measures, as well as the methodology for determining whether the measure is making progress toward or achieving the goal, including how the measures will be compared to baseline data and whether any statistical testing will be applied to determine significance of observed trends.
- f. Targets for the high-performance pool, such that higher performing plans receive larger payments from the high-performance pool.
- g. Description of the earning and distribution methodology for incentive funding at the BHP level described in STC 5.3, program accountability level described in STC 5.11, and high-performance pool level described in STC 5.7.
- h. Description of how the state will convene participating plans and engage stakeholders to facilitate the sharing of best practices, including the sharing of implementation successes as well as discussion of strategies to address challenges.

6. WORKFORCE INITIATIVES

To support workforce recruitment and retention and to promote the increased availability of behavioral health care practitioners who serve Medi-Cal members and uninsured individuals, the state shall implement five statewide workforce initiatives: 1) Medi-Cal Behavioral Health Student Loan Repayment Program; 2) Medi-Cal Behavioral Health Scholarship Program; 3) Medi-Cal Behavioral Health Recruitment and Retention Program; 4) Medi-Cal Behavioral Health Community-Based Provider Training Program; and 5) Medi-Cal Behavioral Health Residency Training Program. Funding for these workforce initiatives must not supplant state and federal funding or duplicate existing workforce programs. The state will consult with the Health Resources and Services Administration (HRSA) as it works on these programs. The aim of these workforce initiatives is to address shortages in qualified practitioners serving Medi-Cal members and uninsured individuals who are living with or at-risk for behavioral health conditions.

6.1. Terms and Conditions Applicable to Each Workforce Initiative. The following shall apply to each of the five workforce initiatives detailed in this section of the STCs:

- a. Full-time service commitments for workforce initiative participants must be fulfilled in safety net settings defined as:
 - i. Federally Qualified Health Centers (FQHC),

- ii. Community Mental Health Centers (CMHC),
- iii. Rural Health Clinics (RHC), or
- iv. Settings with the following payer mix:
 - 1. Hospitals with 40 percent or higher Medicaid and/or uninsured population,
 - 2. Rural hospitals with 30 percent or higher Medicaid and/or uninsured population, or
 - 3. Other behavioral health settings with 40 percent or higher Medicaid and/or uninsured population.
- b. To fulfill the full-time service commitment, qualified practitioners may work at a single organization, or hold part-time positions across multiple provider organizations, so long as all organizations meet the safety net setting definition in STC 6.1(a).
- c. The state shall develop a process for ensuring that practitioners remain in compliance with program requirements and meet the qualifying service commitments. If the service commitment is not met, except in extraordinary circumstances as determined by the state (e.g., disability or death), the state shall not make further payments and the state shall recoup all payments made on behalf of the program participant. In the case of recoupment, regardless of whether the state is able to recover the payments made on behalf of the program participant, the state shall return the federal share of those payments to CMS within 1 year of the breach in the service commitment. Suspension or revocation of a professional license does not constitute an extraordinary circumstance for purposes of not meeting the service commitment. Program participants must pass required professional state licensing or certification examinations and obtain requisite licensure or certification no later than 1 year of completing the degree or certificate programs and meeting clinical hour requirements pursuant to state law, except in extraordinary circumstances as determined by the state (e.g., disability or death). Failure to obtain requisite licensure or certification will constitute a breach in the service commitment requirement.
- d. The state may have multiple rounds/cohorts of disbursements (i.e., awards to new recipients) each year for workforce initiatives, so long as it does not extend beyond the applicable authorized level of funding for each program over the course of the demonstration period or demonstration year, as applicable.
- e. The state will define application and eligibility criteria and select awardees through a competitive process that will allow the state to evaluate the applicants relative to the criteria established. The state may prioritize applicants with cultural and linguistic competence that reflect and respond to the needs of the Medi-Cal population. The criteria must comply with federal civil rights law and not impermissibly discriminate based on race, ethnicity, national origin, sexual orientation, gender identity, disability or any other federally protected classes or characteristics.

- f. The state must ensure all education and training programs are certified or accredited by the state or organizations recognized by the state. If no certification or accreditation is available, education and training programs must meet widely recognized guidelines outlining the core roles and skills considered standard for that discipline and be approved by the state.
- g. The state must ensure that if an individual participates in one of the workforce programs described in STC Section 6, the individual is ineligible to participate in another workforce program funded under STC Section 6 until their service obligations are fulfilled, with the exception of the Behavioral Health Residency Training Program participation and enrollment in the Behavioral Health Student Loan Repayment Program as described in STC 6.7(a).
- h. The state must conduct oversight of provider organizations and educational institutions receiving workforce funding. At a minimum, provider organizations and educational institutions must submit annual reports detailing the use of workforce funding to the state.

6.2. Medi-Cal Behavioral Health Student Loan Repayment Program. The state will make available student loan repayments for behavioral health practitioners specified in STC 6.2(a).

- a. Eligible behavioral health practitioners and loan repayment amounts include:
 - i. Up to \$240,000 per licensed practitioner with prescribing privileges and individuals in training to be a licensed practitioner with prescribing privileges, including but not limited to: Psychiatrists, Addiction Medicine Physicians, and Psychiatric Mental Health Nurse Practitioners.
 - ii. Up to \$180,000 per non-prescribing licensed or associate level pre-licensure practitioner, including but not limited to: Psychologists, Clinical Social Workers, Professional Clinical Counselors, Marriage and Family Therapists; Occupational Therapists, and Psychiatric Technicians.
 - iii. Up to \$120,000 per Alcohol or Other Drug Counselors, Community Health Workers, Peer Support Specialists, Wellness Coaches, and other non-prescribing practitioners meeting the provider qualifications for Community Health Worker services, Rehabilitative Mental Health Services, Substance Use Disorder Treatment Services, and Expanded Substance Use Disorder Treatment Services in the California Medicaid State Plan.
- b. Recipients who are eligible behavioral health practitioners defined in STC 6.2(a)(i) and (ii) commit to practicing full-time for four years in safety net settings meeting the definition in STC 6.1(a).
- c. Recipients who are eligible behavioral health practitioners defined in STC 6.2(a)(iii) commit to practicing full-time in a safety net setting as defined in STC 6.1(a), as follows:

- i. For loan repayments of \$20,000 and greater, practitioners must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).
 - ii. For loan repayments of \$10,000 and up to \$20,000, practitioners must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).
 - iii. For loan repayments less than \$10,000, practitioners must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).
- d. Loan repayments must be made directly to the student loan servicer either by the state or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.
- e. The state may only repay an amount up to the student loan amount owed by the practitioner. The state may not pay an amount that exceeds an individual practitioner's student loan. Only the student loans for educational costs associated with the course of study that led to the highest degree or certificate earned as a pre-requisite to obtaining the relevant practitioner credential may qualify for reimbursement under the program.

6.3. **Medi-Cal Behavioral Health Scholarship Program.** The state will make available scholarship payments while participants receive their education. To participate in the program, individuals must be pursuing behavioral health degrees or certifications specified in STC 6.3(a).

- a. Eligible participants and scholarship amounts include:
 - i. Up to \$240,000 per licensed practitioner with prescribing privileges and individuals in training to be a licensed practitioner with prescribing privileges, including but not limited to: Psychiatrists, Addiction Medicine Physicians, and Psychiatric Mental Health Nurse Practitioners.
 - ii. Up to \$180,000 per non-prescribing licensed or associate level pre-licensure practitioner, including but not limited to: Psychologists, Clinical Social Workers, Marriage and Family Therapists, Professional Clinical Counselors, Occupational Therapists, and Psychiatric Technicians.
 - iii. Up to \$120,000 per Alcohol or Other Drug Counselors, Community Health Workers, Peer Support Specialists, Wellness Coaches, and other non-prescribing practitioners meeting the provider qualifications for Community Health Worker services, Rehabilitative Mental Health Services, Substance Use Disorder Treatment Services, and Expanded Substance Use Disorder Treatment Services in the California Medicaid State Plan.

- b. Recipients who are eligible behavioral health practitioners defined in STC 6.3(a)(i) and (ii) commit to practicing full-time for four years in safety net settings meeting the definition in STC 6.1(a).
- c. Recipients who are eligible behavioral health practitioners defined in STC 6.3(a)(iii) commit to practicing full-time in a safety net setting as defined in STC 6.1(a), as follows:
 - i. For scholarships of \$20,000 and greater, practitioners must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).
 - ii. For scholarships of \$10,000 and up to \$20,000, practitioners must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).
 - iii. For scholarships less than \$10,000, practitioners must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).
- d. Scholarship program eligible participants include individuals who are in a course of study leading toward the qualifying degree or certification required as a pre-requisite to obtaining the relevant provider credential to be licensed and non-licensed practitioners listed in STC 6.3(a).
- e. Scholarship payments must be made directly only to the educational institution by either the state or a procured vendor. Funds will not be provided to individual participants.
- f. The state must require that all Medi-Cal Behavioral Health Scholarship Program participants, make application to the Free Application for Federal Student Aid (FAFSA) and Cal Grant program. The state or intermediary may not make scholarship payments on behalf of a program participant until both the FAFSA and Cal Grant applications have been submitted and a determination has been made on the amount of grant funding that will be received by the program participant.

6.4. Medi-Cal Behavioral Health Recruitment and Retention Program. The state will establish a program to provide recruitment and retention bonuses, supervision support for pre-licensure and pre-certification practitioners, and certification/licensure and training supports with the aim of recruiting and retaining behavioral health practitioners to serve the Medi-Cal population. The state will develop a process to identify provider organizations to receive Recruitment and Retention Program funding, however, funding for payments to the provider organizations described in STC 6.4(a)-(c) must go to the behavioral health practitioners. The Medi-Cal Behavioral Health Recruitment and Retention Program will include:

- a. Up to \$20,000 per practitioner for recruitment bonuses and up to \$4,000 per practitioner for retention bonuses to provider organizations meeting the safety net setting definition in STC 6.1(a). Provider organizations must make these recruitment

and retention bonus payments to licensed behavioral health practitioners and non-licensed practitioners listed in Section 6.2(a)(i)-(iii).

- i. For recruitment bonuses of \$20,000, practitioners must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).
 - ii. For recruitment bonuses of \$10,000 and up to \$20,000, practitioners must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).
 - iii. For recruitment bonuses less than \$10,000, practitioners must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).
- b. Up to \$50,000 per individual for recruitment bonuses to provider organizations meeting the safety net setting definition in STC 6.1(a) to support individuals pursuing behavioral health related associate's degrees, bachelor's degrees, master's degrees, or doctorate programs who are completing required training in advance of their final year of education. Participants must commit to practicing full-time, upon graduation and upon certification or licensure, at safety net settings as defined in STC 6.1(a).
 - i. For recruitment bonuses of \$20,000 and greater, recipients must commit to practicing full-time for four years at a safety net setting, as defined in STC 6.1(a).
 - ii. For recruitment bonuses of \$10,000 and up to \$20,000, recipients must commit to practicing full-time for three years at a safety net setting, as defined in STC 6.1(a).
 - iii. For recruitment bonuses less than \$10,000, recipients must commit to practicing full-time for two years at a safety net setting, as defined in STC 6.1(a).
- c. Up to \$1,500 per practitioner for achieving or maintaining licensure or certification to provider organizations that are safety net settings as defined in STC 6.1(a) to support practitioners pursuing or maintaining licensure or certification for a behavioral health profession, including but not limited to costs of study material, examination costs, and licensing and certification fees. Recipients commit to practicing full-time, upon licensure or certification, for two years at the provider organization making the licensure and certification payments.
- d. Up to \$35,000 per demonstration year to provider organizations that are safety net settings as defined in STC 6.1(a) to support the supervision hours of pre-licensure or pre-certificate behavioral health practitioners training to gain the required hours to qualify for licensure or certification at the provider organization.
- e. Backfill for licensed or certified practitioners who attend training to provide key evidence-based practices, specifically Assertive Community Treatment (ACT),

Forensic ACT, Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), the Individual Placement and Support model of Supported Employment, Clubhouse Services, Multisystemic Therapy, Functional Family Therapy, Parent-Child Interaction Therapy, High Fidelity Wraparound, Community Health Worker Services, and Peer Support Services. To avoid reduced access to care when a practitioner is in training for these key evidence-based practices during practitioner working hours and recognizing the absence requires a temporary or covering worker to perform duties, the state may use funds to pay the provider organization to backfill the practitioner. Backfill costs must not exceed the following rates and no more than 5 days per week for participants in the following programs:

- i. \$750 per day for practitioners with prescribing privileges as defined in STC 6.2(a)(i).
 - ii. \$500 per day for non-prescribing licensed practitioners, as defined in STC 6.2(a)(ii).
 - iii. \$250 per day for other non-prescribing behavioral health practitioners, as defined in STC 6.2(a)(iii).
- f. A practitioner awarded a recruitment bonus under this program is not eligible to receive a retention bonus until the practitioner has fulfilled their recruitment bonus service commitment.

6.5. **Medi-Cal Behavioral Health Community-Based Provider Training Program.** The Behavioral Health Community-Based Provider Training Program is designed to build up the workforce of Alcohol or Other Drug Counselors, Community Health Workers and Peer Support Specialists by funding training and education in order to create a healthcare workforce pipeline to address community-based workforce shortages throughout the state. Participation in the program will be conditioned on a three-year full-time commitment of service in safety net settings as defined in STC 6.1(a).

- a. The state may pay training programs up to \$10,000 per practitioner participating in this program. Funds may only be used for the following activities:
 - i. Program tuition and required program fees for course curriculums necessary to achieve the professional titles of Alcohol or Other Drug Counselor, Community Health Worker or Peer Support Specialist.
 - ii. Textbooks and supplies as required by the educational program curriculum.
 - iii. Professional exam fees and certification or licensure costs.
- b. Payments must be made directly only to the training program on behalf of the practitioner. Funds will not be provided to individual participants.

6.6. **Medi-Cal Behavioral Health Residency Training Program.** The state will provide up to \$250,000 per residency and fellowship slot per demonstration year to allow safety net settings to support new or expanded residency and fellowship slots during the

demonstration period. The state may adjust the individual awards as necessary to reflect the impact of inflation, subject to the total funding for the initiative detailed in STC 6.8. Awards may be made only to safety net settings meeting the definition in STC 6.1(a). Eligible recipient organizations must demonstrate significant training experience and infrastructure, and must align programs with established standards for residency and fellowship training programs to meet a baseline of quality and standardization. The training programs must be certified or accredited by the state or organizations recognized by the state. Residency and fellowship funding is limited to additional slots for the following accredited or certified professional programs:

- a. Psychiatry Residency
- b. Child Psychiatry Fellowship
- c. Addiction Psychiatry/Addiction Medicine Fellowship

6.7. Additional Terms and Operations of the Behavioral Health Residency Training Program. For the demonstration behavioral health residency grant program, the following shall apply:

- a. The state will enroll practitioners filling the residency and fellowship slots into the Behavioral Health Student Loan Repayment Program in STC 6.2. During the residency or fellowship training, the state will make loan repayment awards on behalf of the practitioner, in accordance with the Student Loan Repayment Program requirements. Practitioners must fulfill the Student Loan Repayment Program service commitments at safety net settings defined in STC 6.1(a) following completion of the residency or fellowship program.
- b. To receive funds through the Behavioral Health Residency Training Program, organizations must include a sustainability plan for future years past the funding period. All residency fellowship programs must also gain approval from American College of Graduate Medical Education for new or expanded slots and that process also includes a review of sustainability.
- c. Residency payments may be made directly only to the safety net settings by either the State or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.
 - i. For each yearly issuance of funding for the residency training program, the managing vendor will make a single payment to each safety net setting covering one year's residency slot costs. The state will ensure that the amount of the award does not exceed the cost of operating the slots; if the award exceeds the cost of the residency slots, the award will be reduced so that it matches the cost of the slots.
- d. The state may only claim FFP for expenditures associated with residency and fellowship slots that are filled by qualifying providers. In the event that an individual residency or fellowship slot is not filled for the entirety of a year, the slot

payment is pro-rated for the portion of the year that the slot was occupied. If the payment is made at the start of the year and the slot becomes unfilled mid-year, the state will provide for recoupment and return of FFP if the slot is not re-filled within one month.

- 6.8. **Workforce Initiatives Funding.** Table 2 below shows the maximum amount of funding for each workforce initiative program (including 15 percent administrative costs) by demonstration year.

Table 2. Workforce Initiatives Funding by Demonstration Year

Program	DY 1	DY 2	DY 3	DY 4	DY 5	Total
Behavioral Health Scholarship Program	\$33,000,000	\$81,000,000	\$81,000,000	\$24,000,000	\$15,000,000	\$234,000,000
Behavioral Health Student Loan Repayment Program	\$106,000,000	\$106,000,000	\$106,000,000	\$106,000,000	\$106,000,000	\$530,000,000
Behavioral Health Recruitment and Retention Program	n/a	\$231,000,000	\$231,000,000	\$231,000,000	\$273,000,000	\$966,000,000
Behavioral Health Community-Based Provider Training Program	\$10,000,000	\$15,000,000	\$20,000,000	\$20,000,000	\$20,000,000	\$85,000,000
Behavioral Health Residency Program	\$17,000,000	\$17,000,000	\$17,000,000	\$17,000,000	\$17,000,000	\$85,000,000
Total	\$166,000,000	\$450,000,000	\$455,000,000	\$398,000,000	\$431,000,000	\$1,900,000,000

- a. Subject to the total funding for each program in STC 6.8, the state may carry forward prior year unused workforce initiatives expenditure authority from one year to the next. The state must notify CMS of any updates to annual amounts in the annual monitoring reports.
- b. After DY 2, the state may redistribute up to 30% of Workforce Initiatives funding in table 2 among the workforce programs without submitting an amendment pursuant to STC 3.7. The state must use initial program results (e.g., participation rates, success rates, challenges) to support redistribution of funds. The state must notify CMS of any redistribution of funds in the annual monitoring reports.

- c. Time-limited expenditure authority is granted from January 1, 2030 until December 31, 2033, to allow the state to pay close-out administrative costs of operating the workforce initiative programs and monitoring remaining service commitments. The state must adhere with federal timely filing requirements during this time-limited expenditure authority period. The expenditures will continue to be claimed on the CMS 64 on the specified waiver lines if the date where claims are made go beyond the demonstration period as part of this demonstration period. No payments for student loans, scholarships, retention and recruitment activities, educational and training activities, including residency and fellowship slots, may be made following the demonstration period's expiration (December 31, 2029).
- d. The state must follow all federal statutes, regulations, and policies regarding individual eligibility requirements for Federal educational funding support.
- e. All expenditures for workforce initiatives are only matchable as administrative expenditures. The state must ensure that the workforce initiatives funding expenditures are not factored into managed care capitation payments and that there is no duplication of funds.

7. ACTIVITY FUNDS INITIATIVE

The state will provide to Medicaid and CHIP enrolled individuals Activity Funds for services and items that support an eligible member's (child or youth as described in STC 7.1) inclusion in the community and promote improved behavioral health outcomes.

- 7.1. **Eligibility.** To qualify for the Activity Funds Initiative, a member must be enrolled in Medicaid or CHIP and meet criteria under 7.1(a) and 7.1(b) below.
 - a. Meet one of the following criteria:
 - i. Are under age 21 and are currently involved in the child welfare system in California;
 - ii. Are under age 21 and previously received care through the child welfare system in California or another state within the past 12 months;
 - iii. 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;
 - iv. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or
 - v. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.
 - b. Meet one of the following clinical criteria:
 - i. Have a diagnosed behavioral health condition.

- ii. At high risk for a behavioral health condition that is still being assessed through the diagnostic process, but who have been determined to need the service by a licensed behavioral health professional through clinical assessment.

7.2. **Service Description.** Activity Funds are for items or services that support an eligible member's inclusion in the community and promote improved physical and behavioral health outcomes. These items or services are designed to help participants find a form of expression beyond words or traditional therapies in an effort to reduce anxiety, aggression, and other clinical issues.

- a. Activity funds may be used for the following, as indicated in a member's clinical record by a provider described in 7.3:
 - i. Physical wellness activities and goods that promote a healthy lifestyle (e.g., sports club fees and gym memberships; bicycles, scooters, roller skates and related safety equipment); and
 - ii. Strengths-developing activities (e.g., music lessons, art lessons, therapeutic summer camps).
- b. Activity Funds must be used to support items and services that:
 - i. Promote inclusion in the community; and/or
 - ii. Increase the eligible member's safety in the home environment.
 - iii. Facilitate the eligible member's age-appropriate participation or autonomy in making decisions that improve physical or behavioral health outcomes.
- c. The items and services provided under the Activity Funds Initiative must clearly link to an assessed need established in an eligible member's clinical record and must be determined to meet member need by a provider as described in STC 7.3.
- d. Activity Funds may only be available when the item or service is not available through another source as indicated in STC 7.5(c).
- e. Activity Funds are additive to, and do not duplicate, what is available to an individual under the Medicaid State Plan.
- f. Activity Funds cannot be used to support:
 - i. Items used solely for entertainment or recreational purposes;
 - ii. Tobacco or alcoholic products;
 - iii. Items of the same type for the same member unless there is a documented change in the member's need that warrants replacement; and
 - iv. Activities that are illegal or otherwise prohibited through federal or state regulations.

- 7.3. **Service Delivery.** A provider will document the need for these services in an individual's clinical record and coordinate delivery of the activity in collaboration with the member, their caregiver(s) and social worker, as appropriate, including the following:
- a. Assessment of beneficiary need;
 - b. Identification of appropriate activities for eligible members;
 - c. Documentation of the identified activity in the member's clinical record; and
 - d. Connecting the eligible member with an available activity provider.
- 7.4. **Administration and Payment.** The Activity Funds Initiative will be administered by DHCS and may be distributed in partnership with the California Department of Social Services (CDSS). DHCS will be responsible for overseeing Activity Funds.
- a. DHCS may enter into an inter-agency agreement with CDSS that specifies the roles of each Department in administering Activity Funds and allows for the exchange of data between the two Departments, as needed.
 - b. DHCS may contract with a third-party administrator (TPA) to disburse Activity Fund payments. No funds shall be disbursed directly to a child, youth, or family member. DHCS, or the TPA acting on its behalf, will be responsible for collection and submittal of documentation and paying the activity provider for approved activities.
 - c. DHCS will develop and maintain a list of allowable activity types consistent with those listed in 7.2, as well service delivery provider types, to support providers in identifying services available under this initiative.
- 7.5. **Funding.** Other sources of federal funding for the items or services described in the Activity Fund Initiative must be exhausted prior to the state paying for them with Medicaid or CHIP funding. Medicaid and CHIP are payors of last resort.

8. SERIOUS MENTAL ILLNESS (SMI) PROGRAM AND BENEFITS

- 8.1. **Behavioral Health Plan Participation.** Under this demonstration, FFP for services provided in IMDs pursuant to STCs 1.1-1.6 is available for beneficiaries in participating behavioral health plans (BHPs) that agree to certain conditions and are approved by DHCS. To participate, a BHP must:
- a. Cover all of the following evidence-based practices on a timeline specified by DHCS: Assertive Community Treatment (ACT); Forensic ACT; Coordinated Specialty Care for First Episode Psychosis; Supported Employment; Enhanced Community Health Worker Services; and Peer Support Services, including a forensic specialization; and

- b. Reinvest FFP received for services provided in IMDs to support services and activities that benefit Medi-Cal members served by the BHP.

8.2. **SMI Program Benefits.** Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI Program, to be monitored pursuant to the SMI Monitoring Plan as outlined in STCs 8.5 – 8.7 below.

8.3. **SMI Implementation Plan.**

- a. The state must submit the SMI Implementation Plan within 90 calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within 60 calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under expenditure authority until CMS has approved the SMI Implementation Plan and the SMI financing plan described in STC 8.3(e). After approval of the required Implementation Plan and Financing Plan, FFP will be available prospectively, but not retrospectively.
- b. Once approved, the SMI Implementation Plan will be incorporated into the STCs as Attachment D, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI Program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 14.2.
- c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:
 - i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.
 - 1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and

either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g.,

with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;
3. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the person was referred to;
4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers); and
5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide updates on how it has increased the availability of mental health services in every Annual Monitoring Report);
2. Commitment to implementation of the SMI financing plan described in STC 8.3(e). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.6;
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible; and
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association [e.g., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment and Increased Integration.

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI in treatment sooner, including through supported employment and supported education programs;
2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI conditions sooner and improve awareness of and linkages to specialty treatment providers; and
3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI.

- d. **SMI Health Information Technology (Health IT) Plan.** The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure "ecosystem" at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the

demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 8.3[c])), to develop the infrastructure/capabilities of the state's health IT infrastructure.

- i. The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment D) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.
- ii. The state will include in its Monitoring Plans (see STC 14.5) an approach to monitoring its SMI Health IT Plan which will include performance metrics to be approved in advance by CMS.
- iii. The state will monitor progress, each DY, on the implementation of its SMI Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 14.6).
- iv. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications'¹ (ISA) in developing and implementing the state's SMI Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
- v. Where there are opportunities at the state- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care Organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B "Standards and Implementation Specifications for HIT". If there is no relevant standard in 45 CFR 170 Subpart B, the state should review the Office of the National Coordinator for Health Information Technology's Interoperability Standards Advisory (<https://www.healthit.gov/isa/>) to locate other industry standards in the interest of efficient implementation of the state plan.
- vi. Components of the Health IT Plan include:
 1. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

¹ Available at: <https://www.healthit.gov/isa/sites/isa/files/inline-files/2022-ISA-Reference-Edition.pdf>

2. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.
3. In developing the Health IT Plan, states should use the following resources:
 - States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).
 - States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
 - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.
- e. **SMI Financing Plan.** As part of the SMI implementation plan referred to in STC 8.3(d), the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment D and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:
 - i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

- ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;
- 8.4. **Maintenance of Effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.6.
- 8.5. **Availability of FFP for the SMI Services Under Expenditure Authority #11.** Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.
- 8.6. **Unallowable Expenditures Under the SMI Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:
 - a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
 - b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
 - c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
 - d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

9. COMMUNITY TRANSITION IN-REACH SERVICES

- 9.1. **Overview of Community Transition In-Reach Services and Program Objectives.** The state is authorized to implement Community Transition In-Reach Services for qualifying Medi-Cal members in participating counties that are approved by DHCS to offer the services starting no sooner than January 1, 2025. Counties 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 or at-risk for long-term stays in institutional settings in returning to the community.
- 9.2. **County Participation.** BHPs may opt to cover Community Transition In-Reach Services if they meet the following criteria and are approved by DHCS:
- a. Submit a plan to DHCS to describe how they will assess availability of mental health and/or substance use disorder (SUD) services and housing options, and ensure that an appropriate behavioral health continuum of care is in place within the county so that more Medi-Cal members can live in and receive behavioral health care in community-based settings, rather than institutional settings. The plan should also include the process for how the assessment will inform any needed action steps based on the outcome of the assessment.
 - b. Track and report, on a cadence established by DHCS, data and trends in the number and utilization of beds across inpatient, subacute, and residential facilities (including Institutions for Mental Diseases) in which the county places members. This data and information will additionally serve to inform monitoring and evaluation efforts undertaken by the state.
 - c. Provide Assertive Community Treatment (ACT), Forensic ACT, the Individual Placement and Support model of Supported Employment, and Peer Support Services, including a forensic specialization, within the county and/or ensure these services are covered by the BHP in the county where a member receiving Community Transition In-Reach Services will ultimately reside upon discharge from a qualifying facility.
- 9.3. **County Readiness.** DHCS will establish a process to assess the availability of mental health and/or SUD services and housing options available in counties that opt to cover Community Transition In-Reach Services. A BHP may only participate in this initiative upon approval by DHCS that the appropriate continuum of care is in place for the county. Updates on county readiness must be included in the narrative portion of the monitoring reports, described in STC 14.6.
- 9.4. **Eligibility Criteria.** To qualify to receive Community Transition In-Reach Services, a Medi-Cal member must:
- a. Be enrolled in Medi-Cal.

- b. Be aged 21 years or older or an emancipated minor, as defined by California Family Law Code (Div. 11, Part 6, Ch. 1, §7002).
- c. Meet the Specialty Mental Health Services (SMHS) Program access criteria, as defined in the California state guidance.
- d. Receive care covered by a BHP that has opted to provide Community Transition In-Reach Services regardless of whether the member resides in an in-county or out-of-county facility.
- e. Be experiencing or at risk of experiencing an extended length of stay of 120 days or more in a qualifying facility.
 - i. “Individuals at risk of experiencing extended length of stay” is defined as individuals in inpatient, residential, or subacute settings with lengths of stay shorter than 120 days but who have clinical presentation and progress similar to the patient profiles of individuals whose lengths of stay exceed 120 days. Patient profiles may include but are not limited to the following: previous inpatient or residential stays, difficulty with adherence to prescribed medication, co-occurring disorders, both behavioral and physical, few or limited family/friend supports in the community, civil commitment, guardianship/conservatorship status, experience of homelessness prior to hospitalization, and/or exhibits severe functional impairment based on clinical evaluation.

9.5. **Qualifying Facilities.** In qualifying counties, Community Transition In-Reach Services may be provided in inpatient, residential, or subacute settings, including Institutions for Mental Diseases (IMDs).

9.6. **Scope of Community Transition In-Reach Services.** Community Transition In-Reach Services to support care transition and discharge planning include transitional care management services that include, but are not limited to:

- a. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - i. Taking client history;
 - ii. Identifying the individual’s needs and completing related documentation; and
 - iii. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
- b. Developing a comprehensive individualized care plan that is based on the information collected through the assessment that:

- i. Specifies the self-determined goals and actions to address the medical, social, educational, and other services needed by the individual;
 - ii. Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals and a plan for achieving those goals that reflect the individual's preferences with regard to services and support and types of housing they many need to help them successfully transition out of institutions and into living and engaging in their communities; and
 - iii. Identifies a course of action to respond to the assessed needs and preferences of the eligible individual.
- c. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
- d. Monitoring and follow-up activities:
 - i. Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - 1. Services are being furnished in accordance with the individual's care plan;
 - 2. Services in the care plan are adequate to support them to live in stable housing and engage in their communities; and
 - 3. Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- e. Identifying and addressing other system barriers, including social and financial issues, and facilitating linkages to social supports necessary to support successful reintegration of Medi-Cal members into their communities.

9.7. Duration of Community Transition In-Reach Services. Community Transition In-Reach Services are available for up to 180 days prior to discharge. If an individual is not discharged after 180 days, in-reach services are no longer eligible for FFP.

9.8. Community Transition In-Reach Teams. Community transition teams will be multi-disciplinary and, at a minimum, they must include the following practitioner types for

purposes of providing in-reach and post-discharge care planning, transitional care management, and community re-integration services:

- a. A licensed mental health professional as a team lead;
- b. A certified Peer Support Specialist or other Specialty Mental Health Services practitioner with lived experience of recovery from a significant behavioral health condition;
- c. An occupational therapist (if not serving as team lead), unless the BHP meets the following exemption:
 - i. The BHP submits documentation, in accordance with DHCS standards, that demonstrates:
 - 1. Workforce shortages for qualified occupational therapists in the county and that the Community Transition In-Reach Teams in the county can perform their required functions without an occupational therapist; and
 - 2. A plan to expand the availability of occupational therapists in the licensed mental health professional provider network.
- d. At least one additional Specialty Mental Health Services practitioner.
- e. Access to a prescriber for the purpose of coordinating medication management throughout the care transition.

9.9. **Availability of FFP for the Community Transition In-Reach Services Under Expenditure Authority #5.** Federal Financial Participation is only available for Community Transition In-Reach Services provided to beneficiaries who are residing in an inpatient, residential or subacute setting, including IMDs, when the beneficiary meets eligibility criteria described in 9.4. The state may claim FFP for Community Transition In-Reach services furnished to beneficiaries during IMD stays for up to 180 days prior to discharge. Payments will not be made to facilities where the beneficiary resides.

9.10. **Unallowable Expenditures Under the Community Transition In-Reach Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

- a. Room and board costs for inpatient, residential or subacute treatment service providers, including those that are IMDs, unless they qualify as inpatient facilities under section 1905(a) of the Act.
- b. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

10. HEALTH-RELATED SOCIAL NEEDS (HRSN) SERVICES

10.1. Health-Related Social Needs (HRSN) Services. The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 10.2 and Attachment G, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX and Title XXI, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through state or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary's receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 10.8 (Service Delivery) and Attachment G.

10.2. Allowable HRSN services. The state may cover the following HRSN services:

- a. Housing Interventions, including:
 - i. Room and board-only supports (also referred to as “rent-only” supports or interventions), limited to a clinically appropriate amount of time, including:
 - 1. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

10.3. HRSN Intervention Duration and Frequency.

- a. Subject to STC 10.3.b., housing interventions that are classified as room and board-only support, as described in STC 10.2.a.i.1, may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.
- b. Multiple HRSN housing interventions can be covered for qualifying beneficiaries across all of California's section 1115(a) demonstrations; provided however that CMS will apply a total combined cap of 6 months for all HRSN housing interventions that include room and board supports, per beneficiary, in any rolling 12-month period.
 - i. The state may only offer room and board-only supports to beneficiaries who qualify for other HRSN housing interventions if they have not reached the 6-month global cap, within any rolling 12-month period, for HRSN housing

interventions that include room and board supports across all of California's section 1115(a) demonstrations.

- ii. If the beneficiary received additional HRSN housing interventions providing room and board supports under another one of California's section 1115(a) demonstrations, the state may only provide the remaining balance of month(s) under the 6 month global cap for HRSN housing interventions that include room and board supports within any rolling 12-month period.

10.4. Excluded HRSN Services. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

- a. Construction costs (bricks and mortar);
- b. Capital investments;
- c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 10.2 and 10.3;
- d. Research grants and expenditures not related to monitoring and evaluation;
- e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except case management of HRSN services provided as part of an approved reentry demonstration initiative;
- f. Services provided to individuals who are not lawfully present in the United States;
- g. Expenditures that supplant services and/or activities funded by other state and/or federal governmental entities;
- h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and
- i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.
 - i. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping space are not available to residents 24 hours a day, and facilities without private sleeping space.

10.5. Covered Populations. Expenditures for HRSN services may be made for the populations of focus specified in Attachment G, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid or CHIP (or Medicaid demonstration)-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described STC 10.1, to address the documented

need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment G. Attachment H, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state anticipates incorporating into Attachment G at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment H reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the and social risk factors outlined in Attachment H. Additionally, the state can later include additional clinical and social risk factors in compliance with STC 10.6 and 10.7.

- 10.6. **Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected in Attachment H must be effectuated through the process indicated in STC 10.7. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment G.

If the state adds new HRSN services beyond those specified in STC 10.2 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol must include the following information:

- a. A list of the covered HRSN services (not to exceed those allowed under STC 10.2), with associated service descriptions and service-specific provider qualification requirements.
- b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

- c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be medically appropriate.
 - i. Plan to identify medical appropriateness based on clinical and social risk factors.
 - ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.
- d. A description of the process for developing care plans based on assessment of need.
 - i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.
 - ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

10.7. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services:

- a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachment G and Attachment H. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in Attachment H, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN services or qualifying criteria change in Attachment G by the following process:
 - i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
 - ii. The state must provide public notice.
 - iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.
- b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment H, the state must follow the process below to update the protocol:
 - i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing

so would not require an increase to the amount of the state's HRSN expenditure authority in Table 13.

- ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 10.7.b.
- iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC 10.7.b. This restriction is not applicable to the process and scope of changes outlined in STC 10.7.a.

10.8. **Service Delivery.** HRSN services will be provided in the managed care delivery system(s) and delivered by HRSN service providers. Terms applicable to all HRSN services:

- a. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the following terms will apply:
 - i. HRSN services can be provided by managed care plans and paid on a non-risk basis and must be appropriately included in contracts. This can be accomplished by either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of “non-risk contract” at 42 CFR § 438.2) or as an amendment to a state's existing risk-based managed care plan contract to include a non-risk payment. The state must take measures to ensure there is no duplication of payments for either the delivery of such service or the administrative costs of delivering such services.
 - ii. For a non-risk contract or a non-risk payment, the managed care plan is not at financial risk for changes in utilization or for costs incurred under the contract or payment that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HRSN services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.
 - iii. When the state includes non-risk payments in a risk-based contract, the state must ensure all non-risk payments are separate and apart from risk-based payments and clearly define what services/populations are covered under non-risk payments versus included in risk-based capitation rates. All of the costs of delivering services under a non-risk payment must be excluded from the development of the risk-based capitation rates for the risk-based contracts. Specifically, the costs of delivery the services as well as any costs of administering the non-risk payment must be excluded from the development of the risk-based capitation rates.
 - iv. Prior written CMS approval pursuant to STC 10.9 is required before the state moves to incorporate the HRSN services into the risk-based capitation rates in

Medicaid managed care. When the state incorporates the HRSN services into the risk-based capitation rates in Medicaid managed care, the state must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and may no longer utilize non-risk payments for the services included in risk-based capitation rates.

- v. Any applicable HRSN services that are delivered by managed care plans in a risk arrangement, must be included in the risk-based managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a).
 - vi. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.
 - vii. All expenditures for HRSN services delivered under non-risk contracts must be excluded from MLR reporting. When HRSN services (i.e. HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5) are included in capitation rates paid to managed care plans under risk-based contracts, and only then, should HRSN services be reported in the medical loss ratio (MLR) reporting as incurred claims.
 - viii. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure, as applicable, will be identified and reported in the MLR as non-claims costs.
- b. CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in managed care. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology codes that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 10.17.

10.9. Requirements for HRSN Services prior to being delivered in risk-based managed care. The state's plan to incorporate HRSN into risk-based managed care contracts must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation

rates. At least 6 months prior to moving HRSN services approved under these STCs into risk-based Medicaid managed care contracts, the state must submit to CMS, for review and written prior approval, documentation that details the following information:

- a. Each HRSN service defined in STC 10.2 and each covered population that will receive each HRSN service defined in STC 10.5 where the state is seeking CMS written approval to be delivered through one or more risk-based managed care program(s). The applicable managed care program(s) for each service and population should also be specified.
- b. If the HRSN service will be offered in all regions under each risk-based managed care program or if the offerings will be limited geographically.
- c. The first rating period the state is seeking to start offering the HRSN service(s) through risk-based managed care. If the HRSN services will be delivered through risk-based managed care on a rolling basis, provide the timeline for each service and/or population.
- d. The state's timeline to complete a readiness review pursuant to 438.66(d). Implementation may only begin when each managed care plan has been determined by the state to meet certain readiness and network requirements, including providing any documentation specified by CMS.
- e. A transition of care plan that provide continuity of care for beneficiaries transitioning from another delivery system (e.g. FFS) or non-risk contracts into risk-based contracts.
- f. A description of base data that the state and its actuary plan to use for capitation rate setting process to develop both the benefit and non-benefit costs, including the types of data used (FFS claims data, managed care encounter data, managed care plan financial data, etc.) and the data source(s) that will be used for capitation rate development. Consistent with Medicaid managed care rate development requirements under 42 CFR 438.5(c), CMS requires at least 3 years of encounter data or similar data (e.g. cost reports, claims data) for the HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5 that will be incorporated into risk-based managed care. CMS will consider exceptions to the requirement for 3 years of base data for periods impacted by COVID-19.
- g. The methodology the state's actuary will use in the capitation rate setting process. This includes, but is not limited to, any trend factors and adjustments to the data the state and its actuary will apply to the base data in the capitation rate setting process. The methodology should also include information on the approach the actuary will take to incorporating the HRSN service(s) into capitation rate development (for example, if the actuary will create an add-on that will be applied to some or all existing rates cells, creating a separate rate cell, or some other method) and any changes to or new risk adjustment or acuity adjustments applied due to the inclusion

of the HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5.

- h. If the state is planning to delegate risk for the delivery of HRSN services to clinical providers, community organizations, and/or subcontractors for specific HRSN services, the capitation rate setting plan should include a description of these proposed delegated arrangements and/or sub-capitated payment arrangements that the state intends to use in the delivery of any HRSN services defined in STC 10.2 for covered populations outlined in STC 10.5.
- i. Identification of any in-lieu of services (ILOS) the state currently offers through its managed care programs and if there will be changes to those ILOS as a result of the state moving these HRSN service(s) into risk-based managed care contracts.
- j. Because of the uncertainty associated with HRSN services and in alignment with past guidance about situations with high levels of uncertainty, CMS is requiring the State to implement a 2-sided risk mitigation strategy (such as a 2-sided risk corridor) to provide protection for state and federal governments, as well as managed care plans. The HRSN capitation rate setting plan should provide a description of the risk mitigation mechanism(s) that will be used in the transition of HRSN services to risk-based managed care. As part of plan to incorporate HRSN into risk-based managed care, the State will also need to develop an MLR monitoring and oversight process specific to HRSN services. This process must specify how HRSN services will be identified for inclusion in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs, as applicable, will be identified and reported by managed care plans as non-claims costs.
- k. All state directed payments the state plans to implement for any HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5 that will be provided under risk-based contracts must comply with all applicable federal requirements, including but not limited to 438.6(c). The state should submit this information to establish compliance for any state-directed payments for HRSN services to CMS at statedirectedpayment@cms.hhs.gov.

10.10. Phased In Implementation of HRSN Services. As further discussed in the state's Implementation Plan, the state will phase in their HRSN service, short-term rental assistance, on the following schedule:

- a. No sooner than July 1, 2025, short-term rental assistance will be an optional service for managed care plans to provide.
- b. No sooner than January 1, 2026, and as specified in Attachment G and H and consistent with STC 10.5 and 10.6, short-term rental assistance will be a mandatory service for managed care plans to provide for eligible individuals who meet the access criteria for Medi-Cal SMHS, DMC, or DMC-ODS as specified in Attachment G and Attachment H. Short-term rental assistance will be an optional service for

managed care plans to cover for additional eligible populations as specified in Attachment G and H and consistent with STC 10.5 and 10.6.

- c. No sooner than January 1, 2027, short-term rental assistance will be a mandatory service for managed care plans to provide for all eligible populations as specified in Attachment G and H, consistent with STC 10.5 and STC 10.6.

10.11. **Contracted Providers.** Managed care plan contracts must provide, applicable to all HRSN services:

- a. Managed care plans will contract with providers to deliver the HRSN services authorized under the demonstration and included in the managed care contract.
- b. Managed care plans must establish a network of providers and ensure the HRSN service providers have sufficient experience and training in the provision of the HRSN services being offered. HRSN service providers do not need to be licensed, however, staff offering services through HRSN service providers must be licensed when applicable (i.e., when the staff member is performing activities for which a licensure requirement applies in the state).
- c. The managed care plan and contracted providers will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements. Any state direction of managed care plan expenditures under risk-based contract(s) and risk-based payments would only be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

10.12. **Provider Network Capacity.** Managed care plan contracts must ensure the HRSN services authorized under the demonstration are provided to qualifying beneficiaries in a timely manner and shall develop policies and procedures outlining the managed care plan's approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

10.13. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulation.

10.14. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each individual receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan must be reviewed and revised as appropriate at least every 12 months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

10.15. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

10.16. **CMS Approval of Managed Care Contracts.** As part of the state’s submission of associated managed care plan contracts to implement HRSN services through managed care, the state must include contract requirements including, but not limited to:

- a. Beneficiary and plan protections, including but not limited to:
 - i. HRSN services must not be used to reduce, discourage, or jeopardize beneficiaries’ access to covered services.
 - ii. Beneficiaries always retain their right to receive covered service on the same terms as would apply if HRSN services were not an option.
 - iii. Beneficiaries who are offered or who utilize an HRSN retain all rights and protections afforded under 42 CFR 438.
 - iv. Managed care plans are not permitted to deny a beneficiary a covered service on the basis that the beneficiary is currently receiving HRSN services, have requested those services, has previously qualified for or received those services, or currently qualifies or may qualify in the future for those services.
 - v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.
- b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:
 - i. Data to evaluate the utilization and effectiveness of the HRSN services.
 - ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.
 - iii. Any data necessary to monitor appeals and grievances for beneficiaries.
 - iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.
 - v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.
- c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:
 - i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, these encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement

efforts and subsequent efforts to mitigate health disparities undertaken by the state.

- ii. Any additional information requested by CMS, the state or another legally authorized oversight body to aid in on-going evaluation of the HRSN services initiative or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.
- iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing resources and to avoid duplication of efforts.
- iv. Any additional information determined reasonable, appropriate and necessary by CMS.

10.17. **HRSN Rate Methodologies.** For FFS payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR Part 447, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 7. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable FFS payment rates or methodologies for HRSN and maintain documentation of these FFS payment rates or methodologies on its website described in 42 CFR 447.203. The state may receive FFP for HRSN service expenditures authorized under this demonstration upon implementation of the FFS payment rates and/or methodologies for which it has conducted prior public notice and may begin claiming for this FFP (for dates of service no earlier than the effective date of approval for the relevant expenditure authority) no earlier than the date of submission of the payment rates and/or methodology to CMS for approval. However, any FFS payments to providers or claims for FFP prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved FFS payment rate and/or methodology within one year of CMS's approval. All requirements for timely filing of claims for FFP continue to apply.

For managed care payments and rates (including capitation rates, non-risk payments, and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs. As applicable, the state must also notify CMS at least 60 days prior to intended implementation if it intends to direct its managed care plans on how to pay for HRSN services (i.e., state directed payments).

All rates/payment methodologies for HRSN services, for both FFS and managed care delivery systems, must be submitted to CMS for review and approval, including but not limited to fee-for-service payments as well as managed care capitation rates, any state directed payments that require prior written approval, and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, for both FFS and managed care delivery systems, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public

comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

- 10.18. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan required by STC 10.21 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.6, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.
- 10.19. **Partnerships with State and Local Entities.** To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other state or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the beneficiary's care plans, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 14.6, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.
- 10.20. **Provider Payment Rate Increase.** As a condition of the HRSN services expenditure authorities, California must comply with the provider rate increase requirements in Section 12 of the STCs.
- 10.21. **HRSN Implementation Plan**
- a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STC regarding implementation of demonstration policies that are outlined in the STC. The state must submit the MOE information required by STC 10.18 no later than 90 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan as initiatives

are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment I.

- b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent.
- c. The Implementation Plan must include information on, but not limited to, the following:
 - i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;
 - ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);
 - iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision;
 - iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing assistance programs, relative to the number of total eligible beneficiaries in the state (including those who are eligible but unenrolled);
 - v. An implementation timeline and evaluation considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;
 - vi. Information as required per STC 10.18 (MOE); and
 - vii. Information as required per STC 10.19 (Partnerships with State and Local Entities).

11. DESIGNATED STATE HEALTH PROGRAMS

11.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs (DSHP), subject to the limits described in this Section 11. DSHP are specific state programs that: (1) are population- or public health-focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the DSHP will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. This DSHP authority will enable the state to use state dollars that it otherwise would have spent on the DSHP specified in the Approved DHSP List (Attachment J), for which it may use as non-federal share as specified in Section 11. DSHP Funded Initiatives, on demonstration expenditures to support DSHP-funded initiatives, as described in STC 11.3(c).

- a. The DSHP will have an established limit in the amount of \$1,615,000,000 total computable expenditures, in aggregate, for DY 1 - DY 5.
- b. The state may claim FFP for up to the annual amounts outlined in the table below, plus any unspent amounts from prior years. In the event the state does not claim the full amount of FFP for a given demonstration year, the unspent amount, available for claiming, will roll over to one or more demonstration years not to exceed the total for this demonstration period. The total amount of DSHP FFP that the state may claim in DY 1 - DY 5 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives.

	Table 3. Annual Limits of Total Computable Expenditures for DSHP				
	DY 1	DY 2	DY 3	DY 4	DY 5
Total Computable Expenditures	\$323,000,000	\$323,000,000	\$323,000,000	\$323,000,000	\$323,000,000

- c. The state must contribute \$142,500,000 to add in original, non-freed up DSHP funds, for the remaining demonstration period towards its initiatives described in STC 11.3. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.
- d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of nonfederal share, which may be subject to CMS financial review.

- e. The Approved DSHP List is limited to programs that are: (1) population- or public health- focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the program will impede the primary objective of Medicaid to provide coverage for services for low-income; and (3) serve a community largely made up of low-income individuals and vulnerable populations. The Approved DSHP List is Attachment J. Any changes the state wants to make to its DSHP program will require an amendment as specified in STC 3.7.

11.2. Prohibited DSHP Expenditures.

- a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, or the Centers for Disease Control and Prevention) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.
- b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 5 percent of total provider expenditures or claims through DSHP identified as described in STC 11.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the Approved DSHP List (Attachment J). Therefore, the state can claim up to the program limits in the Approved DSHP List.
- c. In addition to 11.2(a), the following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:
 - i. Bricks and mortar;
 - ii. No shelters, vaccines, and medications for animals;
 - iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;
 - iv. Revolving capital funds; and
 - v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

11.3. DSHP-Funded Initiatives.

- a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs, for which the state may claim FFP in accordance with STC 11.1 and 11.2 to fund the DSHP-funded initiatives as specified in STC 11.3(c).
- b. **Requirements.** CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care.
- c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

- i. Workforce Initiatives;

11.4. **DSHP Claiming Protocol.** The state will develop a DSHP Claiming Protocol, which the state will make available to CMS upon request. State expenditures for the DSHP must be documented in accordance with the protocol.

- a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:
 - i. Certification or attestation of expenditures.
 - ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 11.2.
- b. The state will claim FFP for DSHP quarterly based on actual expenditures.

11.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS, upon request. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

- a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of nonfederal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

- b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.
- c. DSHP will be claimed at the administrative matching rate of 50 percent.
- d. Expenditures will be claimed in accordance with the state's DSHP Claiming Protocol.

11.6. **DSHP Sustainability Report.** The DSHP Sustainability Report will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. As part of the monitoring reports, the state shall submit the DSHP Sustainability Report section in its annual report.

12. PROVIDER RATE REQUIREMENTS

- 12.1. The provider payment rate increase requirements described hereafter are a condition for the DSHP and HRSN expenditure authorities, as referenced in expenditure authorities 6 and 7.
- 12.2. As a condition of approval and ongoing provision of FFP for the DSHP and HRSN expenditures over this demonstration period of performance, DY 1 through DY 5, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.
- 12.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).
- 12.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

- 12.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:
- a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:
 - i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); AND
 - ii. For behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3)); OR
 - b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:
 - i. Service codes must be representative of each service category as defined in STC 14.4;
 - ii. Medicaid and Medicare data must be from the same year and not older than 2019.
 - iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.
- 12.6. To establish the state's ratio for each service category identified in STC 12.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:
- a. The average fee-for-service ratio as provided in STC 12.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); or

- b. The data and methodology for any or all of the service categories as provided in STC 12.5(b) using Medicaid managed care provider payment rate and utilization data.
- 12.7. In determining the ratios required under STC 12.5 and 12.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).
- 12.8. If the state is required to increase provider payment rates for managed care plans per STC 12.2 and 12.6, the state must:
 - a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and
 - b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.
- 12.9. For the entirety of DY 3 through DY 5, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 1, and such rate will be in effect on the first day of DY 3. A required payment rate increase shall apply to all services in a service category as defined under STC 12.4.
- 12.10. If the state uses a managed care delivery system for any of the service categories defined in STC 12.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 3 through DY 5, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 1 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 12.4.
- 12.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 3 (or, as applicable, the first day of the first rating period that starts in DY 3), the state will provide an alternative effective date and rationale for CMS review and approval.
- 12.12. California will provide the information to document the payment rate ratio required under STC 12.5 and 12.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.
- 12.13. For demonstration years following the first year of provider payment rate increases, if any, California will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

- 12.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 12.5 and 12.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment K.

Table 4. California DSHP and HRSN Related Provider Payment Increase Assessment – Attestation Table.

The reported data and attestations pertain to DSHP and HRSN related provider payment increase requirements for the demonstration period of performance DY 1 through DY 5.		
Category of Service	Medicaid Fee-for-Service to Medicare Fee-for-Service ratio	Medicaid Managed Care to Medicare Fee-for-Service Ratio
Primary Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 12.5(a) or STC 12.5(b)]	[insert approach, either ratio derived under STC 12.6(a) or STC 12.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Obstetric Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 12.5(a) or STC 12.5(b)]	[insert approach, either ratio derived under STC 12.6(a) or STC 12.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Behavioral Health Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system]

		for applicable covered service categories]
	[insert approach, either ratio derived under STC 12.5(a) or STC 12.5(b)]	[insert approach, either ratio derived under STC 12.6(a) or STC 12.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]

In accordance with STCs 12.1 through 12.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on *[insert date]*, and will not be lower than the highest rate for that service code in DY 1 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least *[insert date]*.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 12.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]

☐ a. The effective date of the rate increases is the first day of DY 3 (January 1, 2027) and will be at least sustained, if not higher, through DY 5 (December 31, 2029).

☐ b. California has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY 3 (January 1, 2027). California will effectuate the rate increases no later than the CMS approved date of January 1, 2027, and will sustain these rates, if not made higher, through DY 5 (December 31, 2029).

California *[insert does or does not]* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the DSHP and HRSN STCs, I agree to submit by no later than *[insert date]* for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than *[insert date]*.

California *[insert does or does not]* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the DSHP and HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 12.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date]*.

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 12.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.

California further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 12.

I, *[insert name of SMD or CFO (or equivalent position)]* *[insert title]*, attest that the above information is complete and accurate.

[Provide signature_____] *[Provide date_____]*
[Provide printed name of signatory]

13. STATE COMMITMENTS TO PROVIDER RATES

- 13.1. The provider access and rate increase requirements described hereafter are a condition to receive FFP for expenditures under the BH-CONNECT demonstration. These requirements are only in effect for a demonstration year to the extent that the state collects more revenue applicable to a demonstration year from its Managed Care Organization Provider Tax than would be otherwise be permitted through the CMS-approved December 15, 2023 tax waiver of the broad-based and uniformity requirements. Should the state

experience extenuating economic conditions or circumstances that result in an inability to meet this requirement, the state can request specified relief subject to CMS approval.

- 13.2. The following requirements in STCs 13.3 through 13.9 apply to Medi-Cal Managed Care plans. These requirements do not apply to Specialty Mental Health Services plans or Drug Medi-Cal Organized Delivery System plans.
- 13.3. Effective January 1, 2024, California implemented fee-for-service (FFS) and managed care provider payment rate increases for primary care, maternal (obstetrical and doula) care, and outpatient (non-specialty) mental health care to 87.5 percent of Medicare. The state will maintain at least 87.5 percent of Medicaid to Medicare provider rate ratios for these services for the duration of the BH-CONNECT demonstration period (the entirety of DY 1 through DY 5).
- 13.4. This commitment is aligned with the requirements in the access rule and managed care rule for states to publicly compare fee-for-service payment rates and managed care plans' payment rates for primary care, obstetrical care, and outpatient mental health and substance use disorder services to Medicare rates and the implementation of the managed care rule provisions pertaining to appointment wait time standards for primary (adult/pediatric), obstetrical and gynecological, and outpatient mental health and substance use disorder services (adult/pediatric). California will conduct enhanced transparency for the services specified in STC 13.3 for calendar years 2025 and 2026. The state will provide to CMS an annual payment analysis for Medi-Cal Managed Care plans' payment rates for the services specified in STC 13.3, consistent with the requirements outlined in 42 CFR § 438.207(b)(3) for calendar years 2025 and 2026.
 - a. For calendar year 2025, California will submit this analysis no later than June 30, 2026.
 - b. For calendar year 2026, California will submit this analysis no later than June 30, 2027.
- 13.5. In addition, California will collect and report to CMS an annual payment analysis for Medi-Cal Managed Care plans' payment rates for calendar years 2025 and 2026, beyond the required evaluation and management codes identified in 42 CFR § 438.207(b)(3), on all other current procedural terminology codes not reported in STC 13.4, but that are listed in Table 5. This reporting must be consistent with the requirements outlined in 42 CFR § 438.207(b)(3) but applied to all other current procedural terminology codes not reported in STC 13.4, but that are listed in Table 5.
 - a. For calendar year 2025, California will submit this analysis no later than June 30, 2026.
 - b. For calendar year 2026, California will submit this analysis no later than June 30, 2027.
- 13.6. As California moves forward with implementing the required appointment wait time standards for Medi-Cal Managed Care plans under 42 CFR § 438.68(e) in calendar year

2028, California will ensure that any network adequacy exceptions granted under 42 CFR § 438.68(d) are carefully evaluated using the criteria specified in 42 CFR § 438.68(d). By June 30, 2027, California will provide to CMS the standard operating protocol for network adequacy exceptions granted by the state under 42 CFR § 438.68(d) and a description of the process for monitoring network adequacy exceptions.

- 13.7. In addition to the provider payment rates described in STC 13.3, California will increase payment levels for the primary care and specialty providers described in Table 5. By December 31, 2026, these payment increases are expected to achieve a Medicaid to Medicare provider payment ratio specified in Table 5 for each provider type. The state will (at least) subsequently sustain the provider payment levels to meet the requirements in this STC through the end of the BH-CONNECT period (the entirety of DY 3, DY 4 and DY 5).
- 13.8. Of the allowable streamlined eligibility and enrollment strategies outlined to continue in the CMCS Informational Bulletin (CIB) “Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes”², California will maintain strategies to streamline income and resource verification during the ex parte renewal process at the time of demonstration approval through June 30, 2025. The State Medicaid Agency will complete an ex parte renewal when no data sources return income information (Zero-Dollar and 100 percent FPL Income strategies) in accordance with the parameters outlined in the CIB and will document the continued use of these strategies in their verification policies and procedures.

Table 5. Provider Payment Levels by December 31, 2026

Provider	Medicaid to Medicare provider payment ratio
1. Evaluation & Management Codes for Office Visits, Preventive Services, and Care Management	90%
2. Obstetric Services	90%
3. Non-Specialty Mental Health Services (mild and moderate mental health services provided by managed care plans)	87.5%
4. Vaccine Administration	87.5%
5. Evaluation & Management Codes for ED Physician Services	90%
6. Other Procedure Codes commonly utilized by Primary Care, Specialist, and ED Providers	80%

- 13.9. By June 30, 2027, the state will provide to CMS a letter signed by the State Medicaid Director, describing the payment increases required by STC 13.7 and affirming that as a result of the provider payment increases, the state met the expectations of Medicaid to Medicare provider reimbursement ratios in Table 5.

² <https://www.medicaid.gov/federal-policy-guidance/downloads/cibe1411142024.pdf>

- 13.10. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this section.

14. MONITORING AND REPORTING REQUIREMENTS

- 14.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of \$5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due, if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted due to being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps that the state has taken to address such issue, and state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

- 14.2. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to \$5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to \$5,000,000 for services rendered in IMDs will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.
- 14.3. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs. The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.
- 14.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:
 - a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
 - b. Ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and
 - c. Submit deliverables to the appropriate system as directed by CMS.
- 14.5. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol addressing components of the demonstration within 150 calendar days after approval of the demonstration amendment. The state must submit a revised Monitoring Protocol within 60 days after receipt of CMS's comments, if any. Once approved, the Monitoring Protocol will be incorporated into the STCs as Attachment E. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment, as applicable. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and

Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 14.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the SMI component, the Monitoring Protocol must include an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas; a description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 14.6; and a description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and target will be benchmarked against performance in best practice settings.

For the qualitative elements (e.g., operational updates as described in STC 14.6.a), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Monitoring Reports.

14.6. Quarterly and Annual Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The monitoring reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

- a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed.

- b. **Performance Metrics.** Per applicable CMS guidance and technical assistance, the performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration’s program and policy implementation and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on beneficiaries’ outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, and grievances and appeals.
- a. Specifically, the state must undertake reporting on categories of metrics including, but not limited to: enrollment, utilization of services, and quality of care and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration’s policies, objectives, and populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography/county), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration’s initiatives help improve outcomes for the state’s Medicaid population, including the narrowing of any identified disparities.
- i. For the SMI component, the state’s monitoring must cover metrics including, but are not limited to, screening of beneficiaries admitted to psychiatric hospitals or residential treatment facilities, mental health services utilization (e.g., inpatient and outpatient), and average length of stay in IMDs and the demonstration’s four milestones as outlines in the SMDL dated November 13, 2018 (SMDL #18—011).³
- ii. For the Access, Reform and Outcomes Incentive Program, the state should include a summary of implementation updates, plan performance on the incentive measures outlined in STC 5.3 for each focus area, and payment of incentive funds to plans, as well as the results of any future MBHO NCQA assessments. In addition, the program accountability measures described in STC 5.11 will be submitted annually for CMS review via the Monitoring Reports, unless otherwise described in the Incentive Program Protocol.
- iii. For the Community Transition In-Reach Services, the state must provide updates on county readiness in the monitoring reports, as well as data and trends in utilization of beds across inpatient, subacute, and residential facilities (including Institutions for Mental Disease), as described in STCs 9.2 and 9.3.

³ SMDL #18—011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

Additionally, the state must report on metrics related to discharge from residential settings into community/outpatient settings and readmissions to acute levels of care.

- iv. For the Workforce Initiatives, the state must report on the student loan repayment, scholarship, recruitment and retention, training, and residency activities in the Monitoring Reports. The state must provide details in the narrative section of the Monitoring Reports regarding program recruitment, participation, completion, residency slots and program types, and status of service commitments. The state must submit annually the number and amount of recruitment and retention bonuses awarded to the provider organizations and the behavioral health practitioners. The state is required to provide details regarding the types of provider organizations and the behavioral health practitioners who receive the awards.
- v. In order to ensure a link between DSHP-funded initiatives and improvements in health equity and beneficiary health outcomes, CMS and the state will coordinate to use the critical set of disparities-sensitive metrics described above, with applicable demographic stratification.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

- c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements, Section 16 of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly, and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
 - d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
- 14.7. **SMI Mid-Point Assessment.** The state must contract with an independent entity to conduct a Mid-Point Assessment by three years after the demonstration approval date. This timeline will allow for the Mid-Point Assessment to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care plans, health care providers (including SMI treatment providers), beneficiaries, community groups, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after three years after the demonstration approval date. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment with 60 calendar days after receipt of CMS's comments, if any.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the SMI Implementation Plan for ameliorating these risks. Modifications to any of these plans or protocols are subject to CMS approval. Elements of the Mid-Point Assessment must include:

- a. An examination of progress toward meeting each milestone and timeframe approved in the SMI Implementation Plan, the SMI Financing Plan, and toward meeting the targets for SMI performance measures as approved in the Monitoring Protocol;
- b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
- c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
- d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI Implementation Plan or SMI Financing Plan or to other pertinent factors that the state can influence that will support improvement; and
- e. An assessment of whether the state is on track to meet the budget neutrality requirements.

14.8. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

- a. The draft Close-Out Report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close-Out report.
- c. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
- d. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.
- e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 14.1.

14.9. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

14.10. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its Annual Monitoring Report.

14.11. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15. EVALUATION OF THE DEMONSTRATION

15.1. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

- 15.2. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 14.1.
- 15.3. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.
- 15.4. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than one hundred eighty (180) calendar days after the approval date of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of an independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 15.7 and 15.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment components. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

- 15.5. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.
- 15.6. **Evaluation Questions and Hypotheses.** Consistent with attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing must include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures must be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Consumer Assessment of Health Care Providers and Systems (CAHPS), the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and

experience with the various demonstration policy components. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation.

Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Hypotheses must cover all policies and goals of the demonstration and should be crafted to not only evaluate whether overall demonstration goals were achieved but also the extent to which each component contributed to outcomes. Where demonstration components offer tailored service to specific populations, evaluation hypotheses must include an assessment of whether these programs improved quality of care outcomes and access to health care for the targeted population while also promoting the desired administrative and fiscal efficiencies.

- a. The state's evaluation efforts must develop hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing services to address behavioral health.
- b. For the Workforce Initiatives, the state must develop hypotheses and research questions to evaluate the effects of the initiatives on improvements in overall staffing levels, long-term effects of the workforce programs on retention, and improvements in access to and utilization of behavioral healthcare for Medicaid beneficiaries. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention. Because these initiatives may affect a small number of providers, the state is strongly encouraged to use a mixed-methods approach that would incorporate qualitative data sources, including interviews and/or focus groups with participating providers, and a beneficiary experience survey.
- c. The evaluation must also include an assessment of the Access, Reform and Outcomes Incentive Program. Hypotheses should address the impacts of the program on beneficiary access to behavioral health care, beneficiary health outcomes, and delivery system reforms. The evaluation should also cover implementation challenges, successes, and other lessons learned from the program, including at the plan-level.
- d. Hypotheses for the SMI component of the demonstration must relate to, for example, utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, increases in the availability of crisis stabilization services, and improved care coordination.

- e. The Evaluation Design must also include hypotheses and research questions related to the Community Transition In-Reach Services such as how the program may lead to an increase in discharges from residential settings into community/outpatient settings, reduce readmissions to acute levels of care, and increase beneficiary access to care and improve care coordination. The evaluation should also investigate to what extent factors such as length of stay, diagnosis, treatment adherence, co-occurring physical health conditions, and/or homelessness are targeted for the provision of Community Transition In-Reach Services, as well as how health outcomes may vary by these factors. The evaluation should also incorporate insights on beneficiary experience and self-reported outcomes. As part of the evaluation strategy for this program, the state is required to submit a rapid-cycle assessment to cover the first year of program implementation, which will be due to CMS one-and-a-half years after the program is implemented unless otherwise agreed upon by CMS and the state. The rapid-cycle report should include both quantitative and qualitative analysis and cover, to the extent possible, implementation data, utilization of the services within this program, and preliminary data on the health outcomes listed above. Plans for the rapid-cycle assessment should be included in the state's Evaluation Design. CMS will provide the state with technical assistance regarding the rapid-cycle assessment.
- f. Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest to the extent data are available (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography/county). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

As noted above, for any amendment to the demonstration, the state will be required to update the approved Evaluation Design or submit a new Evaluation Design to accommodate the amendment component, as appropriate.

15.7. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report must be posted to the state's website with the application for public comment.

- a. The Interim Evaluation Report must discuss evaluation progress and present findings to date as per the approved Evaluation Design.
- b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

- c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state is not requesting an extension for the demonstration, the draft Interim Evaluation Report is due one (1) year prior to the end of the demonstration.
 - d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.
 - e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website within 30 calendar days.
 - f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.
- 15.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.
- a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.
 - b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.
- 15.9. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report. Presentations may be conducted remotely.
- 15.10. **Public Access.** The state must post the final documents (e.g., Implementation Plan, Monitoring Protocol, Close Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.
- 15.11. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of deliverables, CMS must be notified prior to presentation of these reports or their findings, including in related publications (for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS must be provided a copy including any associated press materials. CMS must be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

- 15.12. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A correction action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16. GENERAL FINANCIAL REQUIREMENTS

- 16.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.
- 16.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 16.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section

1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
- b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

16.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).
- c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries.

Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

16.5. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

16.6. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).
- c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).
- e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

16.7. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration

approval. This deliverable is subject to the deferral as described in STC 14.1. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;
- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

16.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 17:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

16.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles

and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

- 16.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 6. Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Workforce Initiative	Main			X	All expenditures for the Workforce Initiatives described in Section 6.
DSHP	Main			X	All expenditures for DSHP described in Section 11.
Access, Reform and Outcomes Incentive Program	Main			X	All expenditures for the Access, Reform and Outcomes Incentive Program described in Section 5.
SMI	Hypo 1	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment described in Section 8.
Community Transition In-Reach Services	Hypo 2	X		X	All expenditures for services provided as Community Transition In-Reach Services described in Section 9.
Activity Funds	Hypo 3	X		X	All expenditures for the Activity Funds Initiative described in Section 7.
HRSN Services	SHAC		X	X	All expenditures for HRSN initiatives described in Section 10.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

- 16.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00472/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.
- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
 - b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
 - c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
 - d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 17, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

- e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 14, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 7. MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Workforce Initiative	Report all expenditures for the Workforce Initiatives described in Section 6.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29
DSHP	Report all expenditures for DSHP described in Section 11.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29
ARO Incentive Program	Report all expenditures for the Access, Reform and Outcomes Incentive Program described in Section 5.		Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29
SMI	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment described Section 8.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29
Community Transition In-Reach Services	Report all expenditures for the Community Transition In-reach Services described in Section 9.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29

Activity Funds	Report all expenditures for the Activity Funds Initiative described in Section 7.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	1/1/25	12/31/29
HRSN Services	Report all expenditures for HRSN initiatives described in Section 10.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	1/1/25	12/31/29
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

- 16.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 8. Demonstration Years		
Demonstration Year 1	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 2	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 3	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 4	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 5	January 1, 2029 to December 31, 2029	12 months

- 16.13. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s actual expenditures to the budget neutrality expenditure limits described in section 17. CMS will provide technical assistance, upon request.⁴
- 16.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 16.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base

⁴ Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

16.16. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 16.16.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
- i. Provider rate increases that are anticipated to further strengthen access to care;
 - ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
 - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
 - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
 - v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
 - vi. High cost innovative medical treatments that states are required to cover; or,
 - vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
- i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
 - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

17. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 17.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, Hypothetical Budget Neutrality Tests, and a Supplemental HRSN Aggregate Ceiling (SHAC) Budget Neutrality Test as described below. CMS's assessment of the state's compliance with these tests will be based on the

Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

- 17.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 6, Master MEG Chart and Table 7, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 17.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 17.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the SHAC Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the SHAC amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both." Accrued savings from the California Advancing and Innovating Medi-Cal (CalAIM) demonstration shall be included when calculating the Main Budget Neutrality limit. For the current demonstration period, \$5,415,000,000 will be transferred from the CalAIM demonstration to the BH-CONNECT demonstration.

Table 9. Main Budget Neutrality Test

MEG	PC or Agg *	WOW Only, WW Only, or BOTH	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
ARO Incentive Program	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Workforce Initiative	Agg	WW Only	N/A	The state must have savings to offset these expenditures.				
DSHP	Agg	WW Only	N/A	The state must have savings to offset these expenditures.				

*PC = Per Capita, Agg = Aggregate

17.5. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

17.6. Hypothetical Budget Neutrality Test 1: SMI (Expenditure Authority #4) The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit

from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10. Hypothetical Budget Neutrality Test 1								
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
SMI	PC	Both	5.0%	\$11,078.11	\$11,632.02	\$12,213.62	\$12,824.30	\$13,465.52

- 17.7. **Hypothetical Budget Neutrality Test 2:** Community Transition In-Reach Services (Expenditure Authority #5). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11. Hypothetical Budget Neutrality Test 2								
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
Community Transition In- Reach Services	PC	Both	5.0%	\$2,845.00	\$2,987.25	\$3,136.61	\$3,293.44	\$3,458.11

- 17.8. **Hypothetical Budget Neutrality Test 3:** Activity Funds (Expenditure Authority #3). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 12. Hypothetical Budget Neutrality Test 3								
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
Activity Funds	PC	Both	4.7%	\$83.33	\$87.25	\$91.35	\$95.64	\$100.14

- 17.9. **Supplemental HRSN Aggregate Ceiling (SHAC) Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 10), CMS considers these expenditures to be “supplemental HRSN aggregate ceiling (SHAC)” expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state’s expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-ceiling of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects SHAC expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test’s expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the ceiling for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state’s SHAC spending exceeds the SHAC Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the ceiling to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the SHAC.
- 17.10. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset

by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 13. SHAC Budget Neutrality Test							
MEG	Agg	WOW Only, WW Only, or Both	DY 1	DY 2	DY 3	DY 4	DY 5
HRSN Services	Agg	Both	\$244,242,000	\$514,194,000	\$541,257,000	\$569,744,000	\$599,731,000

- 17.11. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration’s approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 17.12. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 1, 2025 to December 31, 2029. If at the end of the demonstration approval period the Main Budget Neutrality Test or a SHAC Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
- 17.13. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 14. Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

18. MONITORING ALLOTMENT NEUTRALITY

18.1. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.

The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.
- b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.
- c. **Premiums.** Any premium contributions collected under the demonstration must be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.
- d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within

two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

- 18.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state must separately identify estimates of expenditures for each applicable title XXI demonstration population.
- a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 18.3. **Title XXI Administrative Costs.** All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.
- 18.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 4 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.
- a. **Exhaustion of Title XXI Funds for CHIP Population.** If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

19. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 15. Schedule of Deliverables for the Demonstration Period

Date	Deliverable	STC
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after demonstration approval	SMI Implementation Plan (including Health IT Plan)	STC 8.3 (a)
60 calendar days after receipt of CMS comments	Revised SMI Implementation Plan (including Health IT Plan)	STC 8.3 (a)
90 calendar days after demonstration approval	Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services	
9 months after demonstration approval	HRSN Implementation Plan	STC 10.21 (a)
At least 60 days prior to intended implementation	Provider Payment Methodologies for HRSN	
Prior to claiming FFP in DY2 through DY5	Incentive Program Protocol	STC 5.13
150 calendar days after demonstration approval	Monitoring Protocol	STC 14.5
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 14.5
180 calendar days after demonstration approval	Draft Evaluation Design	STC 15.4
60 days after receipt of CMS comments	Revised Evaluation Design	STC 15.5
One and a half years after implementation of the Community Transition In-Reach Services	Rapid Cycle Assessment (Community Transition In-Reach Services)	STC 15.6 (e)
No later than 60 calendar days after three years after the demonstration approval date	SMI Mid-Point Assessment	STC 14.7
60 calendar days after receipt of CMS comments	Revised Mid-Point Assessment	STC 14.7
One year prior to the demonstration expiration date, or with renewal application	Draft Interim Evaluation Report	STC 15.7 (c)
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 15.7 (d)

Table 15. Schedule of Deliverables for the Demonstration Period

Date	Deliverable	STC
Within 18 months after the demonstration expiration date	Draft Summative Evaluation Report	STC 15.8
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 15.8 (a)
Monthly Deliverables	Monitoring Calls	STC 14.9
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4 th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 14.6
	Quarterly Budget Neutrality Report	STCs 14.6 (c)
Annual Deliverables - Due 90 calendar days after end of each 4 th quarter	Annual Monitoring Reports, including Budget Neutrality Report	STC 14.6

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

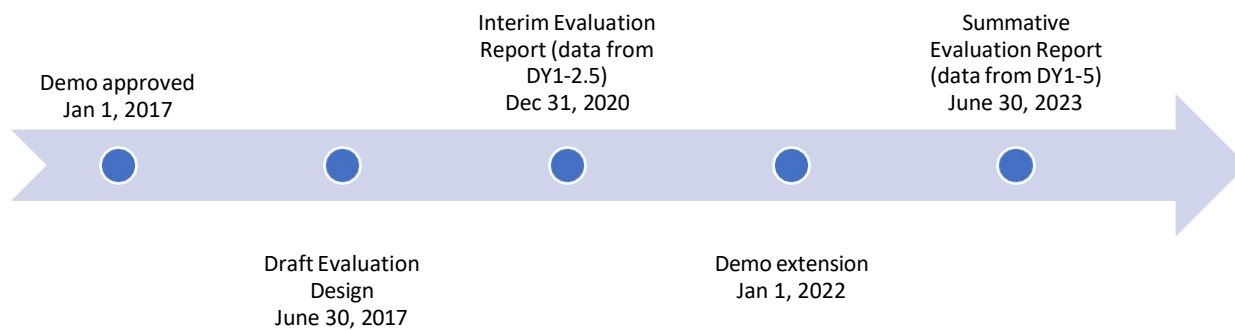
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

- General Background Information
- Evaluation Questions and Hypotheses
- Methodology
- Methodological Limitations
- Attachments

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information. In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
5. Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses. In this section, the state should:

1. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
3. Identify the state's hypotheses about the outcomes of the demonstration:
4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. **Methodology.** In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1. Evaluation Design. Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
2. Target and Comparison Populations. Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. Evaluation Period. Describe the time periods for which data will be included.
4. Evaluation Measures. List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing;

and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
5. Data Sources. Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.
- a. *If primary data (data collected specifically for the evaluation):* The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).
6. Analytic Methods. This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

- c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
7. Other Additions. The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table 16. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome Measures Used to Address the Research Question	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations. This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1. When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS-64 reporting or budget neutrality; and
 - d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments.

1. Independent Evaluator. This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.
2. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
3. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

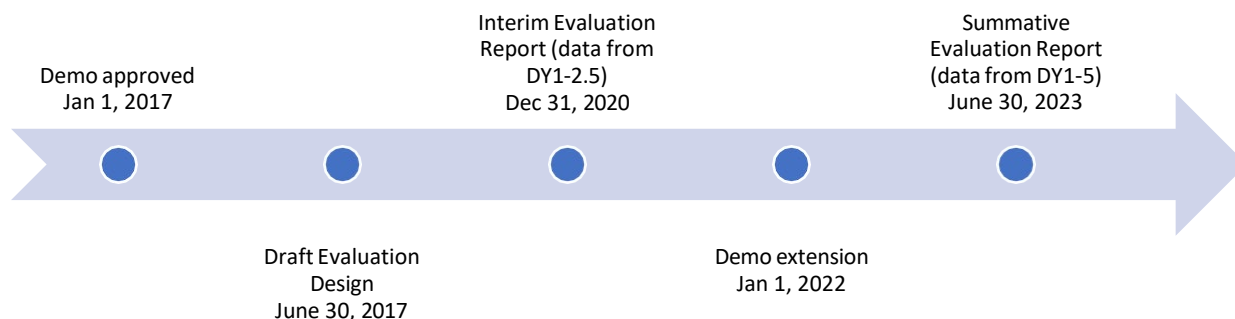
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary
- B. General Background Information
- C. Evaluation Questions and Hypotheses
- D. Methodology
- E. Methodological Limitations
- F. Results
- G. Conclusions
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS, pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

- A. **Executive Summary.** A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. **General Background Information about the Demonstration.** In this section, the state should include basic information about the demonstration, such as:
1. The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
 3. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
 4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
 5. Describe the population groups impacted by the demonstration.
- C. **Evaluation Questions and Hypotheses.** In this section, the state should:
1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
 2. Identify the state's hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

- D. **Methodology.** In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design. Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. Target and Comparison Populations. Describe the target and comparison populations; include inclusion and exclusion criteria.
3. Evaluation Period. Describe the time periods for which data will be collected
4. Evaluation Measures. What measures are used to evaluate the demonstration, and who are the measure stewards?
5. Data Sources. Explain where the data will be obtained, and efforts to validate and clean the data.
6. Analytic Methods. Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. Other Additions. The state may provide any other information pertinent to the evaluation of the demonstration.

- E. **Methodological Limitations.** This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

- F. **Results.** In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration

results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions. In this section, the state will present the conclusions about the evaluation results.

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives. In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations. This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment: Evaluation Design. Provide the CMS-approved Evaluation Design.

ATTACHMENT C

Reserved for Access, Reform and Outcomes Incentive Program Protocol

BH-CONNECT Access, Reform and Outcomes Incentive Program Protocol

State	California
Demonstration Name	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration
Approval Date	January 10, 2025
Approval Period	January 1, 2025 – December 31, 2029
Implementation Date	January 1, 2025

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Section 1. Overview of BH-CONNECT Access, Reforms and Outcomes Incentive Program

One of the key goals of California's BH-CONNECT Section 1115 Demonstration is to improve access and quality for Medi-Cal members living with significant behavioral health needs. To achieve this goal, DHCS will implement the Access, Reforms and Outcomes Incentive Program (hereafter, "Incentive Program"). The Incentive Program will provide performance-based incentives to participating behavioral health plans (BHPs) for demonstrating improvements in access to behavioral health services and outcomes among Medi-Cal members living with significant behavioral health needs.

The Incentive Program is designed to:

- Reward BHPs for improving access to high-quality, timely behavioral health services;
- Support BHPs in establishing coverage of and implementing key evidence-based practices (EBPs) with fidelity;
- Reward improved health outcomes among members living with significant mental health conditions and substance use disorders (SUDs);
- Reduce BHP-specific gaps in behavioral health quality improvement capabilities;
- Support improved integration and care coordination across the behavioral health and managed care delivery systems; and

In accordance with STC 5.1-5.13, this Protocol provides additional detail related to implementation of the Incentive Program beyond what is set forth in the BH-CONNECT Section 1115 Demonstration Special Terms and Conditions (STCs) for Demonstration Approval Period (January 1, 2025 – December 31, 2029). The following sections of this Protocol include information about:

- The three key areas of focus for the Incentive Program: Improved Access to Behavioral Health Services; Improved Health Outcomes and Quality of Life; and Targeted Behavioral Health Delivery System Reforms;
- Specific measures included under each area of focus;
- The methodologies that will be used to identify participating BHPs and allocate available incentive dollars for each participating BHP;
- The parameters that will be used to determine the amount of funding earned by participating BHPs each program year, including high-performance earning opportunities; and
- An accountability framework for the Incentive Program.

Section 2. Incentive Program Areas of Focus

The Incentive Program will include three areas of focus. These areas of focus were identified based on a review of available data on current gaps in California's behavioral health system and barriers faced by Medi-Cal members living with significant behavioral health needs, including from DHCS' comprehensive 2022 assessment of California's behavioral health landscape [Assessing the Continuum of Care for Behavioral Health Services in California](#), current performance on CMS Core Set and other DHCS quality measures, qualitative insights from BHPs, providers, advocates, and other key California stakeholders,

and direction from CMS. Additional information about how each area of focus was determined is available in Appendix 1.

- 1) **Improved Access to Behavioral Health Services:** Participating BHPs may earn performance-based incentive payments related to improved access to behavioral health services, including by improving penetration and retention in behavioral health services; demonstrate timely access to specialty mental health services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services; and increase utilization of specified behavioral health services: Assertive Community Treatment (ACT), Forensic ACT, Coordinated Specialty Care of First Episode Psychosis (CSC for FEP), Supported Employment, Peer Support Specialists, Enhanced Community Health Worker (CHW) Services, Clubhouse Services, Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent Child Interaction Therapy (PCIT), High Fidelity Wraparound (HFW), and Enhanced Care Management (ECM).
- 2) **Improved Health Outcomes and Quality of Life:** Participating BHPs may earn performance-based incentive payments related to improved health outcomes among Medi-Cal members living with significant behavioral health needs, including improved performance on CMS Core Set measures, improved member-reported quality of life, and improved health and wellbeing among members receiving key evidence-based practices (EBPs).
- 3) **Targeted Behavioral Health Delivery System Reforms:** Participating BHPs may earn performance-based incentive payments for reducing BHP-specific gaps in quality improvement capabilities and making other targeted behavioral health delivery system reforms including enhancing data sharing capabilities and improved outreach and engagement to members that meet access criteria for SMHS and DMC-ODS services. County-specific gaps will be informed by an assessment of participating BHPs against key NCQA Managed Behavioral Health Organization (MBHO) accreditation standards.

Goals for Each Area of Focus

Each of the three areas of focus for the Incentive Program supports the overall goals of the BH-CONNECT demonstration and promotes the objectives of the Medicaid program to expand access to care and improve health outcomes for members. In addition, DHCS has identified specific goals related to each key area of focus.

The goals of the “Improved Access to Behavioral Health Services” area of focus are:

- Improving penetration and retention rates in behavioral health services among eligible members and reducing unmet need;
- Improving timely access to specialty behavioral health services after a behavioral health need is identified; and
- Improving utilization of key EBPs that have a robust evidence base for improving health outcomes among members with the greatest need.

The goals of the “Improved Health Outcomes and Quality of Life” area of focus are:

- Improving performance on key behavioral health outcomes measures included in the CMS Core Set;
- Improving member-reported quality of life; and
- Improving outcomes among Medi-Cal members receiving ACT, FACT, CSC for FEP and Supported Employment.

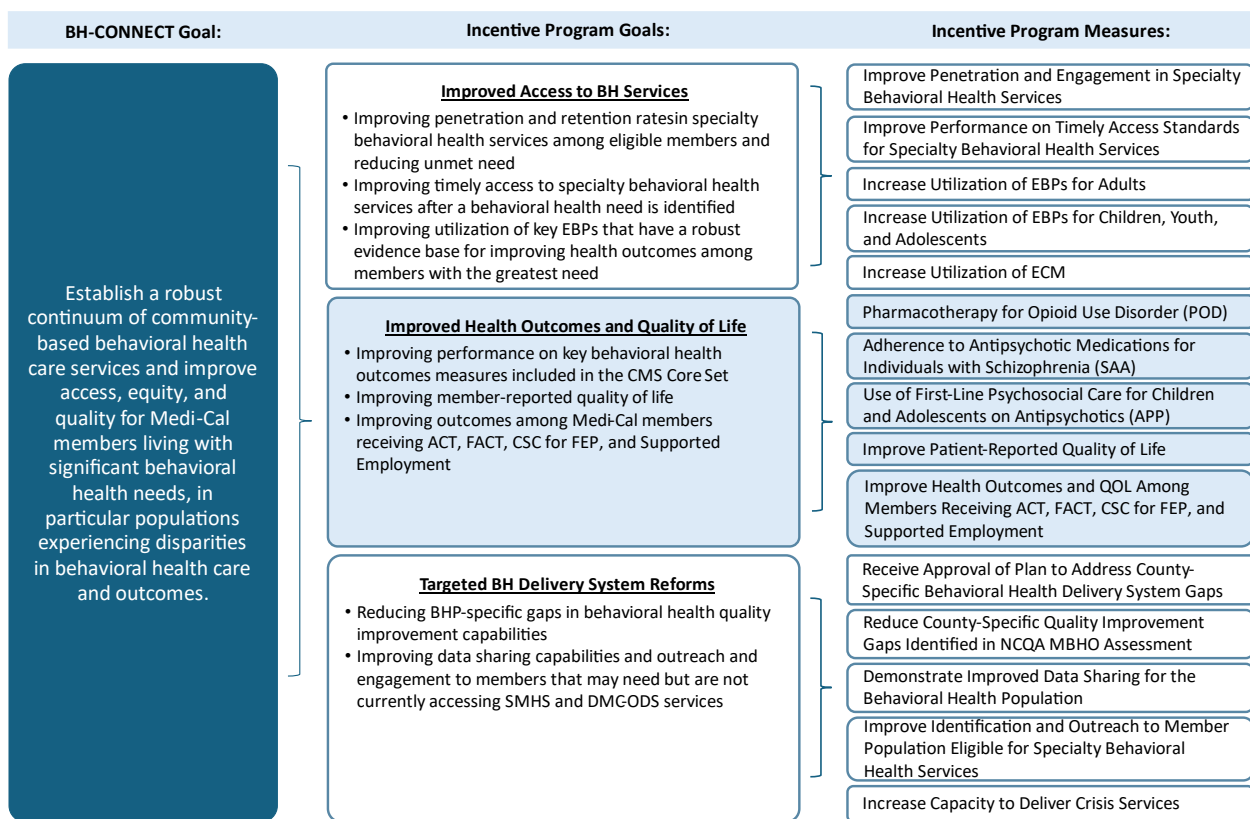
Finally, the goals of “Targeted Behavioral Health Delivery System Reforms” are:

- Reducing BHP-specific gaps in behavioral health quality improvement capabilities; and
- Improving data sharing capabilities and outreach and engagement to members that may need but are not currently accessing SMHS and DMC-ODS services.

Logic Model

The goals for each area of focus identified above informed the identification of specific measures for which BHPs will be eligible to earn incentive payments, as depicted in Figure 1.

Figure 1. Logic Model for BH-CONNECT Incentive Program



Section 3. Measure Details

Requirements for Submission 1

As described in STC 5.12, FFP will be available to DHCS in demonstration year (DY) 1 for incentive payments related to measure 11 of the Incentive Program, *Receive Approval of Plan to Address BHP-Specific Behavioral Health Delivery System Gaps*, shown in Table 1.

Table 1. Summary of Requirements for Measure 11

Measure Name	Requirements for Measure 11	Submission Due
AREA OF FOCUS: Targeted Behavioral Health Delivery System Reforms		
Receive Approval of Plan to Address BHP-Specific Behavioral Health Delivery System Gaps	Complete and timely submission of a report to DHCS describing: 1) BHP-specific gaps related to managed care, quality improvement, care coordination and data sharing capabilities identified as part of self-directed NCQA MBHO assessment; and 2) A plan to reduce the BHP-specific gaps identified as part of the self-directed NCQA MBHO assessment, including timelines and specific actions the BHP will undertake during the demonstration period to improve performance in core MBHO functions and strengthen quality improvement capabilities, including meaningful data exchange.	June 30, 2025

Up to \$50,000,000 total computable will be available for incentive payments to participating BHPs related to this measure in DY 1. DHCS is at risk for all other Incentive Program expenditures until this Incentive Program Protocol is approved.

Measure Details and Reporting Requirements by Demonstration Year

Tables 2 and 3 below include additional details about the full set of Incentive Program measures and performance requirements. Table 2 below outlines the full set of measures for which participating BHPs must meet specified performance requirements to earn incentive payments. Table 2 also specifies which years would be used to collect baseline data (“B”); and which years would be used to provide performance-based incentive payments (“pay-for-performance” or “P”). No incentive payments will be available for reporting of baseline data; incentive payments will be available for demonstrating improved performance only. Table 3 includes additional information about the performance requirements for each measure. Measures were developed with input from stakeholders including BHPs, advocates, providers, and CMS, as well as state and national experts through targeted and public meetings. DHCS will continue stakeholder engagement to support program implementation. Additional information about stakeholder engagement that informed the design of the Incentive Program is available in Appendix 1.

If a measure is retired by a measure steward or is determined to be infeasible, DHCS will replace the impacted measure and share updates with CMS in monitoring reports, so long as the updates do not alter the intention of the measures. If the intention of the measure changes, this protocol will be

updated accordingly. If in a given measurement period a BHP does not meet the minimum denominator or other technical requirements for a measure, the weight attributed to that measure will be apportioned across the other measure(s) in the same area of focus for scoring purposes for that performance period. DHCS will submit summaries of BHP performance to CMS in annual Monitoring Reports. The annual Monitoring Reports will also include information about any mid-course corrections.

To the extent sample sizes are sufficiently large, participating BHPs will be required to stratify data based on the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

Table 2. Measure Details for Participating BHPs

All measures included in Table 2 are calculated on an annual basis at the BHP level. Numerators and denominators refer only to members enrolled in Medi-Cal in the BHP's county.

Measure Name		Measure Description <i>(Numerator and Denominator)</i>	Data Source	Measure Steward	Reporting Type					
					Pre-Demo	DY1	DY2	DY3	DY4	DY5
AREA OF FOCUS: Improved Access to Behavioral Health Services										
1	Improve Penetration and Engagement in Specialty Behavioral Health Services	Penetration in SMHS:** Numerator: Number of members who have one or more claims for SMHS. Denominator: Total number of members enrolled in Medi-Cal.	Claims	CA DHCS	B	P (\$)	P(\$)	P(\$)	P(\$)	P(\$)
	Sub-measures: 4*	Engagement in SMHS: Numerator: Number of members who have five or more claims for SMHS. Denominator: Total number of members enrolled in Medi-Cal.								
		Initiation of SUD Treatment (IET):*** Numerator: New episodes of substance use disorder (SUD) in adults and adolescents 13 years of age and older, after which the individual initiated treatment through an inpatient SUD admission, outpatient visit, telehealth or intensive outpatient encounter or partial hospitalization, or received medication within 14 days of diagnosis. Denominator: New episodes of substance use disorder (SUD) in adults and adolescents 13 years of age and older.		NCQA						
		Engagement in SUD Treatment (IET):*** Numerator: New episodes of substance use disorder (SUD) in adults and adolescents 13 years of age and								

Measure Name		Measure Description (Numerator and Denominator)	Data Source	Measure Steward	Reporting Type					
					Pre-Demo	DY1	DY2	DY3	DY4	DY5
		older, after which the individual initiated treatment and had two or more additional SUD services or medications within 34 days of the initiation visit. Denominator: New episodes of substance use disorder (SUD) in adults and adolescents 13 years of age and older.								
2	Improve Performance on Timely Access Standards for Specialty Behavioral Health Services <i>Sub-measures: 2</i>	Timely Access to SMHS: Numerator: Number of SMHS offered that met timely access standards as defined by appointment wait time standards.¹ Denominator: Total number of SMHS offered. Timely Access to DMC-ODS Services: Numerator: Number of DMC-ODS services offered that met timely access standards as defined by appointment wait time standards.² Denominator: Total number of DMC-ODS services offered.	CA Timely Access Data Tool (TADT)	CA DHCS	B	P(\$)	P(\$)	P(\$)	P(\$)	P(\$)
3	Increase Utilization of EBPs for Adults <i>Sub-measures: 7</i>	EBP Launch (DY1 - DY2): Increase count of adult members who utilized specified EBP (ACT, FACT, CSC for FEP, Supported Employment, Enhanced CHW Services, Peer Support Services, Clubhouse Services) EBP Scaling (DY3 - DY5): Numerator: Number of adult members who utilized specified EBP (ACT, FACT, CSC for FEP, Supported	Claims	CA DHCS	N/A	B	P(\$)	P(\$)	P(\$)	P(\$)

¹ See DHCS' 2024 SMHS timely access standards outlined on page 34 of [BHIN 24-020](#).

² See DHCS' 2024 DMC-ODS timely access standards outlined on page 35 of [BHIN 24-020](#).

Measure Name		Measure Description (Numerator and Denominator)	Data Source	Measure Steward	Reporting Type					
					Pre-Demo	DY1	DY2	DY3	DY4	DY5
		Employment, Enhanced CHW Services, Peer Support Services, Clubhouse Services). Denominator: Total number of adult members who have one or more SMHS claims.								
4	Increase Utilization of EBPs for Children, Youth, and Adolescents Sub-measures: 4	EBP Launch (DY1 – DY 2): Increase count of child/youth members who utilized specified EBP (MST, FFT, PCIT, HFW).	Claims	CA DHCS	N/A	B	P(\$)	P(\$)	P(\$)	P(\$)
		EBP Scaling (DY3 – DY 5): Numerator: Number of child/youth members who utilized specified EBP (MST, FFT, PCIT, HFW). Denominator: Total number of child/youth members who have one or more SMHS claims.								
5	Increase Utilization of Enhanced Care Management (ECM) Sub-measures: 2	ECM Utilization Among Adults: Numerator: Number of adult members who utilized ECM Denominator: Total number of adult members who have one or more SMHS and/or DMC-ODS service claims.	Claims	CA DHCS	B	P(\$)	P(\$)	P(\$)	P(\$)	P(\$)
		ECM Utilization Among Children/Youth: Numerator: Number of child/youth members who utilized ECM. Denominator: Total number of child/youth members who have one or more SMHS and/or DMC-ODS service claims.								
AREA OF FOCUS: Improved Health Outcomes										
6	Pharmacotherapy for Opioid Use Disorder (POD)	Numerator: Number of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a	Claims	NCQA	B	P(\$)	P(\$)	P(\$)	P(\$)	P(\$)

Measure Name		Measure Description (Numerator and Denominator)	Data Source	Measure Steward	Reporting Type					
					Pre-Demo	DY1	DY2	DY3	DY4	DY5
		diagnosis of OUD and a new OUD pharmacotherapy event. • Denominator: Number members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.								
7	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)***	• Numerator: Number of adults aged 18 and older with Schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. • Denominator: Total number of adults aged 18 and older with Schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication.	Claims	NCQA	B	P(\$)	P(\$)	P(\$)	P(\$)	P(\$)
8	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)***	• Numerator: Number of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. • Denominator: Total number of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication.	Claims	NCQA	B	P(\$)	P(\$)	P(\$)	P(\$)	P(\$)
9	Improve Patient-Reported Quality of Life (QOL)	• Numerator: Number of members who reported good QOL. • Denominator: Total number of members who received a QOL assessment.	Survey data	CA DHCS	N/A	N/A	N/A	B	P(\$)	P(\$)
10	Improve Health Outcomes and QOL Among Members	Healthcare Utilization Measures • Decrease count of ED visits among members utilizing specified EBP	Claims, CA Homelessness Integration System (HDIS),	CA DHCS	N/A	N/A	B	P(\$)	P(\$)	P(\$)

Measure Name		Measure Description (Numerator and Denominator)	Data Source	Measure Steward	Reporting Type					
					Pre-Demo	DY1	DY2	DY3	DY4	DY5
	Receiving ACT, FACT, CSC for FEP and Supported Employment <i>Sub-measures: 20</i>	• Decrease count of hospital admissions among members utilizing specified EBP Outcomes Measures • Numerators: Number of: ○ Members utilizing specified EBP experiencing homelessness ○ Members utilizing specified EBP with criminal justice system involvement (ACT, FACT only) ○ Members utilizing specified EBP who are employed or in school (CSC, Supported Employment only) ○ Members utilizing specified EBP with good QOL • Denominator: Total number of members receiving specified EBP	correctional data, survey data collected by providers in partnership with BH-CONNECT Centers of Excellence (COEs)							

Measure Name		DY 1 Measure Description	DY 2-5 Measure Description <i>For each measure and each DY, BHPs must build upon performance from the prior year to be eligible for incentive payments. Specific components may vary by DY.</i>	Submissions Due
AREA OF FOCUS: Targeted Behavioral Health Delivery System Reforms				
11	Receive Approval of Plan to Address County-Specific Behavioral Health	See Table 1 above.	N/A	June 30, 2025

Measure Name		DY 1 Measure Description	DY 2-5 Measure Description <i>For each measure and each DY, BHPs must build upon performance from the prior year to be eligible for incentive payments. Specific components may vary by DY.</i>	Submissions Due
	Delivery System Gaps			
12^	Reduce County-Specific Quality Improvement Gaps Identified in NCQA MBHO Assessment	N/A^^	Submission of a report and data demonstrating: 1. The BHP has completed a re-assessment on the MBHO accreditation standards that have been identified as gaps for that BHP as part of Measure 11 2. The BHP has improved performance on the MBHO accreditation standards identified as gaps for that BHP (partial points may be available if a BHP improves performance on some, but not all, standards it is reassessed on)	June 30, 2026; June 30, 2027; June 30, 2028; June 30, 2029; June 30, 2030
13^	Demonstrate Improved Data Sharing for the Behavioral Health Population ³	Report and documentation describing all of the following: 1. BHP-specific gaps related to data sharing, including identifying: a. Whether or not the BHP is actively participating in a Qualified Health Information Organization (QHIO);	Reports and documentation describing the BHP's progress on addressing data sharing gaps, including all of the following: 1. Active participation in a QHIO, as demonstrated by: a. Being listed on the DxP's Data Sharing Agreement Signatory List; and	June 30, 2026; June 30, 2027; June 30, 2028; June 30, 2029; June 30, 2030

³ A Qualified Health Information Organization (QHIO) facilitates the secure exchange of health and social services information, assisting entities as they create and respond to information requests, receive the results of tests or referrals, and solicit notifications of admissions or discharges. ([Source](#))

Measure Name		DY 1 Measure Description	DY 2-5 Measure Description <i>For each measure and each DY, BHPs must build upon performance from the prior year to be eligible for incentive payments. Specific components may vary by DY.</i>	Submissions Due
		b. If the BHP is a signatory to the California Data Exchange Framework (DxF); and c. If the BHP has implemented consent management tools for data sharing 2. Documentation demonstrating the BHP became a signatory to the DxF 3. Documentation (e.g., transmission logs) demonstrating that the BHP and MCP(s) in the county are able to connect with each other using Fast Healthcare Interoperability Resources (FHIR) APIs on a regular cadence to support care coordination	b. A legal agreement with a QHIO (e.g., signed participation agreement or onboarding agreement) 2. Administrative policies for implementation of the DxF, as demonstrated by policy documents dictating when information must be shared via QHIO, internal educational materials about how to query via QHIO, updated workflow documents, and other materials 3. Implementation and scaling of the use of consent management tools for data sharing 4. Ongoing participation in the DxF, as demonstrated by activities such as: a. The number of Admission, Discharge, and Transfer feed transactions (ADTs) received or exchanged via QHIO each month in the measurement period; b. The number of referrals made and/or received via QHIO; and/or	

Measure Name		DY 1 Measure Description	DY 2-5 Measure Description <i>For each measure and each DY, BHPs must build upon performance from the prior year to be eligible for incentive payments. Specific components may vary by DY.</i>	Submissions Due
			c. The number of queries made via QHIO for Part 2 data sharing	
14^	Improve Identification and Outreach to Member Population Eligible for Specialty Behavioral Health Services	Report and documentation describing all of the following: 1. BHP-specific gaps related to outreach and engagement of Medi-Cal members with behavioral health needs, including identifying: a. How the BHP is currently using local, state and national data sources to identify the population of members that may meet access criteria for but are not currently accessing specialty behavioral health services; and b. Current community engagement strategies to understand barriers in accessing specialty behavioral health services among members 2. Documentation that the BHP has developed a community engagement	Reports and documentation describing the BHP's progress on addressing outreach and engagement gaps, including all of the following: 1. Documentation showing the BHP has improved use of data to identify the eligible member population, including through use of data sets such as: a. National data sets or surveillance reports (e.g., Behavioral Risk Factor Surveillance System, National Health Interview survey, National Survey on Drug Use and Health (NSDUH)); b. State reports (e.g., Homeless Management Information System HMIS), CalFresh (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)), California Department of Public Health (CDPH) overdose data, Rural Indian Health Board Tribal Epidemiology Center data, Medi-Cal Connect);	June 30, 2026; June 30, 2027; June 30, 2028; June 30, 2029; June 30, 2030

Measure Name		DY 1 Measure Description	DY 2-5 Measure Description <i>For each measure and each DY, BHPs must build upon performance from the prior year to be eligible for incentive payments. Specific components may vary by DY.</i>	Submissions Due
		plan and participated in planned 2025 meetings with Local Health Jurisdictions (LHJs), MCPs and/or other community partners 3. Specific activities the BHP will undertake to better use data and deploy culturally and linguistically centered outreach and engagement strategies to better serve the population of Medi-Cal members in their county that would benefit from specialty behavioral health services	c. County or locally generated reports (e.g., claims data, local surveys, MCP data reports/exchange, LHJ data, jail data); d. Methodologies or reports created to identify members eligible but not using specialty behavioral health services 2. Documentation that the BHP has participated in planned meetings with LHJs, MCPs and/or other community partners during measurement period 3. Documentation that the BHP has developed and is utilizing culturally and linguistically centered outreach and engagement strategies for Medi-Cal members with behavioral health needs	
15^	Increase Capacity to Deliver Crisis Services	Report and data (e.g., claims data on utilization, event notifications, certification/licensure) describing all of the following: 1. BHP-specific assessment against state standards of current availability of crisis	Reports and data (e.g., claims data on utilization, event notifications, certification/licensure) describing the BHP's process in building crisis capacity, including all of the following:	June 30, 2026; June 30, 2027; June 30, 2028; June 30, 2029; June 30, 2030

Measure Name	DY 1 Measure Description	DY 2-5 Measure Description <i>For each measure and each DY, BHPs must build upon performance from the prior year to be eligible for incentive payments. Specific components may vary by DY.</i>	Submissions Due
	services across crisis care continuum, such as: a. Mobile crisis services b. Crisis stabilization services c. Crisis residential services d. Urgent behavioral health services e. Coordination/handoffs with 988 and 911 2. Specific activities the BHP will undertake to gather data on: a. Timeliness and access to crisis services b. Coordination of crisis service providers with local law enforcement and other community partners	1. Documentation the BHP is addressing BHP-specific gaps in crisis services across crisis care continuum, such as adding or expanding: a. Mobile crisis services b. Crisis stabilization services c. Crisis residential services d. Urgent behavioral health services e. Coordination/handoffs with 988 and 911 2. Documentation the BHP is collecting, utilizing and sharing data (e.g., development of public dashboard, data sharing to support care coordination) related to timeliness and access to crisis services and coordination of crisis and other community-based services	

*See Section 4 below for additional details on how sub-measures will be accounted for in the Incentive Program scoring methodology.

**For this measure and all subsequent CA DHCS measures, each measurement period will be one calendar year. Additional details are in Table 7 below.

***Included in 2025 CMS [Adult Core Set](#) or [Child Core Set](#).

^The BHP may submit one report each DY that captures the requirements for measures 12-15. DHCS may provide a template for participating BHPs to use for measures 12-15 that ensures each annual submission includes all required details related to each specified delivery system reform, including required data submissions.

^^For measure 12, the DY 1 submission will include the same components as the DY 2-5 submission, as county-specific gaps will have been identified as part of measure 11.

Table 3. Performance Requirements

Measure Name		Performance Requirements
		<i>For each measure, the achievement and/or improvement goal for a BHP will advance each year, such that a BHP may only earn an incentive payment on a measure if they show an improvement from the prior year's performance.</i>
AREA OF FOCUS: Improved Access to Behavioral Health Services		
1	Improve Penetration and Engagement in Specialty Behavioral Health Services	Participating BHPs demonstrate specified achievement and/or improvement towards target penetration/initiation and engagement of members who require specialty behavioral health services in treatment compared to prior measurement period. Incentive payments will reward BHPs that exceed DHCS' performance standards.*
2	Improve Performance on Timely Access Standards for Specialty Behavioral Health Services	Participating BHPs demonstrate specified achievement and/or improvement towards target percentage of SMHS and DMC-ODS services delivered that meet timely access standards as compared to the prior measurement period. Incentive payments will reward BHPs that exceed DHCS' performance standards.
3	Increase Utilization of EBPs for Adults	Participating BHPs demonstrate specified achievement and/or improvement towards target utilization for each of the following EBPs as compared to the prior measurement period: ACT, FACT, CSC for FEP, Supported Employment, Clubhouse Services, Enhanced CHW Services, and Peer Support Services. Benchmarks will be refined based on data from initial DYs, as these are new Medi-Cal services.
4	Increase Utilization of EBPs for Children, Youth and Adolescents	Participating BHPs demonstrate specified achievement and/or improvement towards target utilization for each of the following EBPs as compared to the prior measurement period: MST, FFT, PCIT, and HFW. Benchmarks will be refined based on data from initial DYs, as these are newly clarified Medi-Cal services.
5	Increase Utilization of ECM	Participating BHPs demonstrate specified achievement and/or improvement towards target utilization for ECM as compared to the prior measurement period. Benchmark will be refined based on data from initial DYs, as this data will be newly reported.
AREA OF FOCUS: Improved Health Outcomes and Quality of Life		

Measure Name		Performance Requirements
		<i>For each measure, the achievement and/or improvement goal for a BHP will advance each year, such that a BHP may only earn an incentive payment on a measure if they show an improvement from the prior year's performance.</i>
6	Pharmacotherapy for Opioid Use Disorder (POD)	Participating BHPs demonstrate specified achievement and/or improvement based on benchmarks. Incentive payments will reward BHPs that exceed DHCS' performance standards.
7	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Participating BHPs demonstrate specified achievement and/or improvement based on benchmarks. Incentive payments will reward BHPs that exceed DHCS' performance standards.
8	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Participating BHPs demonstrate specified achievement and/or improvement based on benchmarks. Incentive payments will reward BHPs that exceed DHCS' performance standards.
9	Improve Patient-Reported QOL	Participating BHPs demonstrate specified achievement and/or improvement toward a target of members that report good QOL. Member-reported QOL will be assessed using an evidence-based survey tool selected by DHCS in partnership with the State's technical advisory committee on quality measurement for behavioral health. Benchmarks will be refined based on data from initial DYs, as this data will be newly reported.
10	Improve Health Outcomes and QOL Among Members Receiving ACT, FACT, CSC for FEP, and Supported Employment	Participating BHPs demonstrate specified achievement and/or improvement towards a target for specified outcomes among members participating in ACT, FACT, CSC for FEP, and Supported Employment. Outcomes that will be monitored and reported on include ED utilization, hospital admissions, patient-reported QOL, homelessness, criminal justice system involvement, and work/school involvement. Benchmarks will be refined based on data from initial DYs, as these are new Medi-Cal services, and this data will be newly reported.
AREA OF FOCUS: Targeted Behavioral Health Delivery System Reforms		
11	Receive Approval of Plan to Address County-Specific Behavioral Health Delivery System Gaps	Timely and complete submission of gap-filling plan to DHCS as described in Table 1 above.
12	Reduce County-Specific Quality Improvement Gaps Identified in NCQA MBHO Assessment	Annual reports and data demonstrating progress made against gap-filling plan as described in Table 2 above.

Measure Name		Performance Requirements
		<i>For each measure, the achievement and/or improvement goal for a BHP will advance each year, such that a BHP may only earn an incentive payment on a measure if they show an improvement from the prior year's performance.</i>
13	Demonstrate Improved Data Sharing for the Behavioral Health Population	Annual reports and data demonstrating improved active participation in the DxF as described in Table 2 above. BHPs must build upon performance from the prior year to be eligible
14	Improve Identification and Outreach to Member Population Eligible for Specialty Behavioral Health Services	Annual reports and data demonstrating improved outreach and engagement of the population eligible for specialty behavioral health services as described in Table 2 above.
15	Increase Capacity to Deliver Crisis Services	Annual reports and data demonstrating increased capacity to deliver crisis services as described in Table 2 above.

* For all Incentive Program measures also included in DHCS' [Behavioral Health Accountability Set](#) (BHAS) (IET, POD, SAA, APP), incentive payments will reward BHPs for exceeding the MPL as described in DHCS' [Comprehensive Quality Strategy](#) (CQS).

Section 4. Incentive Program Scoring Methodology

DHCS will hold each participating BHP individually accountable for its performance on the measures described in Table 2 above. Measure-specific performance methodology, including benchmarks, improvement targets, and measure score calculation approach, will be described in detailed technical specifications for the Incentive Program. DHCS will share technical specifications, including performance benchmarks and improvement targets for each measure for the upcoming year, with CMS as part of annual monitoring reports. Technical specifications will also be made available on DHCS' website. They will be updated annually or more frequently as needed to support program implementation.

Performance Benchmarks

DHCS will establish performance benchmarks prior to the start of or during the first pay-for-performance period for each measure, within the following parameters:

- Performance benchmarks for quantitative measures will be set to apply to the full applicable performance period.
- Establishment of performance benchmarks will be informed by inputs such as historical data on BHP performance, contractual requirements, external data/trends, and/or initial baseline and performance data.
 - For any measures with national benchmarks available (e.g., national Medicaid NCQA benchmarks), national benchmarks will be used in BH-CONNECT.

- For any measures for which there are not national benchmarks (for example where DHCS is the measure steward), DHCS will develop benchmarks after baseline data is collected (as described below, baseline data will be collected pre-demonstration wherever possible, or will be collected during initial program years).
- Performance benchmarks may differ by measure based on factors such as performance trends or type of measure.
- Performance benchmarks may include year-over-year self-improvement, gap closure to a defined achievement threshold, achievement compared to a benchmark, absolute percentage point increases, and/or timely and complete submission of reports, as outlined in Table 3 above.

DHCS may revisit performance requirements and refine performance benchmarks after initial baseline and performance data is available.

Scoring Methodology

Each Incentive Program measure will be calculated and scored based on the following factors:

- **Baseline periods.** Wherever possible, baseline data will be collected pre-demonstration. For new measures on which data is not currently collected (e.g., utilization of new Medi-Cal EBP), baseline data will be collected during initial DYs, as indicated in Table 2 above. Subsequent DYs will be used to track improved performance over baseline. Incentive Program funding will not be available to participating BHPs for reporting of baseline data; funding will only be available for demonstrating improved performance.
- **Trending breaks.** When a trending break is identified for any measure calculated in the prior year, baseline data will be re-calculated using specifications for the new measurement period. Calculating two versions of the data, as per the applicable DHCS trending break policy, will account for trending breaks and enable comparison of achievement rates. This may occur if a more reliable data source becomes available or any other changes to measure specifications are needed between two measurement periods, requiring a modification to the following period's performance benchmark.
- **Scoring methodology for pay-for-performance periods.**
 - For each measure, the BHP must meet each of the following gating criteria in order to be eligible to earn an incentive payment:
 - **Contractually required performance.** DHCS maintains contractually required minimum expectations for specific HEDIS measures included in BHAS; BHPs must meet minimum performance levels (MPLs) for these BHAS measures (currently the national NCQA Medicaid 50th percentile). All HEDIS measures in BH-CONNECT are also in BHAS; BHPs will not receive an incentive payment for a HEDIS measure if the MPL is not met.
 - **Improvement compared to prior measurement period.** BHPs will not receive an incentive payment for a given measure if they do not demonstrate statistically significant improvement for that measure compared to their performance in the prior measurement period. Where measure denominators are small enough that

- a statistically significant improvement would be an unreasonable threshold to achieve, DHCS will develop an alternative threshold to define improvement.
- For pay-for-performance periods, measure scoring will include the following components for each measure:
 - One or both of the following:
 1. **Improvement.** BHPs may be incentivized to demonstrate improvement over their performance in the prior measurement period, as outlined in Table 3. For example, BHPs may be incentivized on gap closure toward a defined high-performance benchmark (as described under the *Performance Benchmarks* section). High-performance benchmarks must be substantially above any contractually required performance levels (for example, meeting the 50th percentile NCQA Medicaid HEDIS benchmarks under BHAS). In cases where no benchmarks are yet available (for example, initial years for DHCS stewarded measures), improvement scoring may be based on any statistically significant improvement compared to the prior measurement period. Where measure denominators are small enough that a statistically significant improvement would be an unreasonable threshold to achieve, DHCS will develop an alternative threshold to define improvement.
 2. **Achievement.** For measures where a benchmark can be set (as described under the *Performance Benchmarks* section), incentive payments may reward BHPs that meet or exceed specific benchmarks.
 - **High-performance pool (HPP).** For some measures, BHPs may earn additional incentive funding for meeting improvement and/or achievement above and beyond the performance requirements established by individual Incentive Program measures, as described in Section 6 below.
 - **Scoring methodology.** Performance scores for each measure will be defined as a ratio between 0 and 1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum points that may be earned by each participating BHP for each measure are in Table 4 below. The score will be calculated as follows: Performance measure score = Points earned for each measure / Maximum number of points allowable for the measure.
 - Some measures have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows: Performance measure score = Sum of each (Sub-measure score X Sub-measure weighting). For each measure, any sub-measures will be equally weighted.

- The value of each point is consistent across each measure and each DY. The total number of points that may be earned by a participating BHP over all 5 DYs is 1,900 points.
- For each DY, each participating BHP is able to earn a maximum number of points based on which measures are available for P4P funding that year. The sum of the points earned by the participating BHP in a DY will be used to determine the amount of funding earned by the BHP in that year. For example, if a BHP earned 105 of the 210 points available in DY 1, they would earn 50% of their county-specific allocation for DY 1, or 5.5% of their total county-specific allocation over the five-year period. The methodology used to determine county-specific funding allocations is described in Section 6 below.

Table 4. Maximum Points by Measure and DY

	Measure Name	DY 1	DY 2	DY 3	DY 4	DY 5	Total
AREA OF FOCUS: Improved Access to Behavioral Health Services							
1	Improve Penetration and Engagement in Specialty Behavioral Health Services	24	24	24	24	24	120
2	Improve Performance on Timely Access Standards for Specialty Behavioral Health Services	24	24	24	24	24	120
3	Increase Utilization of EBPs for Adults	0	87.5	87.5	87.5	87.5	350
4	Increase Utilization of EBPs for Children, Youth and Adolescents	0	37.5	37.5	62.5	62.5	200
5	Increase Utilization of ECM	12	12	12	12	12	60
AREA OF FOCUS: Improved Health Outcomes and Quality of Life							
6	Pharmacotherapy for Opioid Use Disorder (POD)	20	20	20	20	20	100
7	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	20	20	20	20	20	100
8	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	20	20	20	20	20	100
9	Improve Patient-Reported QOL	0	0	0	25	25	50
10	Improve Health Outcomes and QOL Among Members Receiving ACT, FACT, CSC for FEP, and Supported Employment	0	0	100	175	175	450
AREA OF FOCUS: Targeted Behavioral Health Delivery System Reforms							

	Measure Name	DY 1	DY 2	DY 3	DY 4	DY 5	Total
11	Receive Approval of Plan to Address County-Specific Behavioral Health Delivery System Gaps	50	0	0	0	0	50
12	Reduce County-Specific Quality Improvement Gaps Identified in NCQA MBHO Assessment	10	10	10	10	10	50
13	Demonstrate Improved Data Sharing for the Behavioral Health Population	10	10	10	10	10	50
14	Improve Identification and Outreach to Member Population Eligible for Specialty Behavioral Health Services	10	10	10	10	10	50
15	Increase Capacity to Deliver Crisis Services	10	10	10	10	10	50
	Total	210	285	385	510	510	1,900

Section 5. BHP Participation Requirements

The Incentive Program will be implemented as a pilot among BHPs in up to 80% of California counties. To be eligible to participate and earn incentive payments, a BHP must:

- 1) Receive DHCS approval of a letter attesting to the BHP's need for funding to improve performance on the access, outcomes, and delivery system reform measures included in the Incentive Program; and
- 2) Complete a self-directed assessment on NCQA's MBHO standards related to managed care, quality improvement, and care coordination capabilities by October 31, 2024.

In addition, to be eligible to earn incentive payments related to utilization of and outcomes for specified EBPs, a BHP must meet requirements 1) and 2) above and cover and implement one or more of the following services, as specified by DHCS:

- ACT;
- FACT;
- CSC for FEP;
- Supported Employment;
- Clubhouse Services;
- Enhanced Community Health Worker Services; and/or
- Peer Support Services, including a forensic specialization.

BHPs that choose not to implement one or more specified EBPs cannot earn incentive dollars for measures related to those EBPs until they are covered and implemented. As described in Section 7

below, unearned incentive dollars will be moved to a High-Performance Pool (HPP). Incentive dollars that remain unearned in the HPP each DY will be forfeited.

Meeting the Incentive Program participation requirements does not guarantee a BHP will earn incentive payments.

Section 6. Incentive Program Funding Methodology

Funding by Demonstration Year and Measure Area

The BH-CONNECT STCs authorize \$1.9 billion total computable for the Incentive Program. Table 5 shows the maximum amount of incentive dollars that may be earned by participating BHPs in each DY by area of focus. Table 6 shows the weighting of incentive dollars by DY within each area of focus. Additional details about Program Accountability to CMS are in Section 8 below.

Table 5. Incentive Program Funding by DY and Area of Focus (\$ in thousands)

Each DY represents one measurement period in which incentive payments may be earned by participating BHPs.

Year	DY 1	DY 2	DY 3	DY 4	DY 5
Maximum Incentive Program Funding	\$210,000	\$285,000	\$385,000	\$510,000	\$510,000
Program Accountability Percent	0%	0%	5%	10%	20%
Program Accountability Dollars	N/A	N/A	\$19,250	\$51,000	\$102,000
Maximum Funds Net Program Accountability	\$210,000	\$285,000	\$365,750	\$459,000	\$408,000
Improved Access to Behavioral Health Services	\$60,000	\$185,000	\$176,338	\$187,050	\$164,100
Improved Health Outcomes and Quality of Life	\$60,000	\$60,000	\$151,915	\$238,580	\$217,160
Targeted Behavioral Health Delivery System Reforms	\$90,000	\$40,000	\$37,498	\$33,370	\$26,740

As described in Section 3 above, up to \$50,000,000 total computable will be available for incentive payments related to Submission 1 (measure 11). DHCS is at risk for all other Incentive Program

expenditures until this Incentive Program Protocol is approved. See additional details regarding the submission and payment timeline for the Incentive Program in Table 7.

Table 6. Measure Weights as Proportion of Annual Expenditures and of Total Expenditures

Year		% by DY					% of
		DY 1	DY 2	DY 3	DY 4	DY 5	Total*
AREA OF FOCUS: Improved Access to Behavioral Health Services							
1	Improve Penetration and Engagement in Specialty Behavioral Health Services	11.4%	8.4%	6.2%	4.7%	4.7%	6.3%
2	Improve Performance on Timely Access Standards for Specialty Behavioral Health Services	11.4%	8.4%	6.2%	4.7%	4.7%	6.3%
3	Increase Utilization of EBPs for Adults	0.0%	30.7%	22.7%	17.2%	17.2%	18.4%
4	Increase Utilization of EBPs for Children, Youth and Adolescents	0.0%	13.2%	9.7%	12.3%	12.3%	10.5%
5	Increase Utilization of ECM	5.7%	4.2%	3.1%	2.4%	2.4%	3.2%
Subtotal		28.5%	64.9%	47.9%	41.3%	41.3%	44.7%
AREA OF FOCUS: Improved Health Outcomes and Quality of Life							
6	Pharmacotherapy for Opioid Use Disorder (POD)	9.5%	7.0%	5.2%	3.9%	3.9%	5.3%
7	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	9.5%	7.0%	5.2%	3.9%	3.9%	5.3%
8	Use of First-Line Psychosocial Care for Children and	9.5%	7.0%	5.2%	3.9%	3.9%	5.3%

Year		% by DY					% of Total*
		DY 1	DY 2	DY 3	DY 4	DY 5	
	Adolescents on Antipsychotics (APP)						
9	Improve Patient-Reported QOL	0.0%	0.0%	0.0%	4.9%	4.9%	2.6%
10	Improve Health Outcomes and QOL Among Members Receiving ACT, FACT, CSC for FEP and Supported Employment	0.0%	0.0%	26.0%	34.3%	34.3%	23.7%
Subtotal		28.5%	21.0%	41.6%	50.9%	50.9%	42.1%
AREA OF FOCUS: Targeted Behavioral Health Delivery System Reforms							
11	Receive Approval of Plan to Address County-Specific Behavioral Health Delivery System Gaps	23.8%	0.0%	0.0%	0.0%	0.0%	2.6%
12	Reduce BHP-Specific Quality Improvement Gaps Identified in NCQA MBHO Assessment	4.8%	3.5%	2.6%	2.0%	2.0%	2.6%
13	Demonstrate Improved Data Sharing for the Behavioral Health Population	4.8%	3.5%	2.6%	2.0%	2.0%	2.6%
14	Improve Identification and Outreach to Member Population Eligible for Specialty Behavioral Health Services	4.8%	3.5%	2.6%	2.0%	2.0%	2.6%

Year		% by DY					% of Total*
		DY 1	DY 2	DY 3	DY 4	DY 5	
15	Increase Capacity to Deliver Crisis Services	4.8%	3.5%	2.6%	2.0%	2.0%	2.6%
Subtotal		43.0%	14.0%	10.4%	8.0%	8.0%	13.2%
Total		100%	100%	100%	100%	100%	100%

*Percentages may not sum due to rounding.

County-Specific Allocation of Incentive Program Funding

Given the heterogeneity of California counties in terms of size, geography, and Medi-Cal membership, each participating BHP will be eligible to earn up to a capped amount of Incentive Program funding each DY based on a county-specific allocation.

Each participating BHP will be eligible to earn a minimum of \$2.5 million over the demonstration period based upon achievement of specified performance targets. County-specific allocations for participating BHPs will be calculated based on total Medi-Cal member enrollment in the county and adjusted on a linear scale with the greatest percentage adjustments for counties with lower Medi-Cal enrollment and smaller adjustments for counties with higher Medi-Cal enrollment. The BHP with the largest total Medi-Cal member enrollment will be scaled at 100% of its enrollment, while BHPs with smaller enrollments will be scaled at progressively higher percentages, to a maximum no higher than 300%.⁴ DHCS will also adjust allocations based on BHPs' scores on the Healthy Places Index (HPI), CDC Social Vulnerability Index, or another similar resource. The specific allocation for each participating BHP will be determined based on the total number of BHPs participating in the Incentive Program and will be shared with CMS as part of annual Monitoring Reports.

Submission and Payment Timeline

To earn Incentive Program funding up to a BHP's total allocated amount each DY, participating BHPs must demonstrate they are meeting specified performance requirements consistent with the timeline in Table 7 below. DHCS will review each submission and determine whether the BHP is meeting performance requirements for that measurement period and is eligible for incentive payments related to that measurement period. DHCS may request additional information from BHPs related to their submission as needed. DHCS also has the discretion to remove a BHP from the Incentive Program due to poor performance or non-compliance with program requirements.

Table 7. Submission and Payment Timeline

⁴ For example, if the smallest county by member enrollment would be allocated \$100 without scaling, it would be allocated up to three times as much (up to \$300) with scaling. Each county with a successively larger enrollment would have its allocation scaled at a successively smaller percentage between 300% and 100%, down to the largest county, which would have no change in its allocation based on scaling. *Note: All figures cited in this example are hypothetical and for demonstration purposes only.*

Year	Submission	Measurement Period	Submission Due	Payment Issued
DY 1	Submission 1	January 1 – December 31, 2024 (NCQA MBHO Assessment completed pre-demonstration)	June 30, 2025	November 30, 2025
	Submission 2	January 1 – December 31, 2025	June 30, 2026	November 30, 2026
DY 2	Submission 3	January 1 – December 31, 2026	June 30, 2027	November 30, 2027
DY 3	Submission 4	January 1 – December 31, 2027	June 30, 2028	November 30, 2028
DY 4	Submission 5	January 1 – December 31, 2028	June 30, 2029	November 30, 2029
DY 5	Submission 6	January 1 – December 31, 2029	June 30, 2030	November 30, 2030

Section 7. High-Performance Pool

The Incentive Program will include a HPP to reward BHPs that meet standards above and beyond expectations in the base Incentive Program. Each year, the HPP will be funded using any unearned incentive payments from the previous year.

HPP funding will be available for the measures in Table 8. HPP measures were identified based on a review of the measures included in the three Incentive Program areas of focus described in Table 2 above; Table 2 includes more detailed specifications of each measure included in the HPP. To the extent that sample sizes are sufficiently large, DHCS may focus each measure on certain stratified sub-populations to address health disparities. DHCS will review data stratified by key demographic, language and/or geographic factors and use those data to identify disparities among specific sub-populations (e.g., rural populations). DHCS may then incentivize improvements toward or achievement of set performance benchmarks by sub-population, with one of the following tied to payment:

- Performance for a limited set of sub-populations; or
- Every sub-population separately measured and then aggregated for overall performance on the measure (to ensure the BHP is incentivized to work with smaller denominator sub-populations).

DHCS may also recalibrate the HPP based on need, including adding up to 3 measures to the HPP from the full Incentive Program measure set. For example, if BHPs are routinely earning the maximum available incentive payments on a particular measure included in the HPP measure set, DHCS might remove that measure from the HPP and add another measure from the full Incentive Program measure set where the opportunity for BHPs to improve performance is greater.

Table 8. Measures Included in HPP

HPP Measure	
1	Improve Penetration and Engagement in Specialty Behavioral Health Services
2	Improve Performance on Timely Access Standards for Specialty Behavioral Health Services
3	Increase Utilization of EBPs for Adults
4	Increase Utilization of EBPs for Children, Youth and Adolescents
5	Utilization of Enhanced Care Management (ECM)
6	Pharmacotherapy for Opioid Use Disorder (POD)
7	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
8	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Eligibility for HPP Funding

To be eligible to earn any HPP funding for a specific DY, BHPs must demonstrate in that DY they had statistically significant increase in half or more of the Incentive Program measures included in the HPP. Where measure denominators are small enough that a statistically significant improvement would be an unreasonable threshold to achieve, DHCS will develop an alternative threshold to define improvement. In addition, to be eligible for HPP payments related to measure 3, *Increase Utilization of EBPs for Adults*, the BHP must cover and implement all of the following services:⁵

- ACT;
- FACT;
- CSC for FEP;
- Supported Employment;
- Enhanced Community Health Worker Services; and
- Peer Support Services, including with a forensic specialization.

HPP Performance Benchmarks and Scoring Methodology

Performance benchmarks for HPP measures will be set and HPP measures will be calculated and scored using the methodology described in Section 4 above. DHCS will establish performance benchmarks for each HPP measure prior to the start of or during the first pay-for-performance period for each measure.

Participating BHPs will be eligible for HPP payments by demonstrating:

- **Improvement** (e.g., gap closure toward a set benchmark) over performance in the prior measurement; and/or
- **Achievement** of specific benchmarks.

⁵ Consistent with the opportunity for BHPs to be eligible for federal financial participation (FFP) for short-term stays in Institutions for Mental Diseases (IMDs), BHPs must implement EBPs on a phased timeline specified by DHCS.

In the HPP, performance targets for each measure will either exceed performance targets established for base Incentive Program measures, or be more granular performance targets for specific sub-populations. Each measure in the HPP will be equally weighted each DY. However, for each measure in the HPP, performance targets will be tiered such that the better the BHP does, the more HPP payment the BHP earns. For example, for improvement methodology, if maximum points are awarded in the base Incentive Program for 20% gap closure to a 90th percentile benchmark, then the HPP might be awarded tiered points on the same metric for 25%, 30%, 35% and 40% gap closure. For achievement methodology, if maximum points are awarded in the base Incentive Program for reaching the 75th percentile, then points could be awarded at 80th, 85th, and 90th percentiles.

Each measure in the HPP will be independently evaluated and scored. For example, a BHP might not qualify for HPP payment on 7 of the 8 measures in the HPP; however, if they meet HPP eligibility criteria and reach HPP performance targets for one measure, then the BHP can earn payment for that single measure.

HPP Funding Allocations

The specific amount of HPP funding available for each participating BHP will be based on:

- The total amount of unearned Incentive Program funds that make up the HPP each year;
- The number of BHPs that meet HPP performance targets in a specified measurement period; and
- The BHP's respective performance on each of the eight measures included in the HPP in the specified measurement period.

Section 8. Program Accountability to CMS

As outlined in STC X.11, a share of total Incentive Program funding will be at risk if the state fails to demonstrate sufficient progress on a program accountability score based on the components identified in Table 9 below. DHCS is accountable for its performance across all three Incentive Program areas of focus, reflected by inclusion of one measure from each of the three areas of focus in the program accountability score.

Table 9. Components of the Program Accountability Score

Area of Focus	Score Weight	Component of Program Accountability Score
Improved Access to Behavioral Health Services	45%	Improve Penetration in SMHS • Number of adult members who had one or more claims for SMHS out of the total number of adult members enrolled in Medi-Cal. • Number of child/youth members who had one or more claims for SMHS out of the total number of child/youth members enrolled in Medi-Cal.

Area of Focus	Score Weight	Component of Program Accountability Score
Improved Health Outcomes and Quality of Life	42%	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) (CMS Core Set specification, CMIT #18^c) Number of adults aged 18 and older with Schizophrenia or schizoaffective disorder who remained on an antipsychotic medication for at least 80 percent of their treatment period out of the total number who were dispensed an antipsychotic medication.
Targeted Behavioral Health Delivery System Reforms	13%	Demonstrate Improved Data Sharing for the Behavioral Health Population Number of data transactions processed demonstrating ongoing participation in the California Data Exchange Framework.

Each component of the program accountability score will be assigned a weight for each DY as indicated in Table 9 above, such that the sum of the weights is 100% each DY. Performance on each component will be multiplied by the associated weight, and then summed together to create an aggregate score, namely the State's Program Accountability Score. The State will report its Program Accountability Score, as well as its metric calculations, to CMS via the monitoring reports once it is available, unless otherwise agreed upon by CMS and the state. The score will then be used by the State and CMS to determine whether the expenditure authority for the Incentive Program will be reduced.

Table 10. Proportion of Incentive Program Funding At-Risk by DY

	DY 1	DY 2	DY 3	DY 4	DY 5
Accountability Distribution	0%	0%	5%	10%	20%

Table 11. Incentive Program Funding At-Risk by DY and Area of Focus (\$ in thousands)

Year	DY 1	DY 2	DY 3	DY 4	DY 5	Total
% Funding at Risk	0%	0%	5%	10%	20%	
Improved Access to Behavioral Health Services (45%)	\$0	\$0	\$8,663	\$22,950	\$45,900	\$77,513

Year	DY 1	DY 2	DY 3	DY 4	DY 5	Total
% Funding at Risk	0%	0%	5%	10%	20%	
Improved Health Outcomes and Quality of Life (42%)	\$0	\$0	\$8,085	\$21,420	\$42,840	\$72,345
Targeted Behavioral Health Delivery System Reforms (13%)	\$0	\$0	\$2,503	\$6,630	\$13,260	\$22,393
Total	\$0	\$0	\$19,251	\$51,000	\$102,000	\$172,250

Areas of focus will have specific gap closure goals to retain at-risk funding by DY. For each area of focus in each individual DY, if 100% of the goal is met then 100% of the funding will be retained. If 75% to 99% of the goal is met, then 75% of the funding will be retained. If 50% to 74% of the goal is met, then 50% of the funding will be retained. If 25% to 49% of the goal is met, then 25% of the funding will be retained. If less than 25% of the goal is met, then no funding will be retained. All retained funding for a focus area will be allocated to the BHPs for the associated focus area through the methodology established above. Each DY will be calculated independent of the prior year outcomes.

Table 12. Incentive Program Funding At-Risk by Benchmarks⁶

Measure	DY	Goal
Improve Penetration in SMHS [^]	1	Measurement of Baseline for adults and for children and youth
	2	Performance reflecting gap closure of at least 10% performance from DY1 Baselines to a penetration target of 4.6% for adults and 5.24% for children and youth
	3*	Performance reflecting at least 35% improvement compared from DY1 Baselines to a penetration target of 4.6% for adults and 5.24% for children and youth

⁶ Benchmarks may differ between the base incentive program and program accountability measures. In the base incentive program, the specific performance targets may vary by individual BHP based on their current performance (for improvement methodology, which may use gap closure). For the program accountability measures, performance targets are set based on current statewide performance.

Measure	DY	Goal
	4*	Performance reflecting at least 65% improvement compared from DY1 Baselines to a penetration target of 4.6% for adults and 5.24% for children and youth
	5*	Performance at level at or above a penetration target of 4.6% for adults and 5.24% for children and youth
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS Core Set specification)	1	Measurement of Baseline
	2	Performance reflecting $\geq 5\%$ gap closure between DY1 performance and national Medicaid 90 th percentile performance during DY1
	3*	Performance reflecting $\geq 10\%$ gap closure between DY1 performance and national Medicaid 90 th percentile performance during DY1
	4*	Performance reflecting $\geq 15\%$ gap closure between DY1 performance and national Medicaid 90 th percentile performance during DY1
	5*	Performance reflecting $\geq 20\%$ gap closure between DY1 performance and national Medicaid 90 th percentile performance during DY1
Demonstrate Improved Data Sharing for the Behavioral Health Population	1	Measurement of Baseline
	2	Performance at reflecting $\geq 5\%$ increase compared to DY1 performance
	3*	Performance at reflecting $\geq 10\%$ increase compared to DY1 performance
	4*	Performance at reflecting $\geq 15\%$ increase compared to DY1 performance
	5*	Performance at reflecting $\geq 20\%$ increase compared to DY1 performance

^The state may revise these targets based on baseline data and/or in the event that the penetration targets are achieved prior to DY5. Updates will be shared with CMS via monitoring reports.

*Only DY3 to DY5 are at-risk for program accountability. DY1 and DY2 are not at-risk for program accountability. The goals for DY 1 and DY 2 listed in Table 12 will not impact Incentive Program funding but will be used to ensure participating BHPs are equipped to meet the goals for DY 3-5.

Appendix 1. Data Informing Incentive Program Goals and Measures

DHCS' approach to the Access, Outcomes, and Reforms Performance-Based Incentive Program was informed by available data on current gaps in California's behavioral health system and barriers faced by Medi-Cal members living with significant behavioral health needs, including from:

- DHCS' comprehensive 2022 assessment of California's behavioral health landscape [Assessing the Continuum of Care for Behavioral Health Services in California](#);
- Current performance on CMS Core Set and other DHCS quality measures, including measures included in the CMS Core Set; DHCS' [Behavioral Health Accountability Set](#) (BHAS) and DHCS' [Comprehensive Quality Strategy](#) (CQS); and standards for timely access to behavioral health services (BHIN [24-020](#));
- Preliminary results from the self-directed county assessment on NCQA's MBHO standards;
- Direction from CMS on designing a measure set that is consistent with national and state priorities to strengthen behavioral health;
- Qualitative insights from county partners and other key California stakeholders, including 12 interviews with national and state experts on EBP implementation and outcomes measurement and QOL and 12 meetings with the [CalAIM Behavioral Health Workgroup](#) and [Behavioral Health Stakeholder Advisory Committee](#); and
- Landscape research on behavioral health quality measurement, including available research from the Agency for Healthcare Research and Quality (AHRQ) on quality metrics for individuals with serious mental illness and existing scales for QOL (e.g., Brief Inventory of Loneliness (BIT), UCLA Loneliness Scale)

To identify specific Incentive Program measures and performance requirements, DHCS also reviewed key data on current BHP performance in the three areas of focus, including:

- **Preliminary findings from the assessment on NCQA's MBHO standards.** Initial findings from NCQA indicate that BHPs demonstrate the greatest areas for improvement related to:
 - Use of population-based quality measures to assess retention and engagement as well as barriers to treatment for their eligible populations;
 - Coordination of behavioral healthcare services;
 - Collaboration between behavioral healthcare and medical care;
 - Data collection, analysis, and integration, including to improve care coordination; and
 - Performance monitoring, reporting, and improvement on behavioral health quality measures, including CMS Core Set measures such as IET and SAA.
- **DHCS' Behavioral Health Accountability Set (BHAS) measures.** Current performance data indicates that BHPs demonstrate room for improvement across BHAS measures, including related to continuity of care for individuals with SMI and SUD (e.g., POD and SAA) and effective use of psychosocial interventions for children and adolescents (e.g., APP).
- **DHCS timely access standards.** Current timely access data indicates that BHPs show opportunities to improve both data completeness and performance regarding DHCS' timely access standards, across both urgent and non-urgent SMHS and DMC-ODS services.

DHCS will continue to monitor available data and research and engage with state and national stakeholders on an ongoing basis through Incentive Program implementation and use those findings to adjust the approach to measures and performance requirements, as needed.

Evaluation of Incentive Program

As outlined in STC 15, DHCS will contract with an independent evaluator to conduct a critical and thorough evaluation of the BH-CONNECT demonstration in its entirety. DHCS will ensure that the final evaluation plan for the BH-CONNECT demonstration includes key metrics to evaluate the success of the Incentive Program.

Convenings to Share Best Practices for Participating BHPs

To support participating BHPs in meeting performance requirements and earning incentive payments, DHCS will facilitate regular convenings between participating BHPs and relevant stakeholders, as appropriate, to share best practices and discuss challenges related to Incentive Program participation. Convenings will address topics such as strategies for implementing and increasing utilization of new Medi-Cal services; ensuring improved QOL of members; and achieving key behavioral health delivery system reforms. DHCS will utilize existing platforms to convene BHPs, including quarterly meetings of county behavioral health Directors and CalAIM behavioral health workgroup meetings. DHCS may also schedule additional ad-hoc learning sessions as needed to meaningfully share best practices and address Incentive Program challenges.

ATTACHMENT D
SMI Implementation Plan and Financing Plan

State	California
Demonstration Name	The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration
Approval date	
Approval period	January 1, 2025 – December 31, 2029
Implementation date	January 1, 2025

Pleases see below for contact information for the State’s point of contact for this demonstration implementation plan:

Name and Title: Tyler Sadwith, State Medicaid Director, Department of Health Care Services

Telephone Number:

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

Introductory Note:

The Department of Health Care Services (DHCS) issues [behavioral health information notices](#) (BHINs) to provide guidance about and interpretation of changes in policy or procedures that impact specialty behavioral health delivery systems. Specialty behavioral health delivery systems include county mental health plans (MHPs) and Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS) counties. Specialty behavioral health delivery systems are required to implement mechanisms to assure compliance in accordance with BHINs. Pursuant to the State's Welfare and Institutions section 14184.102, subdivision (d), DHCS has authority to implement through BHINs the CalAIM Act (Article 5.51) and CalAIM terms and conditions, as defined, without issuing formal regulations. The CalAIM Act encompasses the BH-CONNECT demonstration, making it possible to use BHINs as authoritative guidance that imposes official, enforceable requirements on behavioral health plans (BHPs)¹ as a formal regulation would do. In the future, DHCS may also issue formal regulations to complement guidance issued via a BHIN related to the milestones in this plan. Although they are not formal regulations, BHINs are developed through an intensive process in which DHCS crafts policy with review by multiple internal state agencies and divisions, including our Office of Legal Services, among others, and then issues a draft of the BHIN for public comment. After receiving public comment, DHCS reviews and revises the policy as needed and re-issues the BHIN. If there are significant comments, DHCS may choose to issue an updated draft of a BHIN for further public comment prior to finalization.

DHCS maintains a multifaceted system to ensure oversight and accountability to licensing requirements, contractual requirements and regulations set forth in BHINs, which is deployed to monitor all aspects of compliance. All requirements set forth in certification or licensing, including in statute, regulations, and BHINs, are monitored by the Licensing and Certification Division. Elements set forth within BHP contracts, statute, regulations, and BHINs are monitored by the Medi-Cal Behavioral Health Oversight and Monitoring Division. These bodies collect, track and validate requirements according to existing protocols, provide technical assistance as needed, and issue Corrective Action Plans and/or sanctions. In other words, when this implementation plan references BHINs as the vehicle for implementing policy and procedural changes, it means that the full oversight and enforcement authority used by DHCS to officially set forth requirements for BHPs and licensed or certified providers, and oversee and enforce compliance with those requirements, will be utilized to ensure those changes are implemented and complied with. In addition, DHCS will require any BHP that wants to opt into receiving Federal Financial Participation (FFP) for qualified stays in qualified Institution for Mental Disease (IMD) settings to submit an implementation plan for how it will comply with the requirement applicable to an opt-in county. These include meeting the standards discussed in this Implementation Plan for CMS, as well as providing a specified set of community-based evidence-based practices, as discussed in detail in the BH-CONNECT application. BHPs will be required to monitor facility compliance with the terms of the demonstration, and DHCS will in turn monitor BHP compliance.

Upon approval of the BH-CONNECT demonstration, DHCS plans to issue one or more BHINs within 3-6 months that establish requirements for counties and Participating Psychiatric Settings that opt to participate in BH-CONNECT. These BHIN(s) will provide guidance on all requirements that must be met prior to claiming FFP for services provided during short-term stays to Medi-Cal members in those facilities. The BH-CONNECT BHINs will include information related to changes arising from all CMS milestones described in this Implementation Plan including:

- Accreditation requirements (Milestone 1.a);
- Requirements to screen members for co-morbid physical health conditions, SUDs, and suicidal ideation (Milestone 1.e);

¹ Throughout this Implementation Plan, the term behavioral health plans (BHPs) is defined as including three types of Prepaid Inpatient Health Plans regulated under 42 CFR Part 438: (1) mental health plans (MHPs) that are responsible for Specialty Mental Health Services (SMHS), (2) Drug Medi-Cal Organized Delivery Systems (DMC-ODS) that are responsible for providing specialty substance use disorder (SUD) services, and (3) Integrated Prepaid Inpatient Health Plans that are responsible for providing both SMHS and DMC-ODS.

- Requirements for intensive pre-discharge planning that includes community-based providers in care transitions (Milestone 2.a);
- Requirements to assess beneficiaries’ housing situations and coordinate with housing services providers when needed and available (Milestone 2.b);
- Requirements to contact beneficiaries and community-based providers through the most effective means possible, within 72 hours post discharge (Milestone 2.c); and
- Requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay (Milestone 3.d).

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
<i>To ensure that beneficiaries receive high quality care in hospitals, and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</i>	
<i>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</i>	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	<i>Current Status.</i> <u>Milestone partially achieved.</u> There are three types of hospitals and residential treatment settings in the State that primarily provide mental health treatment to individuals living with SMI or SED and may be IMDs in counties that opt to participate in the BH-CONNECT waiver opportunity (hereafter, “Participating Psychiatric Settings”). DHCS recognizes that while Freestanding Acute Psychiatric Hospitals and select Psychiatric Health Facilities meet criteria for Inpatient Psychiatric Services for Individuals under Age 21, Mental Health Rehabilitation Centers do not. DHCS is not requesting expenditure authority under BH-CONNECT for individuals under age 21 in any such facilities that do not meet criteria for Inpatient Psychiatric Services for Individuals under Age 21. DHCS is not requesting expenditure authority for any Qualified Residential Treatment Programs (QRTPs). • Mental Health Rehabilitation Centers (MHRC) provide intensive support and rehabilitative services in a residential setting to persons with mental disorders who otherwise would have been placed in a state hospital or another mental health facility. They assist persons in developing skills to become self-sufficient and capable of increasing levels of independence and functioning. MHRCs are licensed by DHCS.²

² Cal. Welf. & Inst. Code § 4080.
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	• Psychiatric Health Facilities (PHF) provide 24-hour inpatient psychiatric care for mentally disordered, incompetent, or other persons as described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code. PHFs are licensed by DHCS.³ • Freestanding Acute Psychiatric Hospitals (APH) provide 24-hour inpatient acute psychiatric services as special services in accordance with a general acute care hospital and all structures, equipment, and services. APHs are licensed by the California Department of Public Health. All three Participating Psychiatric Settings described above are licensed or otherwise authorized by the State to primarily provide mental health treatment. BHPs are required to inform the State of any accreditation from a private independent accrediting entity for all three Participating Psychiatric Settings. None of the Participating Psychiatric Settings are required to be accredited as a condition of licensure or Medi-Cal certification, but many are currently accredited by a nationally recognized accreditation entity.
	<i>Future Status</i> The State will require that all participating residential treatment facilities (MHRCs) and inpatient, non-hospital treatment facilities that are not certified as meeting the conditions of participation in 42 CFR Part 482 (PHFs) that wish to receive federal financial participation (FFP) for stays in IMDs of no more than 60 days to obtain accreditation prior to the State claiming FFP for services provided to Medi-Cal members residing in those facilities. The State will fully and expressly capture this requirement for participating residential treatment facilities (MHRCs) and inpatient, non-hospital treatment facilities that are not certified as meeting the conditions of participation in 42 CFR Part 482 (PHFs) as part of a BH-CONNECT BHIN. DHCS will leverage the compliance monitoring systems described above to ensure oversight and accountability to licensing requirements.

³ Cal. Welf. & Inst. Code § 4080.

Prompts	Summary
	DHCS will also update the contracts the state holds with each BHP for counties participating in BH-CONNECT to include the requirement that any IMD facility for which FFP is claimed must be accredited. The state will leverage existing processes for ensuring BHPs are in compliance with BHINs with active engagement by the Medi-Cal Behavioral Health Oversight and Monitoring Division, per the discussion in the Introductory note to this Implementation Plan. <i>Summary of Actions Needed</i> Specifically, the State will issue a BHIN for counties and participating residential treatment settings (MHRCs) and inpatient, non-hospital treatment facilities that are not certified as meeting the conditions of participation in 42 CFR Part 482 (PHFs) that opt to participate in BH-CONNECT to require accreditation by a nationally recognized accreditation entity prior to receiving FFP for services provided to Medi-Cal members residing in those facilities. DHCS intends to issue this guidance in Q1 2025, pending demonstration approval by CMS. The state will not permit facilities to receive Medicaid funding for services delivered in IMDs until they meet accreditation requirements. (Timeline: Within 3-6 months of demonstration approval). As described above, DHCS also plans to amend county behavioral health plan contracts to reflect new requirements related to BH-CONNECT, consistent with existing practices to update contracts as the new policy is promulgated. (Timeline: 3-24 months). In support of counties understanding new requirements, DHCS will offer open webinars and publish Frequently Asked Questions to ensure clarity of expectations and mandates. Further, DHCS will ensure that BHPs understand they may leverage administrative funds allocated within their plan to support providers in meeting the standards. BHPs will be required to demonstrate their capacity to meet the requirements as part of the submission of a county-level implementation plan, which will be reviewed and approved by the state prior to service commencement. As described above in the Introductory Note, participating BHPs will be required to monitor compliance with demonstration terms for facilities in their networks (including but not limited to compliance with accreditation requirements), and DHCS will monitor and enforce BHP compliance with demonstration terms.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements	<i>Current Status. <u>Milestone achieved.</u></i> All Participating Psychiatric Settings are subject to oversight and auditing, including unannounced visits, to ensure compliance with the State’s licensing and certification requirements. Facility Licensure Oversight by DHCS and CDPH • MHRC licensing is based on application approval and on a site review(s) conducted by the DHCS, within 30 calendar days following the MHRC applicant receiving written notification of approval of the application from the Department. Subsequently each MHRC has an annual licensing survey.

Prompts	Summary
	• PHF licensing inspection is conducted by DHCS to approve licensure of the facility. Every PHF and program for which a license has been issued must be periodically inspected by a multidisciplinary team appointed or designated by the DHCS. The inspection must be conducted no less than once every two years and as often as necessary to ensure the quality of care provided. • APHs require an annual license renewal application submitted to CDPH to renew the license. APH are subject to relicensing surveys once every three years. SMHS Oversight by BHPs: Continued SMHS Compliance for County and Contracted Providers To receive Medicaid funding, all Participating Psychiatric Settings must enter into a contract or payment agreement with a BHP. The BHP is then responsible for additional oversight consistent with the terms of its Medi-Cal contract. BHPs must conduct review of each provider for continued compliance with SMHS standards at least once every three years.⁴ BHPs are also responsible for conducting onsite review of contracted providers (with limited exceptions) at least once every three years.⁵ County owned and operated providers are subject to onsite review conducted by DHCS.⁶ The BHP contract also requires BHPs to develop and maintain a compliance program to monitor network providers on an ongoing basis and specifies an auditing process that includes unannounced visits at any time by the State, CMS, federal agencies, state agencies, or their duly authorized representative. Authorized representatives may visit any contracted facility at any time to evaluate performance under contractual requirements, including the quality, appropriateness, and timeliness of services provided and inspect any and all records, documents, and facility premises. <i>Future Status</i> The State and BHPs will continue to provide oversight (including unannounced visits) to ensure compliance with all applicable licensing, certification, and accreditation requirements. <i>Summary of Actions Needed</i> None.
1.c Utilization review process to ensure beneficiaries have access	<i>Current Status.</i> <u>Milestone achieved.</u>

⁴ [MHP Contract Ex. A, Attachment 8, Section 8.A](#)

⁵ [MHP Contract Ex. A, Attachment 8, Section 8.L](#)

⁶ MHP Contract Ex. E, Section G(1)

Prompts	Summary
to the appropriate levels and types of care and to provide oversight on lengths of stay	Services delivered in all Participating Psychiatric Settings will be provided through BHPs. The State’s contracted BHPs are required to conduct utilization review to ensure the medical necessity and appropriateness of all covered services delivered to Medi-Cal members. BHPs are subject to detailed and robust requirements for concurrent review and authorization processes for psychiatric inpatient and residential level of care services. Among other requirements, BHPs must maintain telephone access to receive authorization requests 24 hours a day and 7 days a week; ensure that authorization decisions are overseen by a health care professional that has appropriate clinical expertise; include in the authorization communication the amount, scope, and duration of treatment authorized by the BHP; and make an authorization decision as expeditiously as possible but no later than 72 hours after receipt of the request for services. Authorization procedures and utilization management criteria are based on medical necessity and consistent with evidence-based clinical guidelines, principles, and processes, and BHPs must demonstrate that they have mechanisms in place to ensure consistent application of review criteria for authorization decisions.
	<i>Future Status</i> The State will continue to require BHPs to conduct utilization review of all covered services, including those delivered in Participating Psychiatric Settings, to ensure that members have access to the appropriate levels and types of care and to provide oversight on lengths of stay.
	<i>Summary of Actions Needed</i> None.
1.d Compliance with program integrity requirements and state compliance assurance process	<i>Current Status. <u>Milestone achieved.</u></i> Implementation and oversight of State and federal Medicaid program integrity requirements is provided by the State’s Medicaid Provider Enrollment Division (PED) and Audits and Investigations (A&I) Division. PED oversees risk-based screening of all newly enrolling providers, revalidates existing providers pursuant to the rules in 42 CFR Part 455, and ensures that treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107. A&I manages other types of compliance and enforcement efforts, including conducting audits and investigations to ensure adherence to program integrity requirements related to overpayment and fraudulent billing.
	<i>Future Status</i> The State will continue its program integrity processes for Participating Psychiatric Settings.
	<i>Summary of Actions Needed</i>

Prompts	Summary
	None.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	<i>Current Status.</i> <u>Milestone partially achieved.</u>
	The State’s requirements for psychiatric settings for adults (as listed in 1a) do not yet fully meet this milestone.
	<i>Future Status</i> As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure all Participating Psychiatric Settings screen members for co-morbid physical health conditions, SUDs, and suicidal ideation, and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers). Methods for substantiating this requirement will be outlined in the BHIN and may include DHCS review of policies and procedures, attestations, report submissions and/or client chart reviews. In addition, any BHP that elects to participate in the option to draw down FFP in qualified circumstances for short-term IMD stays must submit an implementation plan subject to review and approval by DHCS. This plan will require BHPs to establish how they ensure Participating Psychiatric Settings have met the requirements to provide screening for beneficiaries for co-morbid physical health conditions, SUDs and suicidal ideation, and facilitate access to treatment for those conditions. BHPs will be required to monitor facility compliance, and BHP compliance (including review of BHP policies, provider subcontracts, provider manuals, and other BHP records) will be monitored by the Medi-Cal Behavioral Health -- Oversight and Monitoring Division, in partnership with DHCS’ Audits and Investigations Division.
	<i>Summary of Actions Needed</i> The State will develop and issue one or more BHINs that outlines requirements for BHPs to ensure Participating Psychiatric Settings meet this requirement (Timeline: 3-6 months). Accompanying the BHIN, the state will offer webinars and draft Frequently Asked Questions guides as needed to ensure facilities and BHPs have the information and tools necessary to achieve and maintain compliance. BHPs, in turn, will be able to utilize DHCS guidance to provide ongoing technical assistance and training to their network providers and ensure all requirements are met, and continued compliance can be supported, prior to commencement of services. Some BHPs may take longer than others to meet the requirements established in the BHIN, but, there is no deadline for opting-in to receive FFP for short-term IMD stays, making it possible for BHPs that need more time to meet the standards to do so. Note that all BHPs seeking to take up the IMD option must submit an implementation plan to DHCS for review and approval prior to beginning to claim FFP for short-term IMD stays; DHCS will ensure that BHPs have met the requirements of this section before finalizing approval of the BHP implementation plan. As noted above, BHPs will be subject to ongoing DHCS monitoring of their compliance with the terms of the BH-CONNECT demonstration as outlined in the BHP contract and applicable BHINs.

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	<i>Current Status</i> <u>Milestone achieved.</u> The State has established a number of requirements designed to ensure quality of care in Psychiatric Settings. These include: • Revisions to the informed consent requirement for anti-psychotic medications to permit verbal consent. • A requirement that SUD recovery or treatment facilities offer medications for addiction treatment (MAT) or have effective referral processes in place for this purpose. • Establishment of Psychiatric Residential Treatment Facilities (PRTFs) as a new category of residential health facilities licensed by DHCS. • Improved quality standards for certain residential psychiatric settings that serve children and youth.
	<i>Future Status</i> The State will maintain existing requirements/policies designed to ensure quality of care. In addition, as part of the BH-CONNECT demonstration the State has proposed to establish the Access, Reform, and Outcomes Incentive Program to incentivize BHPs to improve performance on quality measures and reduce disparities in behavioral health access and outcomes, with a focus on members living with SMI/SED and/or SUD who are otherwise at risk of hospitalization or other significant adverse health outcomes. The State will also explore opportunities to implement policies that will further reduce the use of seclusion and restraint in inpatient and residential treatment settings.
	<i>Summary of Actions Needed</i> None.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
<i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i>	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	<i>Current Status.</i> <u>Milestone partially achieved.</u> Many Psychiatric Settings are subject to discharge planning requirements. Section 1262 of the California Health and Safety Code requires that any mental health patient being discharged from a psychiatric setting, including all three Participating

Prompts	Summary
	Psychiatric Settings shall be given a written aftercare plan prior to the patient’s discharge from the facility. The written aftercare plan shall include, to the extent known, all of the following components: • The nature of the illness and follow-up required. • Medications including side effects and dosage schedules. If the patient was given an informed consent form with their medications, the form shall satisfy the requirement for information on side effects of the medications. • Expected course of recovery. • Recommendations regarding treatment that are relevant to the patient’s care. • Referrals to providers of medical and mental health services. • Other relevant information. No current policies fully and expressly capture the requirement to involve community-based providers in transition efforts. Other state initiatives, however, support this requirement. Under the CalAIM Population Health Management initiative, Medi-Cal Managed Care health plans (MCPs)⁷ are accountable for providing strengthened Transitional Care Services (TCS) – which includes enforcing Admissions, Discharge, and Transfer (ADT) notifications and discharge planning for members in acute care hospitals (including inpatient psychiatric facilities), emergency departments, and skilled nursing facilities – until members have been successfully connected to all needed services and supports – beginning as of January 1, 2023, and fully implemented for all members by January 1, 2024 across all settings and delivery systems. While BHPs are primarily responsible for coordination of care with the member upon discharge from psychiatric settings, under DHCS’ Memoranda of Understanding (MOUs) between MCPs and BHPs, MCPs are required to develop a joint process with BHPs to coordinate TCS for members. MCPs are also required to assign or contract with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services. <i>Future Status</i> As part of one or more BH-CONNECT BHINs, as well as a forthcoming BHIN regarding CalAIM Behavioral Health Data Sharing Policy, the State will fully and expressly capture the requirement for all Participating Psychiatric Settings to carry out intensive pre-discharge planning and include community-based providers in care transitions. This may include policies such as: • Assertive discharge planning after psychiatric hospitalization with a risk of death by suicide. This person-centered, focused effort tailored to specific support needs will be highly participatory and may include immediate access to structured clinical interventions within a step-down level of care, appointments with primary care or other medical

⁷ MCPs are responsible for covering physical health services, and Non-Specialty Mental Health Services, for their enrolled Medi-Cal members and for ensuring their Network Providers coordinate care for Members as provided in the applicable Medi-Cal Managed Care Contract, and coordinating care from other providers of carve-out programs, services, and benefits, including Specialty Mental Health Services. MHPs are responsible for providing or arranging for the provision of Specialty Mental Health Services.

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	follow up, arranged access to prescription medications, family and support system engagement and psychoeducation, peer support engagement, vocational or educational support, crisis response planning, risk factor analysis and safety contracting, strategies to address social determinants of health, and articulated preferred methods for proactive system outreach within the first hours or days following discharge, • Compliance with standards and specifications associated with Electronic Notification requirements in accordance with 42 CFR 482.61(f), as specified in the CMS Interoperability and Patient Access final rule. This requirement will also be reinforced in a separate forthcoming BHIN on the CalAIM Behavioral Health Data Sharing Policy slated for release during or prior to Q1 2025. • Coordination of behavioral health services to include admission, discharge, and transfer (ADT) notifications from acute care hospitals, psychiatric hospitals, state hospitals, and skilled nursing facilities, and data sharing between Medi-Cal Partners, defined as any person or organization that provides Medi-Cal reimbursable health and social services to Medi-Cal members, including BHPs and MCPs.⁸ The State will also consider how providers can initiate services with a community-based provider while a member is still residing in an inpatient/residential facility and explore options for implementation. As outlined in the BH-CONNECT Addendum Request (submitted to CMS in July 2024), DHCS is seeking expenditure authority for Community Transition In-Reach services as part of the continuum of care established by BH-CONNECT. Through this option, BHPs can 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 or at risk for long-term stays in institutional settings in returning to the community. These care transition teams will deploy an in-reach model for individuals who are experiencing or at risk of experiencing extended lengths of stay (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 that BHPs can opt in to cover.
	<i>Summary of Actions Needed</i> As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure all Participating Psychiatric Settings carry out intensive pre-discharge planning, and include community-based providers in care transitions. (Timeline: 3-6 months). Additionally, DHCS will issue a Data Sharing BHIN (Timeline: 3-6 months).
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries'	<i>Current Status.</i> <u>Milestone partially achieved.</u>

⁸ DHCS CalAIM Data Sharing Authorization Guidance: <https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf>

Prompts	Summary
housing situations and coordinate with housing services providers when needed and available	The State has established requirements for some types of psychiatric hospitals and residential settings to address housing challenges for members, and state law also establishes specific requirements for homeless individuals in certain settings, but gaps remain. While this milestone is not achieved in full for all Participating Psychiatric Settings, many Psychiatric Settings do assess members' housing situations and coordinate with housing services providers when needed and available, however, for residential settings, regulations do not specify requirements for transitions connecting those in the community for persons who are homeless or have unsuitable or unstable housing. Inpatient hospitals are specifically required to inquire about a patient's housing status and identify post-discharge destinations for individuals experiencing homelessness. Under Senate Bill 1152 (Chapter 981, Statutes of 2018) acute psychiatric hospitals (along with general acute care hospitals and special hospitals) must comply with a particularly robust set of discharge planning requirements for homeless patients. Specifically, state law provides that these facilities must identify a post discharge destination for any homeless patient at either a social services agency or provider that has agreed in advance to the placement; a dwelling place identified by the homeless patient as their residence; or an alternative location indicated by the homeless patient and documented in his or her record. The facility must prioritize placing the patient at a sheltered location with supportive services. In addition, the hospital must develop a written plan (to be updated annually) for coordinating services and referrals with the county behavioral health agency, health care and social services agencies, health care providers, and nonprofit social service providers, as available. The plan must include a list of local homeless shelters and their hours of operations, admission procedures and requirements, client population served, scope of services available; the hospital's procedure for homeless patient discharge referrals; and training protocols for discharge planning staff. In addition, the State has developed and is seeking to implement several policies designed to address the housing needs of individuals with SMI/SED including: • Behavioral Health Bridge Housing (BHBH), which will provide \$1.5 billion in funding through June 30, 2027 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. • Housing and Homelessness Incentive Program (HHIP), which allows MCPs to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. • Enhanced Care Management (ECM), a statewide Medi-Cal benefit available to select populations of focus, including individuals with SMI or SED, to address clinical and nonclinical needs through intensive coordination of health and health-related services, including providing connections to housing and other resources. • Community Supports services to address members health-related social needs, including through housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing and recuperative care. Managed Care Plans (MCPs) are not required to provide Community

Prompts	Summary
	Supports, but every MCP in California has opted to do so. By January 2025, every MCP will have contracts in place in at least one county for each of the housing-related Community Supports, but not every housing-related Community Support will be available in every county in which each MCP operates. A complete summary of CalAIM Community Supports Managed Care Plan Elections is available here. • Proposition 1, passed by California voters in March 2024, encompasses Senate Bill (SB) 326 and Assembly Bill (AB) 531. SB 326 (Chapter 790, Statutes of 2023) requires counties to allocate behavioral health funding for housing interventions for children and families, youth, adults and older adults living with significant behavioral health needs who are experiencing or at risk of homelessness. Counties may use this funding for rental subsidies, operating subsidies, shared housing, project-based housing assistance, other housing supports, and capital development projects, including affordable housing. DHCS is currently developing guidelines for these allowable uses of funding. AB 531 includes a \$6.38 billion bond to build new treatment facilities, community infrastructure and supportive housing for individuals living with significant behavioral health needs, including: ○ The recent release of \$3.3 billion in competitive grant funding to expand the behavioral health continuum and provide appropriate care to individuals experiencing mental health conditions and substance use disorder; ○ A second round of up to \$1.1 billion in grant funding for additional behavioral health treatment site infrastructure; and ○ Up to \$2 billion to build permanent supportive housing for veterans and others that are homeless or at risk of homelessness and have mental health or substance use challenges.
	<i>Future Status</i> As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure all Participating Psychiatric Settings assess members’ housing situations and coordinate with housing services providers when needed and available. In addition to maintaining the requirements and policies identified above, the State also intends to further support connections to housing through referrals to members’ MCPs for Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, and Housing Deposits (currently covered by all MCPs as Community Supports) and the authority requested under BH-CONNECT for MCP coverage of up to six months of Transitional Rent for members who meet eligibility criteria.
	<i>Summary of Actions Needed</i> As part of one or more BH-CONNECT BHINs, the State will fully and expressly capture the requirement that Participating Psychiatric Settings assess beneficiaries’ housing status and coordinate with housing support providers. (Timeline 3-6 months)

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	<i>Current Status.</i> <u>Milestone partially achieved.</u> While all Psychiatric Settings are subject to discharge planning requirements, and many make a practice of contacting members after discharge and following up with the community-based provider the person was referred to, the relevant requirements for Psychiatric Settings do not fully capture the milestone requirement. <i>Future Status</i> As part of a BH-CONNECT BHINs, the State will fully and expressly capture the requirement to ensure that Participating Psychiatric Settings and/or BHPs contact members and community-based providers through the most effective means possible, including the requirement to ensure that follow-up care is accessed by contacting the member <i>and</i> the community provider the member was referred to <i>within 72 hours</i> post discharge. (Timeline: 3-6 months) <i>Summary of Actions Needed</i> The State will fully and expressly capture the requirement that Participating Psychiatric Settings and/or BHPs contact beneficiaries and community-based providers within 72 hours of discharge as part of the BH-CONNECT BHINs. (Timeline: 3-6 months). BHPs will need to establish their compliance with this requirement in their opt-in implementation plans subject to review and approval by DHCS.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	<i>Current Status.</i> <u>Milestone achieved.</u> The State has implemented and is planning several initiatives to prevent admission and decrease lengths of stay in EDs among members with SMI or SED, including: • Community-Based Mobile Crisis Intervention Services, which was authorized as a Medi-Cal benefit under SPA 22-0043, effective Jan. 1, 2023. One of the goals of this benefit is to help resolve mental health, SED and SUD crises in the community, mitigating the need for ED visits. • CA Bridge Program, a statewide program which launched at 52 hospitals in 2018 and currently supports 266 hospitals, representing 80% of hospitals in the state. CA Bridge trains hospital staff to screen for opioid use disorder and other SUDs, initiate MAT and mental health care in the emergency department, and facilitate access/referrals to community-based providers for follow-up care. DHCS continues to support the sustainability of the CA Bridge Program with State Opioid Response (SOR) III and SOR IV grant dollars through fall 2027 to:

Prompts	Summary
	○ Provide training and technical assistance (TTA) to BHNs and prescribers, empowering them to facilitate access to MAT and other evidence-based substance use disorder (SUD) therapies and support community health worker (CHW) workforce development to ensure seamless patient transitions and care continuity. ○ Provide sustainability TTA to transition the behavioral health navigation services supported through the CA Bridge program from grant-based funding to Medi-Cal reimbursement through implementation of the Community Health Worker (CHW) benefit in accordance with State Plan Amendment 22-001 and All Plan Letter 24-006. This will include identifying and showcasing various CHW billing pathway models to facilitate the implementation of the CHW benefit in EDs on the CA Bridge website. ○ Support the development of six outpatient Bridge Clinics to expand the network of telemedicine capable low-barrier clinics able to receive referrals and provide a best practices guide statewide. ○ Develop and launch an online patient portal, the CA Bridge Treatment Access Network, which will enable patient access to a network of BHNs, low-barrier clinics, and telehealth. ● DHCS’ Comprehensive Quality Strategy (CQS) includes high priority metrics applicable to all BHPs and MCPs to drive annual improvements in quality outcomes by measuring follow-up after ED visits for a mental health or substance use condition. Measures are calculated using data from EDs and are reported as the percentage of ED visits for which the member received follow-up within 7 days and 30 days of the ED visit. Specialty behavioral health and managed care delivery systems must meet minimum performance levels on these metrics (which are also part of CMS’ core set) and will be subject to corrective action, up to and including monetary sanctions, if they fail to meet these targets. ● Under the CalAIM Population Health Management initiative, Medi-Cal Managed Care health plans (MCPs)⁹ are accountable for providing strengthened Transitional Care Services – which includes enforcing Admissions, Discharge, and Transfer (ADT) notifications. As described under Milestone 2a., while BHPs are primarily responsible for coordination of care with the member upon discharge from psychiatric settings, under DHCS’ Memoranda of Understanding (MOUs) between MCPs and BHPs, MCPs are required to develop a joint process with BHPs to coordinate TCS for members. Consistent with the policy that the MCP is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the MCP or its contracted care manager is responsible for ensuring transitional care coordination in instances where the MCP is not the primary source of coverage for the triggering service (e.g., an inpatient psychiatric admission covered by a BHP). MCPs are also required to assign or contract with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services. ● The Behavioral Health Quality Improvement Program (BHQIP) included the following measures as part of its required deliverables for Medi-Cal behavioral health delivery systems (“participating entities”):

⁹ MCPs are responsible for covering physical health services, and Non-Specialty Mental Health Services, for their enrolled Medi-Cal members and for ensuring their Network Providers coordinate care for Members as provided in the applicable Medi-Cal Managed Care Contract, and coordinating care from other providers of carve-out programs, services, and benefits, including Specialty Mental Health Services. MHPs are responsible for providing or arranging for the provision of Specialty Mental Health Services.

Prompts	Summary
	○ Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA); ○ Follow-Up After Emergency Department Visit for Mental Illness (FUM); ● <u>Semi-Statewide Electronic Health Record (EHR) System</u>: The California Mental Health Services Authority (CalMHSA) leveraged its Joint Powers Authority to bring counties together to procure and implement a new semi-statewide EHR. In July 2023, CalMHSA launched the initial phase of the semi-statewide EHR program which covered over 37 percent of the state’s Medi-Cal population at the county option, and CalMHSA will expand the program to additional counties in 2024. The EHR captures relevant milestones as members progress through their care in the behavioral health specialty system. EHR data collection begins with the initial request for services by the member, their support persons and/or professional referral. The behavioral health staff use the EHR to document services received during the course of treatment in multiple programs/care settings. Diagnosis and problems (via a problem list) are used to monitor a member’s progress in recovery until services can eventually be stepped down and the member transferred to a non-specialty level of care/discharged. CalMHSA continues to build additional methods within the EHR to allow for tracking of referrals to agencies/services outside of behavioral health to ensure that members successfully navigate these treatment transitions. The new EHR System will make it possible for BHPs to more readily identify when one of their members has been admitted to an ED for a behavioral health condition, and to ensure that follow up care is provided. Additional initiatives are outlined in Section 3.c below, including developing a bed tracking tool to provide real-time information to behavioral health providers on the availability of inpatient and crisis stabilization beds, in accordance with state and federal HIT standards and regulations, with implementation planned for 2026.
	<i>Future Status</i> The State will continue to build out the continuum of community-based behavioral health care that helps to prevent and decrease lengths of stay in EDs among members with SMI or SED. Additional initiatives to build out the continuum of care are discussed in Topic 3 below, which details how the State is seeking to cover additional community-based services at county option that will help prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission in participating counties, including through Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), and Individual Placement and Support (IPS) model of Supported Employment. In addition to maintaining the policies and programs above, as part of the demonstration DHCS has proposed the Access, Reform, and Outcomes Incentive Program which will drive additional investments in BHPs to support strategies to prevent and decrease lengths of stays in EDs.

Prompts	Summary
	<i>Summary of Actions Needed</i> None.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	<i>Current Status. <u>Milestone achieved.</u></i> The State has implemented several initiatives and requirements to improve care coordination and connections to community-based care. These include: • <u>Enhanced Care Management (ECM)</u> is a statewide Medi-Cal benefit available to select populations of focus, one of which is individuals with serious mental health and/or SUD needs. The ECM lead care manager is charged with coordinating care and addressing needs related to physical health, mental health, substance use disorders and health-related social needs. • <u>Transitional Care Services</u>, a new set of requirements for MCPs that strengthen standards and MCP accountability for assisting members transferring from one setting or level of care to another, such as from institutional or residential settings to community-based care. Requirements include assignment of a single point of contact upon admission. Discharge risk assessment and planning, and post-discharge services and follow-up. This requirement applies even when the BHP or DMC-ODS is the primary payer for services provided during the inpatient stay. • <u>CalAIM Justice-Involved Initiative</u>, under which the State will offer a targeted set of Medicaid services to youth and eligible adults in state prisons, county jails, and youth correctional facilities and help them access key services upon their return to community. • <u>The Behavioral Health Quality Improvement Program (BHQIP)</u>, which incentivized county behavioral health delivery systems to improve data exchange capabilities to improve quality and coordination of care. Over the course of the program, participating entities demonstrated direct sharing of data either with Medi-Cal Managed Care Plans (MCPs) and/or onboarding to a Health Information Exchange (HIE). Counties collaborated and established agreements for bi-directional data exchange through signing the California Health and Human Services Data Exchange Framework Data Sharing Agreement with MCPs or the California Data Use and Reciprocal Support Agreement and California Trusted Exchange Network to onboard with an HIE. These established agreements strengthen the ability to provide effective care coordination for Medi-Cal beneficiaries who are transitioning across behavioral health delivery systems. BHQIP also improved the ability of participating entities to exchange data and report on quality measures. Through BHQIP, DHCS reviewed and approved deliverables specific to data exchange achievements, resulting in more than 50% of counties achieving success across reporting periods with implementing and improving data exchange capabilities. Success in meeting data exchange milestones means that counties submitted supporting documentation that includes data-sharing agreements, transaction logs, and written reports outlining how counties are leveraging direct data exchange to improve care coordination.

Prompts	Summary
	• Peer Support Services, a Medi-Cal benefit under the SMHS, DMC, and DMC-ODS delivery systems available at county option to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery. • CalAIM No Wrong Door Policy, which allows members to receive mental health services regardless of the delivery system where they seek care (specialty behavioral health, MCP or the FFS delivery system). • CalAIM Screening and Transition Tools to support BHPs and MCPs in determining the most appropriate Medi-Cal mental health delivery system referral for members who are not currently receiving mental health services, and to ensure that 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. • BHPs and DMC-ODS are contractually required to conduct care coordination in accordance with 42 C.F.R. § 438.208. • BHPs are also required to provide Targeted Case Management for select populations, including individuals with SMI/SED, which includes coordination of all medically necessary services. • As part of its oversight and monitoring activity, DHCS includes in its auditing process a review of BHP and DMC-ODS compliance with this care coordination requirement.
	<i>Future Status</i> In addition to maintaining the requirements and policies identified above, the State also intends to further support connections to community care and coordination across systems as part of the BH-CONNECT demonstration, including: • Access, Reform, and Outcomes Incentive Program to build upon the work done as part of BHQIP to support county behavioral health delivery systems in strengthening quality infrastructure and improving performance on quality measures, including those related to care coordination. • Requirement for counties that opt-in to the BH-CONNECT demonstration to cover Community Health Worker Services and Peer Support Services with a forensic specialization to ensure members living with SMI and SED have access to community-based supports from individuals living in their community and with lived experience.
	<i>Summary of Actions Needed</i> None.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
<i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities.</i>	

Prompts	Summary
<i>Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i>	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state’s strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state’s demonstration application. The content of annual assessments should be reported in the state’s annual demonstration monitoring report	<i>Current Status.</i> <u>Milestone achieved.</u>
	The State has conducted an assessment of the availability of mental health providers offering mental health services across the state, as required. The assessment is included in Appendix 2 of the application.
	<i>Future Status</i> The State intends to conduct and report the required assessments over the course of the demonstration.
3.b Financing plan	<i>Summary of Actions Needed</i> The State will complete and submit the assessment each year of the demonstration period in the annual demonstration monitoring plan.
	<i>Current Status:</i> See Topic 5 below.
	<i>Future Status:</i> See Topic 5 below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	<i>Summary of Actions Needed:</i> See Topic 5 below.
	<i>Current Status.</i> <u>Milestone not achieved.</u>
	<i>Future Status,</i> DHCS will contract with a vendor to develop and implement a bed tracking service to provide real-time information on the availability of inpatient and crisis stabilization beds, in accordance with state and federal HIT standards and regulations, with implementation planned by July 2026. Initially, DHCS is developing the bed tracking service to focus on, at a minimum, acute psychiatric hospitals, general acute care hospitals with psychiatric units, psychiatric health facilities, provider sites certified to provide crisis stabilization by DHCS or a BHP, and psychiatric residential treatment facilities in the state. The service may be expanded in the future to include other behavioral health facility types. At minimum, the bed availability data generated by the service will be available to authorized users including BH facilities and specialty behavioral health delivery systems participating in the demonstration.

Prompts	Summary
	<i>Summary of Actions Needed</i> DHCS plans to work intensively with stakeholders to develop the final list of participating facility types and reportable data elements, and to identify those entities that may become authorized users within the bed tracking service. DHCS anticipates executing a contract with a vendor for the bed tracking service no later than January 1, 2025, launching the service by July 1, 2026, or within 18 months of the contract effective date. DHCS may adjust this timeline as needed based on the final contract. (Timeline: 18-24 months)
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	<i>Current Status. <u>Milestone not achieved.</u></i> For all children and youth who receive SMHS, including but not limited to those involved in child welfare, providers are required to use the Child and Adolescent Needs and Strengths (CANS) tool, a multi-purpose tool that supports decision-making, though a shared vision and uses youth and family information to inform service planning by identifying youth and family actionable needs and useful strengths, as well as to measure youth functioning." Pursuant to AB 403 and the Continuum of Care Reform (CCR), the California Department of Social Services (CDSS) selected the CANS as the functional assessment tool to be used with the Child and Family Team (CFT) process to guide case planning and placement decisions. DHCS also selected the CANS, as well as the Pediatric Symptom Checklist, to measure child and youth functioning.¹⁰ Under BH-CONNECT, DHCS intends to develop and provide guidance on the use of an aligned CANS tool across the child welfare and specialty mental health systems, in order to: • Ensure both child welfare and behavioral health providers are using the same CANS tool with the same modules • Ensure the CANS tool is administered in the same way, whether done by a specialty mental health provider or by a child welfare worker, so that outcomes can be tracked over time; and • Support a cohesive approach to decision making and service planning across systems. DHCS and CDSS are currently working to align the CANS tool being used in county behavioral health and child welfare and expects to release joint-guidance in December 2024. Beginning in 2025, DHCS and CDSS will use an aligned version of the CANS across children and youth involved in both systems. For adults, there is no current requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay. However, the CalAIM initiative “Screening and Transition of Care Tools for Medi-Cal Mental Health Services” establishes a precedent for this milestone by implementing standardized screening requirements to ensure all Medi-Cal Members receive timely, coordinated services across Medi-Cal mental health

¹⁰ [All County Letter \(ACL\) No.18-85.](#)
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Prompts	Summary
	delivery systems.¹¹ These tools consist of: (1) the Adult Screening Tool for Medi-Cal Mental Health Services; (2) the Youth Screening Tool for Medi-Cal Mental Health Services; and (3) the Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth). The Screening Tools determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or BHP seeking mental health services. The Transition of Care Tool ensures that Members who are receiving mental health services from one delivery system receive timely and coordinated care when their existing services need to be transitioned to the other delivery system, or when services need to be added to their existing mental health treatment from the other delivery system. The results from the BHQIP program demonstrated that participating entities were successful with the implementation of standardizing screening and transition of care tools. In accordance with DHCS Behavioral Health Information Notice 21-074, entities were required to implement standardized, statewide Adult and Youth Screening and Transition of Care Tools to guide referrals of Adult and Youth beneficiaries to the appropriate Medi-Cal mental health delivery system and ensure that beneficiaries requiring transition between delivery systems receive timely coordinated care. Participating entities were required to submit policy and procedures, training plans, and screening and transition tool logs. Through BHQIP, DHCS reviewed and approved deliverables related to the implementation of screening and transition of care tools, resulting in more than 70% success with implementing policies and demonstration of tools. DHCS has also developed standardized, domain-based documentation requirements outlined in BHIN 23-068. Assessments for DMC and DMC-ODS members will continue to occur using the American Society of Addiction Medicine criteria. Assessments for SMHS members under the age of 21 must capture specified clinical data elements organized into seven assessment domains.
	<i>Future Status</i> Under BH-CONNECT, the State will require providers to use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay, and require BHPs to enforce these requirements for their network providers. For children and youth, providers will be required to continue using the CANS tool. For adults, the State will determine a set of allowable assessment tools that providers may use, informed by a variety of factors including but not limited to: • Review of national policy guidance, grey literature, and evidence-base including available systemic reviews and meta-analyses • Implementation-related factors such as the landscape of tools adopted across the State and related costs of adoption of proprietary tools

¹¹ The Screening and Transition of Care Tools for Medi-Cal Mental Health Services can be accessed at: <https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-MediCal-Mental-Health-Services.aspx>.
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Prompts	Summary
	Stakeholder input As part of a BH-CONNECT BHIN, the State will fully and expressly capture the requirement to ensure providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay. The state will synthesize the information gathered to identify an approved set of evidence-based assessment tools for counties to utilize in meeting the BH-CONNECT requirement and, following stakeholder feedback, issue a BHIN to provide counties with the necessary guidance. DHCS will offer webinars and issue Frequently Asked Questions on acceptable tools as needed. BHPs will be required to identify the widely recognized, publicly available patient assessment tool (or tools) for adults that they have selected from the approved list in their Opt-In Implementation Plan and will require providers to use; county implementation plans must also describe how the BHP will oversee and enforce compliance with this and other demonstration requirements among its network providers. (CANS will continue to be used for children and youth under age 21.) <i>Summary of Actions Needed</i> The State will identify assessment tools that BHPs may use to determine the appropriate level of care and length of stay for adults (Timeline: 3-6 months). The State will then issue one or more BHINs for BHPs fully and expressly capturing this requirement, including solicitation of stakeholder input (Timeline: 3-6 months). On an ongoing basis, the State will provide technical assistance to BHPs on use of evidence-based assessment tools, including webinars and Frequently Asked Questions as needed (Timeline: Ongoing, as needed).
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	<i>Current Status:</i> <u>Milestone achieved.</u> The State has been very active in developing initiatives to improve access to a full continuum of behavioral health care, including crisis stabilization. These include: 988 Suicide and Crisis Lifeline, to which DHCS is investing over \$80 million from 2021-22 through 2025-26 to support California’s network of 988 crisis centers to support the launch of the new national 988 hotline for people seeking help during a behavioral health crisis. The Miles Hall Lifeline and Suicide Prevention Act, enacted in 2022, established the California 988 State Suicide and Behavioral Health Crisis Services Fund, consisting of the revenue generated by the 988 surcharge assessed on users under Section 41020 of the Revenue and Taxation Code, providing ongoing support for 988 in California. Community-Based Mobile Crisis Intervention Services, which was authorized as a Medi-Cal benefit under SPA 22-0043, effective Jan. 1, 2023. California Youth Behavioral Health Initiative (CYBHI), which is a multi-faceted \$4.4 billion investment to enhance, expand and redesign the systems that support behavioral health for children and youth, including through early intervention/prevention services, across four strategic areas:

Prompts	Summary
	○ Creating a larger, more representative workforce supporting the emotional, mental, and behavioral health of young people; ○ Developing infrastructure to support behavioral health to ensure there is no wrong door for help; ○ Creating coverage pathways to access behavioral health services, including by implementing dyadic care services as a newly covered benefit under Medi-Cal and creating a statewide multi-payer fee schedule for school-linked behavioral health services; and ○ Reducing stigma and raising awareness around emotional, mental, and behavioral health using culturally – and linguistically – appropriate campaigns. ● Behavioral Health Continuum Infrastructure Program (BHCIP), which 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. ● Community Assistance, Recovery and Empowerment (CARE) Act, which connects individuals struggling with untreated schizophrenia or other psychotic spectrum disorders to county behavioral health treatment services through a civil court process. These individuals can receive an array of services through voluntary engagement, an approved CARE agreement, or a court-ordered CARE plan, which may include clinically prescribed, individualized interventions with medication, a housing plan, and several supportive services, including Supplemental Security Income/State Supplementary Payment (SSI/SSP), Cash Assistance Program for Immigrants (CAPI), CalWORKs (a welfare program that gives cash aid and services to eligible California families in need), California Food Assistance Program, In-Home Supportive Services (a program that provides in-home assistance to eligible older, blind and disabled individuals as an alternative to out-of-home care), and CalFresh (known federally as SNAP). ● CalAIM Behavioral Health Payment Reform, which will 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. ● Expanding SUD services delivered by county Drug Medi-Cal Organized Delivery System (DMC-ODS) plans to include access to all levels of care along the continuum defined in The American Society of Addiction Medicine (ASAM) criteria. ● Recovery Incentives – California’s Contingency Management Program, which is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. ● Medication-Assisted Treatment (MAT) Expansion Program, which 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 282 hospitals/emergency departments, 37 (out of 58) county jail systems, 12 Indian Health Programs, 650 MAT Access Points; and has distributed over 3 million units of naloxone resulting in more than 200,000 reported overdose reversals.

Prompts	Summary
	• Proposal of a \$6.38 billion bond as part of Assembly Bill 531 (Chapter 789, Statutes of 2023) to build new treatment beds and housing units for Californians living with the most acute behavioral health issues. In addition, BHPs are currently required to cover a wide array of community-based mental health services. These services include: • Mental health services • Day treatment intensive services • Day rehabilitation services • Medication support services • Crisis intervention services • Crisis stabilization services • Intensive care coordination (i.e., targeted case management for those under 21) • Intensive home-based services • Therapeutic behavioral services • Therapeutic foster care • Targeted case management including for individuals at risk of institutionalization or in jeopardy of negative health or psycho-social outcomes
	<i>Future Status</i> As part of the BH-CONNECT demonstration and through other complementary initiatives, the State is planning to further strengthen this continuum through the addition of new services and programs. These include: • New community-based behavioral health services for which the State will seek State Plan authority, including ACT, FACT, CSC for FEP, the IPS model of Supported Employment, Community Health Worker (CHW) services, and Clubhouse Services. • A Workforce Initiative as part of the demonstration that would include investments to support recruitment and retention of staff for community-based Medi-Cal behavioral health services providers, thereby expanding access to community-based behavioral health services. • Reforms proposed as part of Assembly Bill 531 (Chapter 789, Statues of 2023) and Senate Bill 326 (Chapter 790, Statutes of 2023) to provide additional resources to care for and house Californians living with the most severe mental health needs and SUDs, including through a bond to fund new treatment beds and supportive housing settings and updates to the Mental Health Services Act (MHSA) to expand resources for housing and workforce and increase accountability for community-based services for prevention and early intervention services.

Prompts	Summary
	<i>Summary of Actions Needed</i> None.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
<i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i>	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported education programs	<i>Current Status:</i> <u>Milestone achieved.</u> The State has implemented several statewide initiatives to identify and engage beneficiaries with or at risk of SMI or SED in treatment sooner. These include: • CalAIM No Wrong Door Policy, which allows members to receive mental health services regardless of the delivery system where they seek care (specialty behavioral health, MCP or the FFS delivery system). NWD policy includes clarification that reimbursement is available for assessments and covered, medically necessary outpatient treatment services before formal diagnosis. The No Wrong Door (NWD) policy applies in all counties throughout the state of California and applies to any Medi-Cal member who requires mental health services, and, as such, potentially offer better access to early intervention and treatment. • Updates to the Specialty Mental Health Services and DMC/DMC-ODS Criteria to access behavioral health services to improve members' access to services and reduce provider administrative burdens. As highlighted in CMS guidance, California covers non-specialty mental health services (NSMHS) such as evaluations and individual, group, and family psychotherapy to individuals with potential mental health disorders not yet diagnosed. NSMHS are provided through Medi-Cal Managed Care Plans and the fee-for-service delivery system. California also covers a range of specialty mental health services (SMHS), including but not limited to targeted case management, crisis services, residential services, and a variety of specialty outpatient mental health services. SMHS are provided through BHPs. For children and youth, medically necessary SMHS are available to beneficiaries with a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. In addition, for children and youth, medically necessary SMHS are available to beneficiaries who have a need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide, and a suspected mental health disorder that has not yet been diagnosed .

Prompts	Summary
	• <u>Complex Care Capacity Building</u>, which is a \$43.3 million investment (authorized under Assembly Bill 153) in 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. Funding uses related to capacity building can include intensive child-specific recruitment, family finding and engagement, and support programs for children with complex needs. This may include, but is not limited to: ○ Specialized permanency support services and activities associated with the Active Supportive Intervention Services for Transition programs. ○ Specialized models of integrated care and support for family-based settings and community-based treatment models that create alternatives to out-of-home or residential placement. • <u>California Youth Behavioral Health Initiative (CYBHI)</u>, which is a multi-faceted \$4 billion state investment to enhance, expand and redesign the systems that support behavioral health for children and youth, including through early intervention/prevention services. The CYBHI is comprised of over twenty (20) different strategies. Under CYBHI’s Public Awareness strategic initiative, the “Never a Bother” Youth Suicide Prevention Media and Outreach Campaign offers a data-driven, multicultural, and multilingual approach to intervention. CYBHI includes behavioral health virtual services platforms for access to web- and app-based platforms aimed at parents and caregivers, young children, teens, and young adults. Media efforts are combined with five rounds of grants funding to youth-serving community-based organizations (CBOs) and tribal entities fostering evidence-based and community-focused suicide-prevention strategies. CYBHI’s all-payer fee schedule for school-based services creates a more approachable billing model and reduces uncertainty around students’ coverage, helping to ensure that youth who need behavioral health support can receive those services, including screening and assessment, in schools. Within the Multi-Tiered System Support (MTSS), students will have access to Certified Wellness Coaches, and educators will gain resources to learn about Adverse Childhood Experiences (ACEs) and leverage a toolkit to support healing. In partnership with the Office of the California Surgeon General, the ACEs Aware initiative has provided 2.3 million screenings across 56 counties, and 17,100 providers eligible for Medi-Cal payment have been trained to identify, screen and respond to ACEs. The dyadic services benefit addresses developmental and behavioral health conditions of children in a dyad with their caregiver. • <u>Student Behavioral Health Incentive Program (SBHIP)</u>, which supports partnerships between MCPs and schools to increase access to preventative services. SBHIP designated \$389 million over three years for meeting predefined goals related to increasing prevention, early intervention, and behavioral health services by school-affiliated providers. This program aims to break down siloes and improve coordination as well as address health equity gaps. As of September 2024, all 58 counties are participating in partnership with 22 MCPs, 57 County Offices of Education (COEs). and approximately 3,789 Local Education Agencies (LEAs). There have been 147 targeted interventions implemented and 1.4 million school aged youth impacted. 48% of those interventions represent new behavioral health services not previously provided by counties.

Prompts	Summary
	• Enhanced Care Management (ECM), a statewide Medi-Cal benefit available to select populations of focus addresses clinical and nonclinical needs of the highest-need enrollees through intensive coordination of health and health-related services. ○ Since its launch on January 1, 2022, 183,700 Medi-Cal MCP members received ECM as of December 31, 2023. In the last twelve months of the reporting period, 62,395 members with SMI/SED and/or living with SUD received ECM. • Community Assistance, Recovery and Empowerment (CARE) Act, which connects individuals struggling with untreated mental illness with a CARE agreement or a court-ordered CARE plan for up to 24 months, which can include clinically prescribed, individualized interventions with several supportive services, medication, and a housing plan. To be eligible, individuals must be in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others. ○ The CARE Act is being implemented in two phases. The counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne, and the City and County of San Francisco (Cohort I) implemented the CARE Act on October 1, 2023. Los Angeles implemented on December 1, 2023, and all other counties (Cohort II) are required to implement the CARE Act by December 1, 2024. • CalAIM Justice-Involved Initiative, which will allow the state to offer a targeted set of Medicaid services to youth and eligible adults in state prisons, county jails, and youth correctional facilities and help them access key services upon their return to community. Correctional facilities will begin to go-live with pre-release services on October 1, 2024. Specialty behavioral health delivery systems and MCPs must coordinate with correctional facilities to support reentry for members as they transition from incarceration into the community and managed care. This will help to ensure continuity of health care coverage after incarceration, enabling access to programs and services like Enhanced Care Management (ECM) and Community Supports, warm linkages to medical and mental health services, and prescription medications in hand upon release. ○ The State is implementing a phased approach for the state prison system and county correctional facilities to go live in several readiness-based cohorts on a quarterly basis over a two-year phase-in period. All county behavioral health agencies will be required to go-live with behavioral health links by October 1, 2024 ○ An estimated 400,000 individuals are released from correctional facilities in the state each year. Of these, an estimated 80-90 percent are eligible for Medi-Cal. An estimated 37% of individuals in prisons are living with SMI/SED and 58% with SUD.¹² • Peer Support Services, a Medi-Cal benefit available at county option to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery. Research speaks to the efficacy of peers in engaging

¹² [SAMSA \(2017\)](#)
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	beneficiaries in treatment sooner, with one study finding an average reduction of over 43% in inpatient services and a 30% increase in outpatient treatment visits for those who received peer-support services.¹³ ○ As of June 2024, 51 counties (covering 99% of Medi-Cal members) include Medi-Cal Peer Support Services as a benefit in one or both of their delivery systems. • Dyadic Services, a preventive Medi-Cal benefit to serve both parent(s) or caregiver(s) and child together, targeting family well-being as a mechanism to support healthy child development and mental health. • Community Health Worker (CHW) Services, a preventive Medi-Cal benefit to address the control and prevention of chronic conditions or infectious diseases; mental health conditions and substance use disorders; need for preventive services; perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and violence prevention. A growing body of evidence demonstrates the effectiveness of CHWs as part of care teams and their importance to the continuum of behavioral health services, including suicide prevention.¹⁴ ○ The State has invested in a multipronged effort to develop and train CHWs, with the goal of adding 25,000 new CHWs to the care economy workforce by 2025. ○ The Medi-Cal CHW benefit launched in FFS and managed care delivery systems in July 2022, and as part of BH-CONNECT, Enhanced CHW services will be made available under the SMHS and DMC/DMC-ODS delivery systems at county option (see Future State). • Full Service Partnership programs, which provide wraparound or “whatever it takes” services to members who are unserved or underserved and who may be homeless or at risk of homelessness. These programs are funded with state dollars and available in all counties throughout California. ○ Over 60,000 individuals are enrolled in an FSP program across the state.
	<i>Future Status</i> As part of the demonstration, the State is seeking to cover additional community-based services at county option that will help identify and engage beneficiaries at risk of SMI or SED in treatment sooner in participating counties, including: • ACT, which leverages an assertive, team-based outreach approach to engage members with significant behavioral health needs in treatment and coordinate care. • FACT, which builds upon the ACT model to address criminogenic risk and needs as part of the treatment plan, including the use of evidence based cognitive behavioral therapies shown to reduce recidivism. • CSC for FEP, which is designed to engage members in treatment as soon as they experience an initial psychotic episode and support ongoing recovery.

¹³ NAMI, “[The Case For Expanding Peer Support](#)” (April 2023).

¹⁴ Commonwealth Fund, “[Medicare Reforms Support Behavioral Health by Expanding Access to Peer Support Specialists and Community Health Workers](#)” (February 2024).

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	○ More than half of counties in the State currently offer CSC for FEP programs funded in part through SAMHSA block grants and with training and technical assistance offered through UC Davis. The SPA will cover CSC for FEP as a new bundled Medi-Cal service at county option. ● Enhanced CHW Services, which utilize a preventative approach that can includes control and prevention of chronic conditions, mental health conditions and substance use disorders through health education and navigation, screening and assessment, and individual support or advocacy. CHW services are available through both FFS and managed care delivery but will be expanded at county option within the SMHS and DMC/DMC-ODS delivery systems to offer CHW services tailored for individuals with behavioral health conditions. ● Clubhouse Services, which offer ongoing social supports to enhance mental and physical health by reducing disconnectedness, reducing risk of social isolation and need for inpatient care. ● Supported Employment, an evidence-based Individual Placement and Support (IPS) model of supported employment for Medicaid members living with significant behavioral health needs. <i>Summary of Actions Needed</i> Pending CMS approval of the BH-CONNECT demonstration and associated State Plan Amendments(s), services described above will be available at county option effective January 1, 2025. Counties that opt to receive IMD funding will be required to implement a full suite of BH-CONNECT community-based services (with the exception of Clubhouse Services) during the demonstration period on a rolling basis as follows: ● Upon IMD Opt-In County go-live: Begin providing Enhanced CHW Services; ● Within One Year of Demonstration go-live: Fully Implementing ACT; ● Within Two Years of Demonstration go-live: Begin providing FACT and CSC for FEP; and ● Within Three Years of Demonstration go-live: Begin providing IPS Supported Employment.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	<i>Current Status:</i> <u>Milestone achieved.</u> Specialty mental health services can be provided in an array of community-based, non-specialty settings, including the home, when appropriate. The State has also implemented several initiatives to increase integration of behavioral health care in non-specialty care settings to improve early identification of SMI/SED and linkages to treatment, many connected to the Children and Youth Behavioral Health Initiative (CYBHI). Key CYBHI initiatives include: ● Student Behavioral Health Incentive Program (SBHIP), which supports partnerships between Medi-Cal managed care plans and schools to increase access to preventative behavioral health services. ● Behavioral Health Integration Incentives (BHI) Program, which aims 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.

Prompts	Summary
	• A statewide e-consult platform launched in 2024 to offer provider access to remote and real-time consultation support with behavioral health professionals. • The Behavioral Health Virtual Services Platform, a new technology-enabled services solution for all children, youth, and families in California, supports the delivery of equitable, appropriate, and timely behavioral health services from prevention to treatment to recovery, provides support and resources, such as interactive digital education, self-monitoring tools, application-based games, and mindfulness exercises, and offers access to free, on-demand one-on-one coaching and counseling supports. The State’s Mental Health Services Oversight & Accountability Commission released a draft statewide strategic plan on Early Psychosis Intervention (EPI) emphasizing measurable and specific goals that include elements such as increasing access to timely, affordable, high-quality EPI care and reduced time to treatment. DHCS has also implemented Dyadic Services, a preventive Medi-Cal benefit to serve both parent(s) or caregiver(s) and child together, targeting family well-being as a mechanism to support healthy child development and mental health.
	<i>Future Status</i> The State will continue to implement the initiatives described above. As part of the BH-CONNECT demonstration, the State is also seeking expenditure authority for a Workforce Initiative that would drive investments in peer training and supports aimed at children and youth; strengthen the pipeline of behavioral health professionals; and establish loan repayment programs for behavioral health professionals.
	<i>Summary of Actions Needed</i> Pending CMS approval, the state intends to implement the Workforce Initiative mid-2025.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	<i>Current Status. <u>Milestone achieved.</u></i> California has several specialized settings and services, include crisis stabilization, for young people living with SMI/SED. These include intensive treatment settings including Short-Term Residential Treatment Programs, Children’s Crisis Residential Programs, and Community Treatment Facilities. The State has also implemented several initiatives to ensure specialized settings and services, including crisis stabilization, are available to children and youth. These include: • Community-Based Mobile Crisis Intervention Services, authorized as a Medi-Cal benefit under SPA 22-0043, effective Jan. 1, 2023, which is available to children and youth. As part of required training for mobile crisis teams,

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	mobile crisis teams must participate in training on strategies to work effectively with children, youth and young adults experiencing behavioral health crises. Training may include, but is not limited to, delivering culturally responsive care, particularly when working with children, youth and young adults who are LGBTQ+, Black, Indigenous, and People of Color, involved in the child welfare system, or living with I/DD. Required training must also include an overview of existing minor consent obligations and appropriate protocols for communicating with parents, guardians and other responsible adults who may or may not be present at the time of the crisis. • School-linked partnership and capacity grants available through the Children and Youth Behavioral Health Initiative (CYBHI). The program provides resources to county offices of education, local education agencies and institutions for higher education to support institutional readiness and promote utilization of the statewide multi-payer school-linked fee schedule. The activities include expanding provider capacity, developing critical partnerships and building necessary infrastructure. DHCS intends to award \$550 million in one-time grants under this program, with approximately \$400 million allocated to public K-12 schools and the remaining dollars leveraged by institutions of higher education. • Family Urgent Response System (FURS), a coordinated statewide, regional, and county-level system designed to provide collaborative and timely response during situations of instability for current and former foster youth and their caregivers. • Behavioral Health Continuum Infrastructure Program (BHCIP), which 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.
	<i>Future Status</i> DHCS will continue to fund and oversee the specialized settings and initiatives described above. It is on track to submit a State Plan Amendment to cover CSC for FEP in the 4th quarter of 2024. The State is also establishing psychiatric residential treatment facilities (PRTFs) as a new category of residential health facilities licensed by the State to treat individuals under 21. DHCS will utilize interim PRTF licensing regulations adopted by the state in February of 2024 to establish final regulations, which are expected to be published no later than December 2027.
	<i>Summary of Actions Needed</i> Pending CMS approval of the BH-CONNECT demonstration and associated State Plan Amendments(s), services will be available at county option effective January 1, 2025. Counties that opt to receive IMD funding will be required to implement CSC within two years of demonstration go-live. Utilizing its existing interim regulations, DHCS will issue final regulations for PRTFs no later than December 2027.

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4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	<i>Current Status. <u>Milestone achieved.</u></i> See initiatives described in 4a. and 4b. above, and in particular those included in: • Student Behavioral Health Incentive Program (SBHIP), which supports partnerships between Medi-Cal managed care plans and schools to increase access to preventative services. • Various initiatives included in the Children’s Youth Behavioral Health Initiative (CYBHI), including efforts to expand awareness of Adverse Childhood Experiences (ACEs) and toxic stress; increase screening of and outreach to youth with mental health needs; a youth suicide reporting and crisis response pilot; a youth peer-to-peer support program; mindfulness and well-being grants; and a virtual services platform to provide resources to children and youth and support the delivery of equitable, appropriate and timely behavioral health services. • Requirement for each county to develop and implement a Memorandum of Understanding outlining the roles and responsibilities of local entities that serve children and youth in foster care to establish a more comprehensive Children and Youth System of Care. • Access to Specialty Mental Health Services for beneficiaries under 21 who meet certain eligibility requirements, without a requirement of a diagnosed mental health disorder. The SMHS access criteria for children and youth are different than for adults. DHCS strives to identify children with significant issues before they turn into a formal diagnosed condition. For example, Medi-Cal members under age 21 qualify for SMHS assessments and services if they are at high risk for a mental health disorder due to the experience of trauma (including being child-welfare involved, juvenile-justice involved, or experiencing homelessness), or if they have a need for specialty mental health services, prior to a formal diagnosis being established. The July 2024 release of ACL 24-35 requires that child welfare and juvenile probation submit referrals for connection to SMHS within three business days of opening a case. • Coordinated Specialty Care for First Episode Psychosis, based on an evidence-based early intervention service model for individuals experiencing a first episode of psychosis (FEP) that can improve their quality of life and social and clinical outcomes. More than half of counties in the State offer CSC for FEP programs funded in part through SAMHSA block grants, with training and technical assistance offered through UC Davis. ○ The State also plans to submit a State Plan Amendment to cover CSC for FEP as a bundled Medi-Cal service at county option.
	<i>Future Status</i> Continue to implement the initiatives described above. In addition, the State plans to implement a joint initial child welfare and specialty mental health assessment at the entry point into child welfare.
	<i>Summary of Actions Needed</i>

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	Effectuation of the joint initial child welfare and specialty mental health assessment (for which DHCS is not requesting any waiver or expenditure authority) is under evaluation by DHCS with a target of 2025. DHCS will utilize BHINs to put forth the requirements, offering webinars to ensure clarity of guidance and compiling frequently asked questions as needed.
SMI/SED. Topic_5. Financing Plan	
<i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.</i>	
5.a Increase availability of non- hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	<i>Current Status. <u>Milestone achieved.</u></i> The State has expanded access to non-hospital, non-residential crisis stabilization services using a coordinated community response including through: • BHCIP Round 1: (Crisis Care Mobile Units) awarded more than \$205 million to 47 grantees, including 403 mobile crisis teams and 159 vehicles purchased in order to produce or improve mobile crisis response teams in the state of California. As of July 15, 2024, 25,142 total CCMU dispatches with CCMU services were provided. Other services include clinical assessments by mental health professionals, triage/screening on-site, crisis and safety planning, de-escalation, conflict resolution, referral to outpatient behavioral health services, welfare checks, support for family and friends, peer support services, referral to medical services, and transportation. • BHCIP Round 5: Crisis and Behavioral Health Continuum, \$430 million awarded to 33 grantees. These grants will support behavioral health facilities to expand capacity to serve a projected 73,848 individuals served on an annual basis in new or expanded outpatient settings. Round 5 focused on the construction and expansion of crisis and behavioral health facilities across the state, including the addition of seven Behavioral Health/Mental Health Urgent Care walk-in centers with voluntary stabilization-oriented services specific to individuals experiencing behavioral health and/or mental health crisis for less than 24 hours. • Medi-Cal coverage of Community-Based Mobile Crisis Intervention Services, a community-based intervention to provide de-escalation and relief to individuals experiencing a mental health or substance use-related crisis that must be provided statewide by all specialty behavioral health delivery systems. As of September 2024, all counties have submitted implementation plan to begin delivering mobile crisis services under Medi-Cal. 45 counties have received final approval and are actively delivering services compliant with DHCS guidance; these counties cover more than 97% of the state's Medi-Cal population., ○ BHIN 23-025 includes detailed requirements for county behavioral health delivery systems to ensure that mobile crisis services available under Medi-Cal are aligned with federal guidance and national best practices. County behavioral health delivery systems are required to coordinate with the 988 Suicide and Crisis Lifeline,

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	local law enforcement and 911 systems, the Family Urgent Response System (FURS), and community partners to ensure beneficiaries have information about mobile crisis services. County behavioral health delivery systems must also coordinate with law enforcement to determine how mobile crisis teams and law enforcement can best work together to safely resolve and de-escalate behavioral health crises, minimizing the role of law enforcement except when necessary and appropriate for safety reasons. • FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth. • The Community Paramedicine or Triage to Alternate Destination Act, which offers an opportunity for counties to further develop alternative transportation options that would allow an individual in crisis to be transported from the community to a variety of health facilities using the least restrictive methods possible. Currently approved Triage to Alternate Destination Programs are located in Fresno County, Los Angeles County, San Francisco County, and Stanislaus County. AB 767 extended the Community Paramedicine or Triage to Alternate Destination Act until January 1, 2031, and expanded the allowable community paramedicine services program specialties to include provision of short-term, post-discharge follow-up, including collaboration with, and by providing referral to, home health services when eligible. • The 988 Suicide and Crisis Lifeline, in which DHCS has invested over \$130 million of combined federal grant and state funding from State Fiscal Years 2021-22 through 2025-26, supports California’s network of 988 crisis centers to support the launch of the national 988 hotline for people seeking help during a behavioral health crisis. The Miles Hall Lifeline and Suicide Prevention Act, enacted in 2022, established the California 988 State Suicide and Behavioral Health Crisis Services Fund, consisting of the revenue generated by the 988 surcharge assessed on users under Section 41020 of the Revenue and Taxation Code, providing ongoing support for 988 in California. Commercial health plans are also required to cover behavioral health crisis services that are provided to member by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in-network or out-of-network provider or facility.
	<i>Future Status</i> • As described above, the State is working closely with county behavioral health delivery systems to implement Community-Based Mobile Crisis Intervention Services as a required Medi-Cal service. The State is facilitating comprehensive training and technical assistance to mobile crisis services providers and county behavioral health delivery systems to train and support new mobile crisis teams to ensure services are available 24/7/365 across the state. The BHCIP Round 1 2024 Launch Ready Request for Application is open until December 13, 2024. This round of grant funding makes \$3.3 billion available for eligible applicant types including Behavioral Health Urgent Care/Mental Health Urgent Care, Community Wellness/Prevention Center and Crisis Stabilization Unit. The

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	remaining thirteen counties are working towards approval of their implementation plans. These counties remain subject to DHCS corrective action, including corrective action plans and sanctions, until they implement the Medi-Cal benefit in a compliant manner. They are also required to deliver mobile crisis services to the extent possible while they work to come into full compliance; all are able to deliver mobile crisis response in at least some regions of the county and/or during some time periods (though they may not yet be able to provide 24/7 mobile response countywide). Over the course of the BH-CONNECT demonstration, the State will continue to expand access to existing crisis services that may be delivered in non-hospital, non-residential settings, including mental health crisis stabilization and intervention and SUD crisis intervention. As part of the Access, Reform and Outcomes Incentive Program, county behavioral health delivery systems will be eligible to earn incentive payments for increasing their capacity to deliver crisis services. In addition, the State plans to submit a State Plan Amendment to cover ACT and CSC for FEP as bundled Medi-Cal services; both evidence-based practices include crisis support for members with SMI/SED as part of the comprehensive treatment model. More than half of counties in the State offer CSC for FEP programs funded in part through SAMHSA block grants training and technical assistance offered through University of California, Davis.
	<i>Summary of Actions Needed</i> DHCS will partner with counties to approve outstanding mobile crisis implementation plans and determine community-responsive methods for bolstering crisis response. Depending on the size and population density of counties the interventions will vary. DHCS expects counties to continue to build mobile crisis capacity over time. BHCIP Rounds 1, 2, and 5, support continued expansion of facility-based services, including but not limited to crisis services. For BHCIP funded projects awarded in Rounds 3 through 5, communities can anticipate an expansion of new behavioral health facilities by 2027. By the end of 2024, 21 projects are anticipated to complete construction and more BHCIP funded projects will be underway to leverage gaps in the behavioral health care continuum. Through the BHCIP program and Behavioral Health Transformation Bond funding (see milestone 2b), the State is continuing to invest in behavioral health facility infrastructure expansion to an unprecedented degree. DHCS will implement over \$4 billion in grant funding to expand behavioral health facility capacity, including the implementation of the Bond BHCIP Round 1: Launch Ready RFA which commits \$3.3 billion to expand community-based behavioral health treatment infrastructure based on local needs, including Behavioral Health Urgent Care, Mental Health Urgent Care, Crisis Stabilization Units, and Community Wellness/Prevention Centers (for Tribal entities).

Prompts	Summary
	The state will continue to expand its 988 program to ensure more robust coordination with local mobile crisis dispatch to support connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner, by promoting collaboration and coordination of state, county and regional behavioral health and cross sector partners to connect individuals in behavioral health crises to immediate and ongoing care, and developing a process and/or structure to support connection and coordination with mobile crisis services. The Access, Reform and Outcomes Incentive Program will launch in 2025. ACT and CSC for FEP will be available for county option in January 2025 per guidance to be released in the BH-CONNECT BHIN and subsequent implementation guidance.
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	<i>Current Status.</i> <u>Milestone achieved.</u> BHCIP Rounds 2-5 awarded competitive grants to qualified entities to expand the continuum of behavioral health treatment resources including by increasing capacity for community and outpatient behavioral health services, and other clinically enriched longer-term treatment and rehabilitation opportunities for individuals with behavioral health disorders, in the least restrictive and least costly setting. • Round 2 (County and Tribal Planning Grants) awarded \$16 million to 18 tribal entities and 30 county behavioral health agencies. • Round 3 (Launch Ready) awarded \$518.5 million to 45 grantees. These grants will support behavioral health facilities to expand capacity to serve a projected 130,321 individuals on an annual basis in new or expanded outpatient settings. Round 3 was determined, in part, through a statewide needs assessment that identified significant gaps in available crisis services. • Round 4 (Children and Youth) awarded \$480.5 million awarded to 52 grantees. These grants will support behavioral health facilities to expand capacity to serve a projected 76,977 individuals on an annual basis in new or expanded outpatient settings. See also Section 4.a. for a description of the State’s efforts to increase the availability of community-based services and services in integrated settings. <i>Future Status</i> As described in milestone 4a, the State intends to submit a State Plan Amendment to cover an enhanced set of community-defined services and evidence-based practices under Medi-Cal. Beginning in 2025, opt in counties will begin implementing ACT, CSC, etc., with the intent of serving all members eligible for the service, including ACT, FACT, CSC for FEP, CHW Services, and Clubhouse Services. To ensure these services are widely available for Medi-Cal members for whom they

Prompts	Summary
	are medically appropriate, the State is developing bundled payment rates for new services that cover the full cost of delivering the team-based models. In addition, as part of the BH-CONNECT demonstration the State has proposed to establish the Access, Reform, and Outcomes Incentive Program to incentivize BHPs and DMC-ODS counties to improve performance on timely access to outpatient services and increased utilization of community-based evidence-based practices with a focus on members living with SMI/SED and/or SUD who are otherwise at risk of hospitalization or other significant adverse health outcomes. In addition, the State intends to clarify that Intensive Outpatient or Partial Hospitalization programs that meet the Medi-Cal requirements for the current State Plan service Day Treatment Intensive, may be Medi-Cal certified to provide Medi-Cal reimbursable Day Treatment Intensive Services (and existing State Plan benefit) for Medi-Cal members. This will allow a provider to offer a single program that simultaneously meets the requirements of Intensive Outpatient or Partial Hospitalization for the purposes of commercial insurance and Day Treatment Intensive for the purposes of Medi-Cal. This clarification is designed to increase access to these service types for Medi-Cal members. Bond BHCIP grant funding, totaling \$4.4 billion, will be released in state fiscal years 2024-25 (round 1) and 2025-26 (round 2). Bond BHCIP Round 1 (Launch Ready) Request for Applications was released on July 17, 2024 with applications due December 13, 2024. Anticipated award announcements in May 2025 awarding up to \$3.3 billion statewide. Bond BHCIP Round 2: Unmet Needs RFA is expected to be released in mid-May 2025 for up to \$1.1 billion in funding. Bond BHCIP is estimated to fund 26,700 outpatient treatment slots for behavioral health and will build on other major behavioral health initiatives in California. Under Proposition 1, AB 531 includes a \$6.38 billion bond to build new treatment facilities, community infrastructure and supportive housing for individuals living with significant behavioral health needs, including: • The recent release of \$3.3 billion in competitive grant funding to expand the behavioral health continuum and provide appropriate care to individuals experiencing mental health conditions and substance use disorder; • A second round of up to \$1.1 billion in grant funding for additional behavioral health treatment site infrastructure; and • Up to \$2 billion to build permanent supportive housing for veterans and others that are homeless or at risk of homelessness and have mental health or substance use challenge <i>Summary of Actions Needed</i> Pending CMS approval of the BH-CONNECT demonstration and associated State Plan Amendments(s), services described above will be available at county option effective January 1, 2025. Counties that opt to receive IMD funding will be required to implement a full suite of BH-CONNECT community-based services (with the exception of Clubhouse Services) during the demonstration period.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
<i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”¹⁵ The HIT Plan should also describe, among other items, the:</i>	
<i>• Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i> <i>• Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i>	
<i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i>	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.	<i>Current Status. <u>Partially achieved.</u></i> California has sufficient health IT and data exchange governance, policy, technical, and operational infrastructure at every level to support the goals of the BH-CONNECT demonstration. Examples of this statewide infrastructure are below: California Data Exchange Framework (DxF): At the state level, California’s data exchange efforts are guided by the California Data Exchange Framework (DxF). In accordance with California Health and Safety Code § 130290, the California Health and Human Services Agency (CalHHS) launched the DxF initiative with a vision that “every Californian, and the health and human service providers and organizations that care for them, will have timely and secure access to usable electronic information that is needed to address their health and social needs and enable the effective and equitable delivery of services to improve their lives and wellbeing.” On July 5, 2022, CalHHS released the DxF, a Data Sharing Agreement (DSA), and an initial set of DxF Policies and Procedures. California Health and Safety Code § 130290 requires that on or before January 31, 2023, the DxF DSA shall be executed by providers and hospitals that include “physician organizations and medical groups” and “acute psychiatric hospitals.” Beginning January 31, 2024, DSA signatories must exchange health information or provide health information to and from other signatories. California Health and Safety Code § 130290 stipulates that physician practices with fewer than 25 physicians, acute psychiatric hospitals, and state-run acute psychiatric hospitals are not required to exchange data in conformance with the DxF until January 31, 2026. As of November 1, 2023, more than 2,000 organizations had signed the DxF DSA. Health Information Exchanges (HIEs): With respect to California’s data exchange technical infrastructure, nine health information exchanges (HIEs) and two community information exchanges (CIEs) were operational as of June

¹⁵ See SMDL #18-011, “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.” Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

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	2023. Based on a 2019 survey, the nine HIEs included data exchange with behavioral health providers, and two of the HIEs were identified as providing functions specific to priority domains and are described below.¹⁶ A range of incentives and funding opportunities have been made available to support behavioral health providers’ access to HIEs. In 2023, one HIE launched analytic dashboards to support California’s behavioral health providers in meeting the requirements of the state’s Behavioral Health Quality Improvement Program (BHQIP). The dashboards allow provider organizations to view, analyze, and enhance the management of patient populations. DHCS’s Incentive Payment Program (IPP) provides incentives for Managed Care Plans (MCPs) to support HIE across their entire network, including with behavioral health providers. DHCS’s Providing Access and Transforming Health (PATH) program has health IT-related grant funding for community and county-based providers, including behavioral health providers. CalHHS’s Center for Data Insights and Innovation (CDII) has a grant program that supports onboarding to qualified Health Information Organizations (HIOs) and is open to behavioral health providers and counties. EHR Adoption: At the county level, electronic health records (EHRs) have become an integral part of ensuring the highest quality of care for members receiving behavioral healthcare. Most BHPs implemented newer EHRs with California’s Mental Health Service Act technology funds that became available between 2008 and 2013. Statewide, 24 out of 56 BHPs (43 percent) maintain member health records fully electronically, one BHP had not yet implemented an EHR system as of July 2021, and the rest maintain a combination of both electronic and paper records.¹⁷ However, many EHR systems fall short of being fully interoperable and supporting behavioral health business needs. As such, the California Mental Health Services Authority (CalMHSA) leveraged its Joint Powers Authority to bring counties together to procure and implement a new semi-statewide EHR system specifically tailored to the needs of behavioral health entities and providers. • CalMHSA released a request for proposals on September 20, 2021, and selected Streamline Healthcare Solutions’ SmartCare EHR. In July 2023, CalMHSA launched the initial phase of the semi-statewide EHR program which covered over 37 percent of the state’s Medi-Cal population, and CalMHSA will expand the program to additional counties in 2024.¹⁸ • CalMHSA has customized the EHR to meet the needs of the public behavioral health system in several ways. In California, the BHPs function as both a managed care plan, and, depending on the county, can also operate as a provider of services, and the EHR supports both roles. The EHR supports plan-level functions related to provider network management (service rates, claims adjudication, etc.) and to benefit management (service authorizations, utilization management, etc.) as well as supporting reporting of population level indicators and outcomes. CalMHSA has customized the EHR to allow for, with appropriate client consent, the integration of substance use and mental health treatment information, which empowers providers to provide integrated comprehensive care. The converse is

¹⁶ Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator’s national survey of HIOs included in DHCS’s [California State Medi-Cal Health Information Technology Plan](#). Published online March 2022. ¹⁷ Behavioral Health Concepts, Inc. [FY 2021-2022 Statewide Technical Report: Medi-Cal Specialty Mental Health](#). Published online April 26, 2023. ¹⁸ CalMHSA [Semi-Statewide EHR website](#). Accessed August 9, 2023.

Prompts	Summary
	also true, with data from mental health and substance use treatment providers being segmented from each other if client consent to share information is not given. Additionally, this data segmentation ensures that the EHR data is configured for data exchange opportunities. The CalMHSA continues to customize the EHR to support the unique workflows, provider types and settings in which behavioral health practitioners operate, including inpatient, residential, and psychiatric inpatient settings. • The participants in CalMHSA's semi-statewide EHR program currently leverage CalMHSA Connex to achieve robust interoperability standards. CalMHSA Connex is a specialized Health Information Exchange (HIE) which enables comprehensive regulatory interoperability compliance to multiple current requirements, including the California Data Exchange Framework (DxF) and the Centers for Medicare & Medicaid Services (CMS) Interoperability mandates. The behavioral health-focused HIE meets DxF requirements through its integration with the Care Quality framework, ensuring seamless data exchange across various healthcare systems and a variety of EHR systems. At the organizational level, hospitals and ambulatory care providers have varying rates of EHR adoption and HIE integration. ○ Hospital adoption of EHRs in California is high. As of 2019, 83.2 percent of hospitals had adopted either a basic or a comprehensive EHR. The most common EHR vendors used by California hospitals are Cerner, Epic and Meditech.¹⁹ Specific hospital IT functionalities related to Section 1115 demonstration capabilities are described below. Adoption of EHRs in the behavioral health ambulatory care market has been dominated by three legacy vendors (Cerner, NetSmart, and Echo). The recent increase in EHR implementation is marked by the entry of several new vendors that offer updated products that promise to enhance BHP capabilities to meet recently released DHCS requirements and more seamlessly care for Medi-Cal members. In addition to the examples of statewide infrastructure listed above, DHCS has several ongoing initiatives that support BH-CONNECT's goals. The BH-CONNECT demonstration is integral to California'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 Center for Medicare and Medicaid Services' (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 continue expanding and strengthening the continuum of care for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED) through targeted incentive programs and contractual requirements. • DHCS' Contractual Requirements for BHPs: DHCS' Memoranda of Understanding (MOU) between MCPs and BHPs require all parties to share information necessary to facilitate referrals across sectors and coordinate care. They must have policies and procedures for: timely exchange of member information, including behavioral health and

¹⁹ Adler-Milstein J. California Health IT Landscape Assessment

Prompts	Summary
	physical health data; maintaining the confidentiality of exchanged information and data; supporting bidirectional monitoring of data exchange processes; and obtaining member consent. The data elements to be shared must be agreed upon jointly by the parties, reviewed annually, and set forth in the MOU. They must share, at a minimum, member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the member’s health and/or welfare. Starting in January 2024, MCPs are required to enter into MOUs with various programs and services, including BHPs to facilitate care coordination and information exchange. The state intends to leverage the standards under the CMS Interoperability Rules to ensure that health information can be exchanged seamlessly. These standards are required for Medi-Cal contracted plans and are being adopted by the California Data Exchange Framework. • Behavioral Health Related Incentives: The BHQIP is a statewide incentive program that supports BHPs and Drug Medi-Cal State Plans (DMC) as they prepare for and implement changes under CalAIM and other administration priorities. These entities can earn incentive payments by completing deliverables tied to milestones. The incentive funds may be used to assist counties in pursuing CalAIM requirements, which may include staffing, technology, infrastructure, or training costs. Relevant to health IT, the BHQIP is currently incentivizing bi-directional data exchange between BHPs, DMCs, and MCPs with the goal of enhancing care coordination efforts. To receive incentive payments, entities must either demonstrate direct sharing of data with MCPs or demonstrate onboarding to a HIE. BHQIP has three domains, one of which focuses on data-sharing agreements among MCPs and BHPs. Additionally, the BHQIP incentivizes the implementation of standardized screening tools, assessment tools, and documentation. The movement towards standardized tools and documentation standards throughout California will allow for greater interoperability of behavioral health data. While BHQIP is set to conclude in March 2024,²⁰ BH-CONNECT will continue to build on the BHQIP and incentivize BHPs’ infrastructure for quality measurement and reporting. • Children and Youth Behavioral Health Initiative: As part of California’s Children and Youth Behavioral Health Initiative (CYBHI), in January 2024 DHCS will launch a statewide e-Consult solution that will enable primary care physicians (PCPs), pediatricians and other health care providers to consult with licensed behavioral health professionals (including child and adolescent psychiatrists) via a technology-enabled service platform. This statewide platform will better equip PCPs with the knowledge, skills, and abilities to appropriately provide treatment to members living with behavioral health needs. Also in January 2024, DHCS launched two virtual services platforms to provide members with one-on-one coaching, educational resources, peer communities and more. One platform will serve children ages 0-12 and their parents/caregivers. The other platform will provide services to youth and young adults

²⁰ State of California Department of Health Care Services. CalAIM Behavioral Health Quality Improvement Program. Published online September 21, 2022. <https://www.dhcs.ca.gov/bhqip>

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	ages 13-25. The CYBHI is a payer agnostic and not specific to the Medi-Cal program; however, Medi-Cal members will have access to and be able to benefit from these programs.
Statement 2: Please confirm that your state’s SUD Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	<i>Current Status. <u>Partially achieved.</u></i> California’s Substance Use Disorder (SUD) Health IT Plan is aligned with California’s broader State Medicaid Health Information Technology Plan (SMHP). In March 2022, DHCS released the final SMHP which required DHCS to assess the impacts of the Medicaid Promoting Interoperability Program (titled the Medi-Cal Promoting Interoperability Program in California). DHCS formulated six future goals based on its HIT landscape assessment. Those goals were to: 1. Establish the CalHHS DxF, which creates: • Standards for statewide data exchange. • A functional HIE network throughout the state. 2. Meet key business needs supported by the CalHHS DxF that: • Meet the needs for whole person care and CalAIM. • Improve access to bidirectional exchange with public health registries. • Increase utilization of HIEs by emergency services. • Establish a statewide registry for advanced directives. 3. Implement the CMS Interoperability and Patient Access Rule to increase member access to health care data through payer, formulary, and patient access application programming interfaces (APIs). 4. Identify funding for existing gaps in the HIT/HIE landscape as recommended by the CalHHS DxF Advisory Group, including: • Financial stability for the state’s HIEs. • Increased EHR adoption by professionals who have been ineligible for the Medi-Cal Promoting Interoperability Program with associated technical assistance on EHR and HIE use to address gaps. • Increased EHR adoption by hospitals and other facilities that have been ineligible for the Medi-Cal Promoting Interoperability Program with associated technical assistance on EHR and HIE use to address gaps. 5. Establish universal broadband access throughout California as supported by the California Broadband Council under the Broadband for All Action Plan, which in turn supports: • Continued increased use of telehealth throughout California after the end of the COVID-19 public health emergency.

Prompts	Summary
	6. Improve availability to equipment and technical assistance for low-income Californians to bridge the digital divide, access their health information, and benefit from the Interoperability and Patient Access Final Rule. On May 22, 2023, CMS approved California's SUD Monitoring Protocol, which included “Attachment E: SUD Health IT Plan.”
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	<i>Current Status.</i> <u>Partially achieved.</u> DHCS intends to assess and consider the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B and implement them as appropriate. • DHCS Initiatives: As per Behavioral Health Information Notice 22-068, BHPs must comply with the CMS Interoperability and Patient Access Final Rule, including implementing and maintaining standards-based Application Programming Interfaces (APIs) and a publicly accessible Provider Directory API. BHPs are to comply with 42 CFR 438.242, 45 CFR 170.215, and the provider directory information requirements specified in 42 CFR 438.10. DHCS requires BHPs to implement and maintain a Patient Access API that can connect to provider EHRs and practice management systems, in accordance with requirements specified at 42 CFR section 431.60. The Patient Access API must permit third-party applications to retrieve, with the approval and at the direction of a member or member’s authorized representative, data specified in this BHIN through the use of common technologies and without special effort from the member. BHPs must also implement and maintain a publicly accessible standards-based Provider Directory API as described in 42 CFR section 431.70 and meet the same technical standards of the Patient Access API, excluding the security protocols related to user authentication and authorization. California DxF: In addition, all signatories to the California DxF DSA must exchange data in conformance with the DxF’s Technical Requirements for Exchange Policy and Procedure which stipulates that signatories abide by standards approved by the DxF Governance Entity, which will review and consider new and maturing “national and federally adopted standards” (i.e., standards specifically included by the U.S. Department of Health and Human Services in a published version of the Standards Version Advancement Process) for potential inclusion in the DxF.
<i>To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states “for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers.” For more on the availability of this “HITECH funding,” please contact your CMS Regional Operations Group contact.</i>	

Prompts	Summary
<i>Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established “No Wrong Door System.”</i>	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e- referrals from physician/mental health provider to physician/mental health provider	<i>Current Status.</i> <u>Milestone partially achieved.</u>
	Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider can be accomplished directly through EHR capabilities or facilitated through HIEs. • External Landscape (Counties and HIEs): At the county level, 50 percent of California’s BHPs reported that their contracted providers were using operational EHRs that included referral management capabilities as of 2022.²¹ With respect to regional data exchange, four HIEs in California made referral data available to connected providers as of 2019.²² As of 2022, two California HIEs offer, or are in the process of implementing, e-referrals and closed loop referral capabilities. At this time, the HIE-facilitated referrals are not fully closed loop – the referral form is completed and delivered electronically, and then loop closure is determined upon receipt of the progress note (i.e., there is no tracking of referral status). One of California’s operational CIEs also supports e-referrals. • California DxF: In addition, all signatories to the California DxF DSA must exchange data in conformance with the DxF’s Technical Requirements for Exchange Policy and Procedure which stipulates that signatories that create “Health and Social Services Information regarding a specific Individual in conjunction with an Order or Referral must send that Health and Social Services Information to the ordering Participant electronically via Information Delivery if the ordering Participant is technically capable of electronic receipt.”
	<i>Future Status</i> At the county level, CalMHSA’s semi-statewide behavioral health EHR system was launched in July 2023 and now covers over 37 percent of the state’s Medi-Cal population.²³ CalMHSA will expand the EHR to additional counties in 2024.²⁴ The semi-statewide behavioral health EHR system will include closed loop referral capabilities.²⁵

²¹ Behavioral Health Concepts, Inc. [FY 2021-2022 Statewide Technical Report: Medi-Cal Specialty Mental Health](#). Published online April 26, 2023.

²² Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator’s national survey of HIOs.

²³ As of November 1, 2023, according to [CalMHSA’s website](#), twenty-three California counties were participating in the semi-statewide behavioral health EHR system: Colusa, Contra Costa, Fresno, Glenn, Humboldt, Imperial, Kern, Kings, Lake, Marin, Mono, Nevada, Placer, Sacramento, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Siskiyou, Sonoma, Stanislaus, Tulare, Ventura.

²⁴ CalMHSA [Semi-Statewide EHR website](#). Accessed August 9, 2023.

²⁵ Miller A. Interview with the California Mental Health Services Authority (July 25, 2022).

Prompts	Summary
	California’s requirements for statewide data exchange via the DxF and DHCS’ contractual requirements and incentive programs with MCPs will accelerate behavioral health providers’ connectivity to and exchange of information via HIEs which, in turn, will create opportunities for behavioral health providers to access and utilize closed loop referrals. DHCS requires that MCPs’ MOUs with BHPs must require BHPs to support closed loop referral services. By January 1, 2025, BHPs must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, Enhanced Care Management (ECM) benefits, and/or community-based resources.²⁶ The Parties must work collaboratively to develop and implement a process to ensure that MCPs and BHPs comply with the applicable provisions of closed loop referrals guidance within 90 days of issuance. The parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar forthcoming guidance.
	<i>Summary of Actions Needed</i> • Continue expansion of CalMHSA’s semi-statewide behavioral health EHR system • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs • Assess opportunities to expand DxF requirements to include requirements for closed loop referrals • Provide additional guidance and technical assistance to BHPs to support the expanded use of closed loop referral systems • Provide funding for the adoption and deployment of closed loop referral systems
1.2 Closed loop referrals and e- referrals from institution/hospital/clinic to physician/mental health provider	<i>Current Status:</i> Please see response to section 1.1.
	<i>Future Status:</i> Please see response to section 1.1.
	<i>Summary of Actions Needed:</i> Please see response to section 1.1.
1.3 Closed loop referrals and e- referrals from physician/mental health provider to community based supports	<i>Current Status.</i> <u>Milestone partially achieved.</u> CalAIM offers a wide array of Community Supports and facilitates coordination between physician and mental health providers to community-based organizations (CBOs). Currently, closed loop referrals and e-referrals from physician/mental health provider to CBOs are being supported through HIEs, CIEs, and social drivers of health (SDOH)-focused closed loop referral systems.

²⁶ As referenced in the [CalAIM Population Health Management \(PHM\) Policy Guide](#), [APL 22-024](#), and the 2024 Managed Care Contract, as amended from time to time, and as set forth by DHCS through APL, or other, similar guidance.

Prompts	Summary
	As of September 2023, two of California’s HIEs offer e-referral capabilities to a range of their data exchange participants. • One HIE is developing e-referrals to CBOs for multiple referral types. • One HIE currently uses the Unite Us community resource referral platform to provide closed loop CBO referrals. California’s two operational CIEs provide information on the availability of community-based support services.
	<i>Future Status</i> California’s requirements for statewide data exchange (i.e., the DxF) and DHCS’ contractual requirements and incentive programs with MCPs will accelerate behavioral health providers’ connectivity to and exchange of information via HIEs which, in turn, will create opportunities for behavioral health providers to access and utilize closed loop referrals for community-based supports. • DHCS Initiatives: DHCS requires MCPs to have MOUs with BHPs, and all parties must enact policies and procedures that include a process for the BHP to send regular, real-time or batch referrals to ECM providers and Community Supports referrals to MCPs. MCPs’ MOUs with BHPs will require all plans to support closed loop referral services. By January 1, 2025, BHPs must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Policy Guide, APL 22-024, and the 2024 Managed Care Contract, and as set forth by DHCS through APLs, or other, similar guidance. The parties must work collaboratively to develop and implement a process to ensure that BHPs comply with the applicable provisions of closed loop referrals guidance within 90 days of issuance. The parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.
	<i>Summary of Actions Needed</i> • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs, CIEs, and SDOH closed-loop referral systems • Assess opportunities to expand DxF requirements to include requirements for closed loop referrals • Provide additional guidance and technical assistance to support expansion of closed loop referral systems among MCPs, BHPs, and other entities • Provide funding for the deployment of closed loop referral systems
Electronic Care Plans and Medical Records (Section 2)	
	<i>Current Status.</i> <u>Milestone partially achieved.</u>

Prompts	Summary
2.1 The state and its providers can create and use an electronic care plan	The ability for stakeholders to create electronic care plans has been and remains a priority for DHCS. • DHCS Initiatives: The DHCS Population Health Management program requires that entities providing Complex Care Management (CCM) or ECM must include a comprehensive assessment of each member’s condition, available benefits, and resources (including Community Supports), as well as develop and implement a care management plan with goals, monitoring, and follow-up.²⁷ Under the CalAIM Documentation Redesign Initiative, DHCS shifted from away from requiring the documentation of standalone treatment plans toward allowing treatment planning activities to be recorded more flexibly within an EHR (i.e., within a problem list and/or progress notes) as long as the treatment plan can be easily extracted and shared. These flexibilities are allowed except for in cases where federal requirements mandate a standalone treatment plan. On November 20, 2023, DHCS implemented BHIN 23-068 which replaced BHPs’ client plan documentation requirements with a problem list and progress notes documentation. This shift was intended to help behavioral health providers align terminology and data elements with the physical health care system, allowing for easier data sharing and care coordination. Providers responsible for a member’s care are responsible for creating and maintaining a problem list, as well as updating the problem list on a regular basis to reflect the member’s current condition. Through BHQIP, BHPs are incentivized via payments to meet specific milestones, one of which is implementing DHCS’ revised documentation standards, including problem lists and progress notes. Earned incentive funds may be used to assist counties in pursuing CalAIM requirements, which may include staffing, technology, infrastructure, or training. • External Landscape: At a regional level, five of California’s HIEs make care plan field data, including goals and instructions, available.²⁸ All signatories to the California DxF DSA must exchange data in conformance with the DxF’s Data Elements to Be Exchanged Policy and Procedure which stipulates that signatories must exchange data elements in the United States Core Data for Interoperability (USCDI) Version 2, including data elements for care plans.
	<i>Future Status</i> As per DHCS’ requirement that MCPs have MOUs with BHPs, all parties must share information necessary to facilitate referrals and coordinate care. They must have policies and procedures for exchanging member information and data, including behavioral health and physical health data, in a timely manner; maintaining the confidentiality of exchanged

²⁷ [CalAIM: Population Health Management \(PHM\) Policy Guide: Updated May 2023.](#)

²⁸ Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator’s national survey of HIOs.

Prompts	Summary
	information and data; bidirectional monitoring of data exchange processes; and obtaining member consent. The data elements to be shared must be jointly agreed upon by the parties, reviewed annually, and set forth in the MOU. The data elements must include, at a minimum, member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the member’s health and/or welfare. BHPs and MCPs must also develop joint processes for reviewing and updating a member’s problem list, as clinically indicated. The joint processes must also describe circumstances for updating care plans and coordinating with outpatient SUD providers. <i>Summary of Actions Needed</i> • Assess opportunities to expand DxF requirements to include requirements for electronic care plan creation and transmission • Provide additional guidance to support expansion of electronic care plan creation and transmission • Provide funding for electronic care plan creation and transmission
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	<i>Current Status.</i> <u>Milestone partially achieved.</u> An additional milestone of the BHQIP involves behavioral health entities demonstrating improved data exchange capabilities. To receive incentive payments, entities must: • Demonstrate direct sharing of data with MCPs or demonstrate onboarding to a HIE • Demonstrate an active Fast Healthcare Interoperability Resources API that will allow the BHP to be compliant with CMS-mandated interoperability rules • Demonstrate that the BHP has mapped data elements to the USCDI Version 2 standard set While not specific to electronic care plans, improved data exchange capabilities supported through BHQIP may facilitate the interoperability and accessibility of electronic care plans among BHPs. As of 2022, two of California’s HIEs had capabilities to share electronic care plans. One HIE currently shares electronic care plan information, though electronic care plans cannot be modified after sharing on the HIE. Additionally, another HIE currently shares electronic care plans via Activate Care, a health IT product featuring social needs screening and care coordination/referral capabilities to address patients’ social needs, which was implemented in February 2021. <i>Future Status</i>

Prompts	Summary
	As per DHCS’ requirement that MCPs and BHPs enter into MOUs, all parties must share information necessary to facilitate referrals and coordinate care. They must have policies and procedures for exchanging member information and data, including behavioral health and physical health data, in a timely manner; maintaining the confidentiality of exchanged information and data; bidirectional monitoring of data exchange processes; and obtaining member consent. The data elements to be shared must be jointly agreed upon by the parties, reviewed annually, and set forth in the MOU. The data elements must include, at a minimum, member demographic information, behavioral and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the member’s health and/or welfare. BHPs and MCPs must also develop joint processes for reviewing and updating a member’s problem list, as clinically indicated. The joint processes must also describe circumstances for updating care plans and coordinating with outpatient SUD providers.
	<i>Summary of Actions Needed</i> • Assess opportunities to expand DxF requirements to include requirements for electronic care plan creation and transmission • Provide additional guidance in the State Health Information Guidance (SHIG) to support expansion of electronic care plan creation and transmission • Provide funding for electronic care plan creation and transmission
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	<i>Current Status.</i> <u>Milestone partially achieved.</u> To avoid duplication of care and to facilitate transitions between healthcare systems, DHCS developed and implemented the Transition of Care Tool for Medi-Cal Mental Health Services for Youth and Adults to leverage existing clinical information to document a member’s mental health needs and facilitate a referral to the member’s MCP or BHP, as needed. The Transition of Care Tool is used when a member who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system (i.e., MCP or BHP) or 2) services need to be added to their existing mental health treatment from the other delivery system. These tools are part of CalAIM and are available on DHCS’ Screening and Transition of Care Tools for Medi-Cal Mental Health Services website and are further detailed in BHIN 22-065. According to CalMHSA, every BHP operates an integrated record with a client ID that is age agnostic. This allows for medical records and care plans/problem lists to flow as members transition from youth to adult care.²⁹ In addition, a number of California’s HIEs provide capabilities to support the transition of youth to adult behavioral health systems. For example,

²⁹ Miller A. Interview with the California Mental Health Services Authority (July 25, 2022).
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Prompts	Summary
	one HIE does not automatically share records or care plans when a youth transitions to adult services, but adult services organizations can query and access medical records and care plans from youth care.
	<i>Future Status</i> Improved usage of child and adult transition of care tools
	<i>Summary of Actions Needed</i> - Monitor and assess the implementation and usage of child and adult transition of care tools - Support increased usage through technical assistance or funding (e.g., incentives), as appropriate
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	<i>Current Status.</i> <u>Milestone partially achieved.</u> See section 2.3 for a discussion of transitions from youth to adult behavioral health care. As the state moves away from requiring the documentation of standalone care plans and toward allowing increased flexibility for providers to document care planning activities anywhere within the clinical record (e.g., problem lists and progress notes) as long as the information can be easily extracted and shared as needed, this information is expected to become more interoperable between providers. Under CalAIM, DHCS developed policies to support the innovative use of EHR capabilities and facilitate the meaningful use of EHRs, care coordination, and quality assurance through the flexible use of EHR capabilities. In addition, DHCS removed burdensome and duplicative treatment planning documentation requirements (BHIN 23-068) except for instances where a standalone treatment plan is mandated by federal requirements. DHCS implemented standardized "Screening and Transition of Care Tools for Medi-Cal Mental Health Services" (BHIN 22-065). The purpose of standard "Screening and Transition of Care Tools for Medical Health Services" is to ensure coordination between delivery systems, including when service needs change for members over age 21 or under age 21. Under CalAIM, documentation is standardized between providers and delivery systems. See section 2.1 for more discussion on Problems List and progress notes and 2.3 for more discussion of transitions between youth to adult behavioral health care. <i>Future Status</i>

Prompts	Summary																								
	Improved usage of child and adult transition of care tools. For example, beginning January 31, 2024 for most DSA signatories, health information exchange must be conducted in conformance with the DxP’s Data Elements to Be Exchanged Policy and Procedure which stipulates that signatories must exchange data elements in the USCDI Version 2, which includes data elements for intake, assessment and screening tools.																								
	<i>Summary of Actions Needed</i> • Monitor and assess implementation and usage of child and adult transition of care tools • Conduct a comparative analysis and feasibility assessment of aligning the tools with industry standards, specifications, and formats where applicable, to support streamlined integration and exchange of information across providers systems • Support increased usage through technical assistance or funding (e.g., incentives), as appropriate																								
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	<i>Current Status.</i> <u>Milestone partially achieved.</u> As described above, support for transitions of care through electronic communications are part of CalAIM and are available on DHCS’ Screening and Transition of Care Tools for Medi-Cal Mental Health Services website. In the 2020 American Hospital Association (AHA) IT Supplement survey, <u>seven</u> California psychiatric hospitals reported on their ability to send and receive a summary of care record when a patient transitions to another care setting outside the organization, using various electronic modalities.³⁰ See table below. <table><tr><th>Ability to send and receive a summary of care record when a patient transitions to another care setting outside the organization, using the following electronic modalities:</th><th>Send</th><th>Receive</th></tr><tr><td>eFax using her</td><td>4</td><td>3</td></tr><tr><td>Provider portals that allow outside organizations to view records in your EHR system</td><td>2</td><td>2</td></tr><tr><td>Interface connection between EHR systems (e.g., Health Level 7 (HL7) interface)</td><td>0</td><td>1</td></tr><tr><td>Login credentials that allow access to your her</td><td>1</td><td>0</td></tr><tr><td>Health Information Service Providers that enable messaging via the DIRECT protocol</td><td>3</td><td>1</td></tr><tr><td>Regional, state, or local (HIE/HIO); not a local proprietary, enterprise network</td><td>3</td><td>1</td></tr><tr><td>EHR vendor-based network that enables exchanges with the vendor's other users (e.g., Epic's Care Everywhere)</td><td>1</td><td>1</td></tr></table>	Ability to send and receive a summary of care record when a patient transitions to another care setting outside the organization, using the following electronic modalities:	Send	Receive	eFax using her	4	3	Provider portals that allow outside organizations to view records in your EHR system	2	2	Interface connection between EHR systems (e.g., Health Level 7 (HL7) interface)	0	1	Login credentials that allow access to your her	1	0	Health Information Service Providers that enable messaging via the DIRECT protocol	3	1	Regional, state, or local (HIE/HIO); not a local proprietary, enterprise network	3	1	EHR vendor-based network that enables exchanges with the vendor's other users (e.g., Epic's Care Everywhere)	1	1
Ability to send and receive a summary of care record when a patient transitions to another care setting outside the organization, using the following electronic modalities:	Send	Receive																							
eFax using her	4	3																							
Provider portals that allow outside organizations to view records in your EHR system	2	2																							
Interface connection between EHR systems (e.g., Health Level 7 (HL7) interface)	0	1																							
Login credentials that allow access to your her	1	0																							
Health Information Service Providers that enable messaging via the DIRECT protocol	3	1																							
Regional, state, or local (HIE/HIO); not a local proprietary, enterprise network	3	1																							
EHR vendor-based network that enables exchanges with the vendor's other users (e.g., Epic's Care Everywhere)	1	1																							

³⁰ [AHA Healthcare IT Database](#).
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Prompts	Summary		
	National networks that enable exchanges across different EHR vendors (e.g., CommonWell, e-Health Exchange, Carequality)	1	1
	Additionally, one HIO currently uses Activate Care to offer this capability. Improving provider-patient attribution and care team identification is on its roadmap to improve in the coming years.		
	<i>Future Status</i> - Improved usage of transition of care tools - Infrastructure in conformance with and in support of the DxF		
	<i>Summary of Actions Needed</i> - Monitor and assess the implementation and usage of transition of care tools - Support increased usage– through technical assistance or funding (e.g., incentives), as appropriate		
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)			
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	<i>Current Status.</i> <u>Milestone partially achieved.</u> Efforts are occurring statewide and at HIEs to support and operationalize electronic consent. DHCS Initiatives: As per DHCS’ requirements, MCPs and BHPs must adopt joint policies and procedures to ensure data is exchanged timely and maintained securely and confidentially and in compliance with applicable rules and regulations. They must share protected health information for the purposes of medical and behavioral health care coordination pursuant to CAL. CODE REGS. tit. 9, § 1810.370(a)(3) and in compliance with the Health Insurance Portability and Accountability Act and its implementing regulations, as amended (HIPAA), 42 CFR Part 2, as well as other state and federal privacy laws. With respect to statewide guidance, CalHHS published the SHIG on Sharing Behavioral Health Information in June 2017. The SHIG clarifies the circumstances under which mental health and SUD information can be exchanged. This is accomplished through the use of scenarios developed through comprehensive research and stakeholder input. The guidance contained in the SHIG is considered to be authoritative but non-binding and is continuously updated to reflect new rules, regulations, and policies. SHIG version 1.2, which focuses on the sharing of behavioral health information in California, was released in April 2023.		

Prompts	Summary
	DHCS also released CalAIM Data Sharing Authorization Guidance in March 2022 that included exemptions to California rules that implicate sharing of mental health information. In October 2023, DHCS released an updated version of the guidance, CalAIM Data Sharing Authorization Guidance Version 2. On October 7, 2023, Governor Newsom signed Assembly Bill 1697, the Uniform Electronic Transactions Act, which amended the California Medical Information Act and allows electronic signatures to be accepted to authorize sharing of information related to sensitive services effective January 1, 2024. • External Landscape: Among California’s HIEs, three offered consent management to their participants as of 2019.³¹
	<i>Future Status</i> As described above, beginning January 31, 2024, for most DSA signatories, health information exchange must be conducted in conformance with the DxF’s Privacy and Security Policy and Procedure which stipulates that signatories abide by applicable laws with respect to disclosure decisions. DHCS is developing detailed data sharing toolkits that will be published in 2024. Stakeholders requested behavioral health specific guidance and on-the-ground technical assistance to clearly define specific data sharing requirements for BHPs. DHCS will provide the guidance through a BHIN and focused technical assistance for stakeholders. DHCS is developing plans for a consent management approach that includes standardized processes, tools, and services to obtain and manage a Medi-Cal member’s consent for sharing sensitive health information. Consent management services could be used for multiple purposes contemplated by DHCS, including: 1. Facilitating the protection of sensitive personal information (e.g., Part 2 data) that requires informed consent to be shared. 2. Supporting and respecting member preferences regarding sharing of admission, discharge, and transfer (ADT) notifications with other CalAIM partners (health plans, providers, etc.). 3. Supporting DHCS’ Interoperability and Patient Access Final Rule requirements to provide Medi-Cal members with access to their Electronic Health Information. In 2023, DHCS piloted the Authorization to Share Confidential Medi-Cal Information (ASDMI) Form and consent management service (collectively referred to as the “ASDMI Pilot”). The ASDMI Form is a standard release of information that is intended to inform Medi-Cal members of their rights and expressed preferences to share sensitive physical, social, and behavioral health information. ASDMI forms are securely stored and managed by contracted HIE and CIE organizations

Prompts	Summary
	and can be accessed by members and their providers, health plans, county agencies, and others. In the summer of 2023, DHCS launched an evaluation of the ASCMI Pilot to identify best practices, issues, and operational complexities of implementing the ASCMI Form and consent management service to inform a broader rollout in the future. The ASCMI pilot demonstrated the infrastructure that is necessary for the exchange of data to implement programs such as ECM and Community Supports, which requires obtaining members’ consent for sharing sensitive data, as mandated by state and federal law. At the local level, CalMHSA plans to implement this standardized consent form in its behavioral health EHR system.³² In addition, two HIEs are planning to develop comprehensive universal consent management systems within the next few years.
	<i>Summary of Actions Needed</i> • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs • Address infrastructure necessary to support consent management • Develop more detailed CalAIM Data Sharing Authorization Guidance toolkits, release an updated BHIN, and support the provision of technical assistance to behavioral health stakeholders
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	<i>Current Status.</i> <u>Milestone partially achieved.</u> Current efforts to improve the collection and exchange of intake, assessment, and screening information as structured data include the following DHCS initiatives and external activities. • DHCS Initiatives: As part of CalAIM, DHCS developed and implemented standardized screening and transition of care tools. These tools are outlined in BHIN 22-065 available on DHCS’s Screening and Transition of Care Tools for Medi-Cal Mental Health Services website. The standardized screening tools, one for youth and one for adults, help identify the appropriate delivery system to meet the member’s needs. DHCS has also developed standardized, domain-based documentation requirements outlined in BHIN 23-068. Assessments for DMC and DMC-ODS members will continue to occur using the American Society of Addiction Medicine criteria. Assessments for SMHS members under the age of 21 capture seven assessment domains.

Prompts	Summary
	• External Landscape: As of 2019, six California HIEs provided assessment and plan of treatment data.³³ For example, one HIE receives and sends screening forms, though only as PDF files. Similarly, another HIE shares assessments as PDF files which can be converted to CSV files or exported as HL7 messages.
	<i>Future Status</i> As described above, beginning January 31, 2024 for most DSA signatories, health information exchange must be conducted in conformance with the DxF's Data Elements to Be Exchanged Policy and Procedure which stipulates that signatories must exchange data elements in the USCDI Version 2, which includes data elements for intake, assessment and screening tools. DHCS is working alongside the California Department of Social Services to align on a single Child and Adolescent Needs and Strengths assessment tool for BHPs to use that will help inform the various assessment domains. The movement toward standardized screening and assessment tools throughout California will allow for greater interoperability of behavioral health assessment and screening data. CalMHSA plans to pilot the implementation of these screening and assessment tools as part of its semi-statewide behavioral health EHR implementation.
	<i>Summary of Actions Needed</i> • Continue expansion of behavioral health providers connectivity to and exchange of information via HIEs • Assess opportunities to expand DxF requirements to include requirements for assessment data
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	<i>Current Status.</i> <u>Milestone partially achieved.</u> California defines telehealth as “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site.”³⁴ A brief history and overview of DHCS’ telehealth policies and initiatives to encourage uptake is below. • Early Policy: DHCS’ telehealth coverage began in 1996 with the passage of the California Telemedicine Advancement Act (SB 1665), which established telemedicine payment and provision of care requirements, and additional legislation continued to expand access to services through the 2000s. The passage of the Telehealth

³³ Adler-Milstein J. Data from 2019 UCSF and U.S. DHHS Office of the National Coordinator’s national survey of HIOs.

³⁴ [Business and Professions Code section 2290.5\(a\)\(6\)](#)

Prompts	Summary
	Advancement Act (AB 415) in 2011 laid the foundation for Medi-Cal to drastically expand coverage of telehealth in Medi-Cal, eliminating the ban on email and telephone-delivered services, permitting patients to verbally consent to telehealth, and enabling all California-licensed and Medi-Cal enrolled providers to practice via telehealth. • Policy Updates in 2019: In August 2019, DHCS clarified telehealth policies for MCPs in APL 19-009. While selected psychiatric diagnostic and therapeutic services are existing benefits, the APL allows DHCS to further utilize telehealth services for behavioral health needs. More information was included in BHIN 20-009 which provided behavioral health programs with flexibilities granted by CMS and through Governor Newsom’s executive orders to ensure ongoing access to care. The notice emphasized telehealth as an allowable mechanism to provider clinical services. • COVID-19 Pandemic: In response to the COVID-19 pandemic, DHCS implemented telehealth flexibilities via waivers and Disaster Relief state plan amendments. Behavioral health needs across the state intensified due to the COVID-19 pandemic. The pandemic also created new barriers for members living with SMI/SED and SUD, as well as increased the prevalence of these conditions. DHCS implemented the Behavioral Health Response and Rescue Project (BHRRP) to increase access to behavioral health care for all Californians. Funds for the BHRRP have been used to support and expand the full continuum of behavioral health care needs, including further expansion of the telehealth infrastructure by March 2023. • Policy Updates in 2021: In 2021, DHCS released a Request for Application for behavioral health providers to request additional support to develop, enhance, and/or expand the telehealth infrastructure due to the COVID-19 pandemic. DHCS utilized available federal grant funding provided by the Substance Abuse and Mental Health Services Administration to support activities to improve the existing behavioral health telehealth infrastructure. The goal of the project was to address the needs of providers who provide treatment and recovery services to members living with SUD and/or mental health disorders, including youth and adults with SEDs. • Policy Updates in 2023: In April 2023, DHCS updated the Telehealth Services Policy in APL 23-007 for MCPs, which superseded APL 19-009 and established that “effective no sooner than January 1, 2024, all Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. Also effective no sooner than January 1, 2024, to preserve a Member’s right to access Covered Services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following: (1) offer those same services via in-person, face-to-face contact or (2) arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.”

Prompts	Summary
	DHCS updated its guidance for BHPs and DMC programs, releasing Behavioral Health Information Notice 23-018 in April 2023, which superseded prior policy guidance, and ensured Medi-Cal covered services delivered via telehealth (synchronous audio-only and synchronous video interactions) are reimbursable. • The Substance Abuse and Mental Health Services Administration’s 2020 National Mental Health Services Survey reported on uptake of telehealth among California’s mental health providers. It found of the 868 California-based mental health treatment facilities surveyed, 634 (73 percent) offered telemedicine-based therapy.³⁵ During the COVID-19 pandemic, California actively worked to remove policy and regulatory barriers to telehealth utilization and reimbursement. One study of California community health centers found that the total number of behavioral health visits remained stable during the pandemic largely because telehealth visits were able to replace in-person visits. DHCS also implemented new grants and programming during the pandemic, allowing behavioral health entities to purchase telehealth equipment and Medi-Cal members to receive a broadband benefit covering up to \$50 per month for Internet costs.³⁶ Survey data from 53 county behavioral health agencies in California captures the proportion of different types of professionals offering SUD services via telehealth before and during the COVID-19 pandemic. Agencies were asked “in your agency, which types of professionals provided SUD services to clients via telehealth? Please check all that apply.” Prior to the pandemic the range across types of professionals was 2 percent to 21 percent. The most common telehealth user roles included: physicians (21 percent), certified SUD counselors (19 percent), and licensed marriage and family therapists (13 percent); the least common telehealth user roles included: psychiatric technicians (2 percent), licensed clinical psychologists (4 percent), and licensed clinical social workers (4 percent). Higher proportions of professionals reported offering telehealth SUD treatment during the pandemic, with a range of 15 percent to 89 percent. The most common telehealth user roles included: certified SUD counselors (89 percent), registered SUD counselors (75 percent), licensed marriage and family therapists (70 percent); the least common telehealth user roles included: nurse practitioners and physician assistants (4 percent), psychiatric technicians (15 percent), and community health workers (21 percent). The survey was conducted by UCSF in collaboration with the California Behavioral Health Directors Association (CBHDA) to inform the development of a long-term strategy to inform the public behavioral health system’s workforce needs.³⁷ <i>Future Status</i>

³⁵ Data from the National Mental Health Services Survey (N-MHSS). Published online 2021. <https://www.samhsa.gov/data/data-we-collect/n-mhss-national-mental-health-services-survey>

³⁶ State of California Department of Health Care Services: Assessing the Continuum of Care for Behavioral Health Services in California - Data, Stakeholder Perspectives, and Implications. <https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf>

³⁷ Coffman J. Data from the 2021 UCSF and CBHDA Behavioral Health Workforce Survey.

Prompts	Summary
	DHCS continues to support the use of telehealth through policy and technical infrastructure and advance efforts that will improve the ability to track and monitor telehealth usage in behavioral health settings. In specialty behavioral health settings, modifiers for telehealth and audio-only visits were implemented effective November 1, 2021 (with extensions given to January 1, 2022, if needed due to the public health emergency). Through use of the modifier, DHCS can monitor variations in telehealth data reporting across providers to assess for data quality and compliance, which could include reporting back to data submitters. ³⁸ Using this data, DHCS will publish a bi-annual Telehealth Utilization Report and a telehealth dashboard that will include behavioral health utilization.
	<i>Summary of Actions Needed</i> • Continue to advance DxF and broadband capabilities to support telehealth • Continue to support mental health providers’ uptake of telehealth
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment)	<i>Current Status.</i> <u>Milestone partially achieved.</u> According to CalMHSA, many BHPs have implemented alerting capabilities in their systems for patients at risk of discontinuing care or who have stopped engaging in care.³⁹ There are also more general alerting capabilities that could be expanded to support this use case. For example, two of five psychiatric hospitals (as reported in the 2020 AHA IT survey) with emergency departments routinely provide electronic notification to a PCP after an emergency department visit. Additionally, as of 2022, all of California’s operational HIEs offered some form of alerting services (e.g., gaps in care) and/or event notification (e.g., ADT) for HIE participants.
	<i>Future Status</i> California’s DxF requirements, DHCS Population Health Management program’s guidelines and requirements, and DHCS’ contractual requirements and incentive programs will accelerate behavioral health providers’ connectivity to and exchange of information via HIEs which, in turn, will create opportunities for behavioral health providers to access and use notifications and alerts. As per DHCS’ requirements, BHPs must enact policies and procedures to implement the following with regard to information sharing:

³⁸ [DHCS Telehealth: Research and Evaluation Plan](#) (December 19, 2022).

³⁹ Miller A. Interview with the California Mental Health Services Authority (July 25, 2022).
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Prompts	Summary
	• A process for BHPs to send regular real-time or batch referrals. • A process for BHPs to send ADT data to MCPs when members are admitted to, discharged from, or transferred from facilities contracted by BHPs (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities), and for MCPs to receive this data. • A process to implement mechanisms to alert MCPs of behavioral health crises (e.g., BHPs alert MCPs of uses of mobile health, psychiatric inpatient care, and crisis stabilization; MCPs alert BHPs of a member’s visits to emergency departments and hospitals). • A process for MCPs to send ADT data to BHPs when members are admitted to, discharged from, or transferred from facilities contracted by MCPs (e.g., emergency departments, inpatient hospitals, nursing facilities), and for BHPs to receive this data. For inpatient residential SUD treatment provided by a DMC-ODS facility or for inpatient hospital admissions or emergency department visits known to MCPs, the process must include the specific method to notify each party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services. DHCS is also developing contractual requirements for health plans that will be in place in 2024 and will require all hospitals and skilled nursing facilities with Certified EHRs to send ADT notifications to MCPs and all necessary care team members (including behavioral health providers).
	<i>Summary of Actions Needed</i> • Continue to advance DxF’s and CMS’ Interoperability Rule requirements to support care coordination
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	<i>Current Status.</i> <u>Milestone partially achieved.</u> As of 2021, 41 BHPs (71 percent) in California offer dedicated programs serving members experiencing their first episode of psychosis (FEP). These programs include psychotherapy, medication management, case management, family education and support, and intensive care coordination services.⁴⁰ However, as of 2022, half of California BHPs’ EHRs lacked care coordination functionalities, and they continued to rely on communication from providers and other manual processes to assist in the coordination of services as members transition between locations of care.⁴¹ UC Davis, a nationally recognized leader in providing outpatient, team-based coordinated specialty care for early psychosis, developed and leads the EPI-CAL Network. This network provides statewide training, technical assistance, and outcome

⁴⁰ State of California Department of Health Care Services: [Assessing the Continuum of Care for Behavioral Health Services in California - Data, Stakeholder Perspectives, and Implications](#).

⁴¹ Behavioral Health Concepts, Inc. [FY 2021-2022 Statewide Technical Report: Medi-Cal Specialty Mental Health](#). Published online April 26, 2023.

Prompts	Summary
	evaluation for California’s FEP programs. All participating FEP programs collect the same data over the same time periods. EPI-CAL then leverages a FEP-focused technology system so programs can learn from their own data and from others in the network. FEP program managers get access to survey data from their clinics on this technology platform so they can evaluate performance, compare their outcome data to the network, and identify areas of strength or for improvement. The technology platform also collects and visualizes client data across recovery-oriented measures, allowing providers, clients, and their families to use this data in care decisions and appointments. ⁴²
	<i>Future Status</i> • The DxF will create the technical, legal, and operational infrastructure to support data exchange for care coordination. DxF has established technical requirements for all DxF Participants (organizations that has signed the DxF Data Sharing Agreement), including policies and procedures for data exchange. These standards are aligned with federal interoperability standards, and specifically indicate that: “Participant[s] [are] encouraged to support delivery using HL7 Fast Healthcare Interoperability Resources (FHIR) Release 4 conforming to the US Core Implementation Guide for Information Delivery.” HL7 FHIR includes specifications for an Application Programming Interface, or APIs that have been adopted to ONC. • Other federal standards that have been adopted by the DxF include the Applicability Statement for Secure Health Transport (i.e., Direct Secure Messaging); the IHE Cross-Enterprise Document Reliable Interchange (XDR) and the IHE Cross-Community Document Reliable Interchange (XCDR) exchange profiles – the latter of which have been adopted with the TEFCA national networks (which are federally qualified health information networks).
	<i>Summary of Actions Needed</i> • Continue to advance DxF’s and CMS’ Interoperability Rule requirements to support care coordination
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child’s electronic medical records with their respective parent/caretaker medical records	<i>Current Status.</i> <u>Milestone partially achieved.</u> California administers the Medi-Cal program through multiple delivery systems, including MCPs, fee-for-service, and BHPs. Additionally, the data exchange landscape in California includes multiple HIOs that facilitate data exchange between providers and associated EHRs. Given this environment, DHCS does not have visibility into the specific medical record functionality asked about in this item. Based on feedback from HIOs, full medical record linkage is uncommon due to privacy

Prompts	Summary
	and 42 CFR issues, especially as a child ages. In regard to HIOs, if name and contact information about a child’s next of kin and/or support person is available, the HIO may share this information as part of the normal HIE and CIE workflows.
	<i>Future Status</i> Improved ability for stakeholders to link a child’s health information with their respective parent/caretaker’s records
	<i>Summary of Actions Needed</i> Monitor and assess stakeholders’ ability to link a child’s health information with their respective parent’s/caretaker’s records
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	<i>Current Status.</i> <u>Milestone partially achieved.</u> California administers the Medi-Cal program through multiple delivery systems, including MCPs, fee-for-service, and BHPs. Additionally, the data exchange landscape in California includes multiple HIOs that facilitate data exchange between providers and associated EHRs. Given this environment, DHCS does not have visibility into the specific medical record functionality asked about in this item.
	<i>Future Status</i> In response to California Health and Safety Code § 130290, CalHHS published a Strategy for Digital Identities in July 2022. As described above, beginning January 31, 2024 for most DSA signatories, health information exchange must be conducted in conformance with the DxF’s Technical Requirements for Exchange Policy and Procedure which stipulates that signatories must exchange specific identifiers related to health if maintained by the DxF Participant and only as permitted by applicable law when specifying a person to match or a matched Individual in a request for information or identifying an individual in information delivery or notifications of ADT events if supported by the technical exchange standard in use, including but not limited to state or federal identifiers related to health (e.g., Medi-Cal or Medicare ID) and local identifiers related to health (e.g., medical record number or plan member identification number). Participants may also retain and use specific identifiers related to health and exchange them as an aid in person matching. CalHHS seeks to develop and implement a new cross-agency digital person identity matching capability that will provide query and linkage functionalities to different records that exist in different data sources managed by different agency departments. The new technology capability will provide an intermediary service that makes linking cross-agency records

Prompts	Summary
	possible to better enable a whole-person view of a person’s records without disruption of the data source(s). DHCS and DxF participants are expected to align their digital identity matching capabilities in accordance with the CalHHS digital identity matching technology standards and specifications. Per the CalHHS Data Exchange Framework policy and procedures documentation, it is CalHHS’ intent to align with National and Federally Adopted Standards, whenever possible.
	<i>Summary of Actions Needed</i> • Continue to advance the DxF Strategy for Digital Identities • Continue to implement policies, requirements, and systems to support compliance with the patient access provisions of the CMS Interoperability Rule and HIPAA

ATTACHMENT E
Reserved for Monitoring Protocol

Evaluation Plan

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

Joshua Breslau, Marcela Horvitz-Lennon, Rachel Burns, Elizabeth Marsolais, Amy Shearer

RAND Health Care

[Doc. number] PR-X000-0

March 20, 2026

Prepared for the California Department of Health Care Services

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About This Evaluation Plan

RAND will conduct the evaluation of the California Department of Health Care Services' (DHCS) Section 1115 demonstration focusing on services for Medi-Cal members with significant behavioral health (BH) needs. The demonstration, known as the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), was approved by the Centers for Medicare & Medicaid Services (CMS) on December 16, 2024. BH-CONNECT is comprised of a coordinated series of reforms and investments that collectively aim to improve access to care, quality of care, and health outcomes for individuals with significant BH needs. This draft evaluation plan provides the background for BH-CONNECT and an overview of the proposed evaluation design. It subsequently describes each of the five demonstration programs and the methods and data that will be used to evaluate them.

This research was funded by the California Department of Health Care Services and carried out within the Access and Delivery Program in RAND Health Care.

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RAND Health Care Communications
1776 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138
(310) 393-0411, ext. 7775
RAND_Health-Care@rand.org

Statement of Objectivity

This evaluation is being conducted independently and objectively by RAND. The authors have no conflicts of interest to disclose.

Acknowledgments

We thank the California Department of Health Care Services for its support of this evaluation plan and sharing their knowledge of the planned implementation of the BH-CONNECT waiver,

particularly Tina Flores and Ye Ji Kim. We are also grateful to Chandra Garber for improving the clarity of this draft evaluation plan.

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Chapter 1. General Background Information

This document describes the design for RAND’s evaluation of the California Department of Health Care Services’ (DHCS) Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration focusing on services for Medi-Cal members with significant behavioral health (BH) needs. The BH-CONNECT demonstration was approved by the Centers for Medicare & Medicaid Services (CMS) on December 16, 2024, under a Serious Mental Illness Section 1115 demonstration opportunity (CMS, undated) that allows states to receive federal financial participation (FFP) for qualifying short-term care provided in institutions for mental disease (IMDs), conditional on improvements in quality of IMD care and in access to community-based BH services. BH-CONNECT is comprised of a coordinated series of reforms and investments that collectively aim to improve access to care (including expanded coverage for evidence-based practices (EBPs) for adults and clarified coverage for EBPs for children), quality of care, and health outcomes for individuals with significant BH needs. This initial chapter provides the background for BH-CONNECT and an overview of the proposed evaluation design. In subsequent chapters, we describe each of the five demonstration programs and the methods and data that will be used to evaluate them.

Specific Goals of the BH-CONNECT Demonstration

The “Special Terms and Conditions” (STCs) governing the demonstration authorized waivers and expenditure authorities to “test the effectiveness of innovative practices aimed at strengthening the continuum of community-based behavioral health services,” and thus achieve the CMS-approved goals. These goals are central to the evaluation because they comprise the primary long-term goals against which the demonstration should be evaluated. As documented in the STCs, which specify requirements for the demonstration, CMS has approved the following goals for BH-CONNECT:

- Expand the continuum of community-based BH services and evidence-based practices (EBPs) available through Medi-Cal
- Strengthen family-based services and supports for children and youth living with significant BH needs, including children and youth involved in the child welfare system
- Invest in statewide practice transformations to better enable county BH delivery systems and providers to support Medi-Cal members living with significant BH needs
- Strengthen the workforce needed to deliver community-based BH services and EBPs to Medi-Cal members
- Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness

- Reduce use of institutional care by those individuals most significantly affected by significant BH needs
- Shorten lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration
- Promote improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.

BH-CONNECT Programs

To address BH-CONNECT's specific goals, CMS authorized the state to implement the following five demonstration programs, which this evaluation design will address:

- Access, Reform, and Outcomes Incentive Program (IP): A financial incentive program that encourages county BH delivery systems to improve access to BH services; improve outcomes among Medi-Cal members living with significant BH needs; and make targeted BH delivery system reforms.
- Workforce Initiatives Program (WIP): A series of five initiatives supporting recruitment and retention to increase the availability of behavioral health providers working in Medi-Cal safety-net settings that provide BH services to Medi-Cal members and uninsured populations living with BH needs.
- Activity Funds Initiative: A program that provides flexible funding to cover the cost of activities and items that support improved behavioral health outcomes for children and youth with behavioral health conditions that are involved in the child welfare system.
- SMI Program: Permits behavioral health plans (BHPs) that administer specialty mental health services (SMHS) to receive federal financial participation (FFP) for mental health services provided to adult Medi-Cal members ages 21-64 years during short-term stays in IMDs, as defined by CMS. Counties that opt into the SMI program must also meet several CMS requirements, including requirements related to community-based services.
- Community Transition In-Reach Services: A program that provides transitional care management services to support members with significant behavioral health needs who are returning to the community after extended stays in inpatient, subacute, and residential facilities.
- Short Term Rental Assistance Program (i.e., Transitional Rent¹): Provides time-limited housing assistance to Medi-Cal members who are homeless or at risk of becoming homeless to improve physical and behavioral health and functioning.

Table 1.1 shows which of the demonstration goals are addressed by each of the above BH-CONNECT programs, according to the evaluation team. The evaluation designs for each

¹ Under the BH-CONNECT waiver, CMS refers to this service as Short-Term Rental Assistance. DHCS will continue to use the service name, Transitional Rent, throughout this document and subsequent evaluation reports.

program, which are presented in subsequent chapters of this document, focus on the goals indicated for that program in the table. Each chapter provides a logic model which shows how the program components are expected to impact long- and short-term outcomes and lists potential confounding and moderating factors. Specific evaluation questions, hypotheses, and the data sources that will be used to examine the evaluation questions are detailed in subsequent chapter sections.

Table 1.1. Potential Association between BH-CONNECT Programs and BH-CONNECT Goals

Demonstration Goals	Incentive Program	Workforce Initiatives Program	Activity Funds Initiative	SMI Program	In-Reach Services Program	Transitional Rent
Expand the continuum of community-based BH services and EBPs available through Medi-Cal.	Associated	Not associated	Not associated	Associated	Not associated	Not associated
Strengthen family-based services and supports for children and youth living with significant BH needs, including children and youth involved in child welfare.	Associated	Not associated	Associated	Not associated	Not associated	Not associated
Invest in statewide practice transformations to better enable county BH delivery systems and providers to support Medi-Cal members living with significant BH needs.	Associated	Not associated	Not associated	Associated	Not associated	Not associated
Strengthen the workforce needed to deliver community-based BH services to Medi-Cal members.	Not associated	Associated	Not associated	Not associated	Not associated	Not associated
Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness.	Associated	Not associated	Not associated	Associated	Not associated	Associated
Reduce use of institutional care by those individuals most significantly affected by significant BH needs.	Associated	Not associated	Associated	Associated	Associated	Not Associated

Demonstration Goals	Incentive Program	Workforce Initiatives Program	Activity Funds Initiative	SMI Program	In-Reach Services Program	Transitional Rent
Shorten lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration.	Not associated	Not associated	Not associated	Associated	Associated	Associated
Promote improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.	Associated	Not associated	Not associated	Associated	Associated	Associated

BH-CONNECT Evaluation Overview

As recommended by CMS (2020), the evaluation will use mixed qualitative and quantitative methods to examine implementation of the BH-CONNECT programs and their impacts. Implementation will be assessed using a combination of document reviews, key informant interviews, analyses of administrative data, and surveys of providers and participants. The implementation assessments will provide detailed information from multiple perspectives on what was done under the program, barriers to implementation, and potential unintended consequences. Impacts of the demonstration programs will be assessed primarily through analyses of administrative data. The impact analyses will use methods permitting causal inferences with observational data that will be selected based on their ability to ensure the most robust answers to the evaluation questions. The evaluation design suggests analytic approaches to address the evaluation questions, with the understanding that these analytic approaches may need to be adjusted based on data availability and preliminary data analyses.

The evaluation design takes account of the decentralized structure of California's specialty BH delivery systems for Medi-Cal members and the uninsured living with a serious mental illness (SMI) or serious emotional disturbance (SED), or a substance use disorder (SUD). Medi-Cal behavioral health services are "carved-out" from other Medi-Cal services and managed at the county level through Prepaid Inpatient Health Plans, which the STCs refer to as behavioral health plans (BHPs).² The IP, SMI Program, and the In-Reach Services Program are all implemented by county mental health plans (MHPs). Because of this decentralized structure, the evaluation focuses primarily on tracking implementation and impact at the county level. In contrast, the Workforce Initiatives and the Activity Funds Initiative administered by DHCS on a statewide basis. For these programs, the evaluation will take a state-level view, with attention to regional variations in need, implementation, and outcomes.

Deliverables and Timeline

CMS approved the demonstration for a five-year period beginning on January 1, 2025. However, implementation timelines will vary across the programs and across participating

² In most counties, specialty mental health services for Medi-Cal beneficiaries and the uninsured with significant mental health needs are managed through a Mental Health Plan, while substance use disorders (SUD) are managed through the Drug Medi-Cal Organized Delivery System. There are some exceptions where SUD services are provided through an older Drug Medi-Cal program that is not a PIHP, or where both mental health and SUD services are provided through an integrated behavioral health plan. At present all PIHPs and Drug Medi-Cal programs are administered by counties.

counties. The program-specific timelines are described in each of the chapters below. Here we summarize the timeline for the evaluation deliverables (see Table 1.2).

The evaluation will have five deliverables:

- **Evaluation Design:** Describes a detailed plan for the independent evaluation of the demonstration program. Final approved version of the current document.
- **Rapid Cycle Assessment:** Describes preliminary qualitative and quantitative findings on the first year of implementation of the Community Transition In-Reach Services initiative. The Rapid Cycle Assessment will report on initial implementation data, utilization of In-Reach services, and preliminary findings on health outcomes among participants.
- **SMI Mid-Point Assessment:** Reports on evaluation results covering approximately the first two-and-a-half years of the demonstration based on input from key stakeholders and analysis of administrative data, including performance measures as approved in the monitoring protocol (described in Table 5.2 below). The objective of the Mid-Point Assessment is to examine progress toward achieving the goals of the program, including meeting the milestones within the approved time frames; determine factors that may have hindered progress; and determine factors that may affect future progress.
- **Interim Evaluation Report:** Describes findings of the evaluation, as per the approved evaluation design, covering completed years of the demonstration.
- **Summative Evaluation Report:** Describes the findings of the independent evaluation of the demonstration program for all years of the demonstration.

The timeline for submitting these five deliverables is presented in Table 1.2. For each deliverable, a Final Revision will be submitted 60 days after receipt of CMS’ comments. Thirty days after CMS approves the deliverable, a final version of the deliverable that is compliant with the Americans with Disabilities Act will be publicly posted to the DHCS website.

Table 1.2. Timeline of Deliverables

Deliverable	Initial Draft to CMS
Evaluation Design	08/08/2025
Rapid Cycle Assessment	One and a half years after implementation of Community Transition In-Reach Services
Mid-Point Assessment	02/14/2028
Interim Evaluation Report	12/31/2028
Summative Evaluation Report	06/30/2031

Data Sources and Methods

The evaluation will use a wide range of existing administrative, clinical, and survey data, supplemented by strategic collection of new data designed to minimize burden on participants. Sources of existing data will include but are not limited to Medi-Cal claims, encounter, and other administrative data (hereinafter referred to as “Medi-Cal data”); data collected as part of the

STCs, state licensure data; and data from the Department of Health Care Access and Information (HCAI) on the workforce initiatives. An exhaustive list of data sources to be used or considered for use is in Appendix A. The individual chapters provide more details on the data sources that will be used to address each evaluation question and hypothesis.

County Profiles

RAND will compile profiles of county BH delivery systems (hereinafter referred to as “county profiles”) and update these profiles over the course of the evaluation to assess changes. The county profiles will draw as much as possible on existing data to minimize the need to collect new data from counties. The data sources will include RAND’s Mental Health and Addiction Treatment Tracking Repository (MATTR) data system, which includes records of all mental health and substance use treatment facilities listed in the treatment finder maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, we will develop an automated data pipeline to draw data from the DHCS Licensing and Certification Division databases and other data sources to track the BH workforce and capacity in psychiatric hospitals and other BH services. These existing data will be supplemented by data collected directly from counties using an online portal through which surveys or reports can be submitted to the evaluation team. To reduce the burden of data collection, counties will have the option of completing structured reports or providing the relevant information in other existing documents, such as the Annual Availability Assessment of Mental Health Services; three-year Integrated Plan, budget reports and Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) required by the Behavioral Health Services Act (BHSA); or self-assessments using the National Committee on Quality Assurance (NCQA) Managed Behavioral Health Organization assessment tool. Information submitted through documents will be abstracted by the RAND team to complete the county profiles. The county profiles will be used to track change in service capacity across levels of community-based care, including provision of evidence-based practices, community engagement efforts, and health information technology (HIT) systems used in county BH care.

Semi-structured Interviews

Semi-structured interviews will be used in the evaluation of all demonstration components, providing details on implementation that will inform interpretation of the quantitative assessments of impact and suggest additional hypotheses or sub-group analyses. The types of interviewees will vary across the components but will include state officials, county officials, providers, and Medi-Cal members. State and county officials, including BHP personnel, will be asked about the strategies they have pursued to implement the demonstration programs, the reasoning behind those strategies, barriers to implementation, and how implementation challenges have been addressed. These interviews may also be used to collect information on

state or county actions or policies, clarify questions arising from document review or analysis of survey or administrative data, and to help with recruitment of additional interviewees.

Interviews with providers, who may be in administrative or direct care roles, will focus on how the strategies employed by policymakers have affected their practices. We will ask about whether the anticipated impacts of the policy changes have occurred in practice and whether there are groups that may be less well served than others. The interviews will then explore providers' perspectives on why these changes have or have not occurred, what barriers were experienced, and how implementation challenges were met. Interviews with Medi-Cal members will be used in contexts where a small, targeted sample can provide valuable information that could not be better collected through a Medi-Cal member survey. For instance, qualitative interviews will be conducted with Medi-Cal members receiving In-Reach Transition services to ask about their perceptions of that program. Interviews with Medi-Cal members will be offered in English and Spanish.

To ensure the quality of the interview data, all interviewers will undergo a standard training on California's BH system and specific training to understand each type of interview respondent and the specific evaluation questions of interest. We will develop interview guides with input from the DHCS and other stakeholders to ensure that all relevant topics are covered. With interviewee permission, interviews will be recorded and transcribed for analysis. RAND will take several steps to reduce the burden of data collection on participants. First, where possible, we will use fully structured report forms that can be completed independently by staff members prior to interviews. This ensures that detailed factual data, such as numbers of programs of different types, do not need to be collected during qualitative interviews. Second, the interviews will be informed by the county profiles, which will be compiled primarily from document review. Interviewers will review the county profiles prior to the interview so that they can ask informed questions. In addition, questions related to all the components of the evaluation will be combined into a single interview protocol for each interviewee. Third, each year, we will interview a sample of counties, rotating the sample so that all counties will eventually be included. This reduces the number of interviews each county will be asked to complete over the course of the evaluation.

Interview protocols will be developed by the RAND team for each qualitative data collection effort described in subsequent chapters. RAND will initially develop a set of content domains that will be covered in the interview and seek input on the domains from DHCS and other stakeholders. For domains for which there is a published literature, RAND will review measurement approaches to ensure that domains regularly covered in structured instruments are covered in our semi-structured interview protocols. Interview questions for each domain will be developed by the RAND team and shared with stakeholders for input prior to beginning data collection.

Interview data will be analyzed with thematic analysis (Guest, MacQueen, and Namey, 2012), using Dedoose, a cloud-based platform designed for mixed-methods research. The

analysis will combine a deductive approach—applying a structured coding scheme based on pre-specified themes derived from the literature and our logic model—with an inductive approach to identify emergent themes that arise organically from the data. Coders will apply both types of codes to transcripts, enabling the identification of patterns across interviews while remaining open to unanticipated insights. Dedoose facilitates this process through features that support team coding, code co-occurrence analysis, and data visualization.

Survey Data

The evaluation will use survey data for evaluation of three of the demonstration components: the IP, the workforce initiatives, and the activity funds initiative. For the IP, the evaluation will analyze data from the Medi-Cal member survey on quality of life that will be conducted by DHCS. For the workforce initiative, RAND will survey awardees of workforce funds, which will include individual trainees and clinical programs that receive funds for recruitment and retention. For the activity funds initiative, RAND will survey adult participants and family members of child participants. Surveys conducted by RAND will be online and will offer participants a small incentive for participation. Details on the surveys are in the relevant chapters that follow.

Quantitative Methods

Following CMS guidance, including best practices for causal inference (Contreary, Bradley, and Chao, 2018), we will strive to address the evaluation questions and hypotheses with robust quasi-experimental methods enabling a rigorous evaluation of demonstration impacts. Although quasi-experimental methods may be subject to biases, we will interrogate the assumptions needed to justify causal inferences through indirect quantitative assessments, and targeted sensitivity analyses and robustness checks (see below).

Method selection will be grounded in the understanding that the method's robustness depends on its ability to address variation of outcomes and risk factors over time due to secular trends, potential heterogeneity in program implementation effects, and the effects of concurrent initiatives or unobserved factors. Comparison groups in general and in this setting strengthen the premise for drawing causal inferences, so we will take advantage of such comparisons when they are available. Because we will have pre-intervention data available on both intervention and comparison groups and because we believe there are likely to be unobserved differences between intervention and comparison groups, we will use a difference-in-differences (DD) approach to analysis in these cases because of its robustness to certain types of unobserved confounding. In the DD approach, the comparison group controls for background secular trends so that significant differences that remain between intervention and control groups may be validly attributable to the impacts of program implementation. A valid DD analysis must be principled, i.e., the characteristics of the target population, the intervention, and the context in which it is implemented should credibly support the plausibility of observing true effects, and it must address related methodological concerns: violations of the parallel trends (or common shocks)

assumption. We will assess the plausibility of parallel trends by estimating differences in pre-program trends in the outcome between program participants and non-participants and will propose sensitivity analyses to account for potential departures from parallel trends (Rambachan, Ashesh, and Roth, 2023). We will address the possibility that shocks may differentially impact the intervention and control groups through robustness checks, for example, by excluding from analyses the counties that are subject to known major shocks during the demonstration period. An additional methodological concern pertains to serial correlation in outcomes over time, which we will address by calculating empirical standard errors adjusted for clustering.

If the test for parallel trends is not satisfied, the model will be adapted to accommodate diverging trends in a different quasi-experimental approach—a Comparative Interrupted Time Series (CITS) model. The CITS model explicitly accounts for diverging pre-period trends in participants and non-participants when estimating program effects, at the expense of stronger assumptions about how the pre-period relates to the post-period.

Ideal comparison groups are contemporaneous groups of individuals who are not exposed to the program and who have similar characteristics to exposed individuals prior to the implementation of the program, permitting comparison of pre-post differences in outcomes between exposed and unexposed individuals. Such comparison groups may result, for example, from implementation of BH-CONNECT programs at different time points. If no within-state comparison groups can be identified, we may consider valid out-of-state comparison groups. When valid comparison groups are not available, we will implement Interrupted Time Series (ITS), the most robust among the quasi-experimental methods that permit assessing hypotheses without a comparison group by minimizing the confounding effect of other potential drivers of observed effects. ITS assesses risk-adjusted changes in the level and trend in the outcome measures from the baseline to the post-implementation period and uses the estimates to test hypotheses about program impacts.

Because counties can opt in and out of some of the BH-CONNECT programs at their discretion (SMI Program, Community Transition In-Reach Services Program), planned analyses will need to account for differential timing of county participation in these programs. Traditional methods, such as two-way fixed effect models, can incur bias in these settings if the effect of the intervention changes over time because the estimated effect may be influenced by comparisons between counties implementing the program at different times during the study period. We will use recently developed methods that handle staggered adoption to ensure that these types of comparisons do not occur (Callaway and Sant’Anna, 2021; Wing, Coady, Freedman, and Hollingsworth, 2024).

For selected evaluation questions and hypotheses where stratified descriptive analyses suggest that BH-CONNECT Program effects are moderated by key Medi-Cal member characteristics, and if feasible depending on sample sizes, we will estimate difference-in-difference-in-differences (DDD) models. These models, also referred to as triple D models, will permit examination of outcome disparities by sex, age, race and ethnicity, English language

proficiency, primary language, disability status, geographic location, and other variables of interest.

Integration of Qualitative and Quantitative Analyses

The mixed-methods approach will be sequential and iterative, with qualitative findings informing subsequent quantitative analyses and quantitative results informing subsequent qualitative methods. Initially, sampling for qualitative interviews will be informed in part by administrative data collected as part of the county profiles and basic implementation information provided by DHCS (e.g. which counties are participating in which programs, contact information for county officials). The initial round of qualitative interviews will precede the quantitative assessments of program impacts. We use this design because of the time lag involved in gaining access to the main sources of quantitative data (Medi-Cal data) and because the qualitative data that we collect on program implementation will inform some of the impact analyses. For instance, qualitative findings on variation in implementation across counties or inclusion of providers who speak languages other than English may suggest quantitative investigations of heterogeneity in treatment effect across groups of counties or English language proficiency.

Qualitative interviews may also suggest factors that may confound the quantitative analysis that should be adjusted for in statistical models. Initial quantitative analysis results will then inform questions for later rounds of qualitative data collection. For instance, if we find that the IP impacts a quality of care measure in some counties and not others, we will add questions to our interview guides to investigate implementation issues in both types of counties, thus highlighting differences that may have led to differences in outcomes. Our approach to combining qualitative and quantitative methods for the interim and summative reports will be integrative, combining qualitative and quantitative information, triangulating findings to identify points of convergence, complementarity and divergence.

Evaluation Timeline

This section summarizes the planned activities for each year of the evaluation period. The evaluation team will streamline data collection efforts of the BH-CONNECT initiatives, to the extent possible, to minimize the burden for initiative administrators and participants.

Evaluation Year 1: 2025

RAND will draft the evaluation design and begin to track implementation of the BH-CONNECT initiatives as they are launched by the State of California.

Evaluation Year 2: 2026

RAND will finalize the evaluation design and begin significant data collection efforts in 2026, including administering surveys developing county profiles, and assessing health IT. RAND will also begin conducting interviews with state officials, county officials, program

participants, and other stakeholders. Depending upon the implementation start date for the Community Transition In-Reach Services Program, RAND may begin or continue work on the Rapid Cycle Assessment. RAND will begin analysis of Medicaid and other secondary data, including performance data, Timely Access Data Tool (TADT), and survey data. RAND will also begin analyses of program administrative data to the extent that such data are made available.

Evaluation Year 3: 2027

RAND will continue the data collection efforts and data analyses described as part of Evaluation Year 2 (2026), as program implementation continues. Depending upon the implementation start date for the Community Transition In-Reach Services Program, RAND may complete and submit the Rapid Cycle Assessment. RAND will draft the Mid-Point Assessment of the SMI program.

Evaluation Year 4: 2028

RAND will continue data collection and analysis efforts previously described. The Mid-Point Assessment will be submitted to CMS, and RAND will revise the Mid-Point Assessment in response to CMS comments. RAND will develop, complete, and submit the Interim Evaluation Report.

Evaluation Year 5: 2029

RAND will continue data collection and analysis efforts that, at this stage of the demonstration, are expected to provide valuable insights into a more mature implementation of the various BH-CONNECT programs. RAND will begin drafting the final summative report.

Evaluation Year 6: 2030

RAND will complete analyses of all secondary data sources including program administrative data and Medicaid data and complete the analysis of surveys fielded by RAND. RAND will finalize and submit the final summative report by June 30, 2031.

Limitations

The evaluation design has several limitations that are important to note. First, the evaluation design is based on estimates of county, provider, and/or individual participation in the various programs. The planned evaluation strategies may need to be updated if the actual participation rates diverge from expected levels. Similarly, delays in the implementation timeline may require that the evaluation design be adjusted to ensure adequate coverage of participants. Of particular concern in this regard is the Activity Funds Initiative, where there is a potential for small sample sizes. Second, depending on the availability of data (including delays in county reporting and missing data), our ability to access data, and preliminary analyses, there is a possibility that the

proposed quantitative analytic approaches will need to be revised. For instance, there may be limited access to data preceding the demonstration, which would prevent the evaluation team from using a DD approach. Third, the evaluation will not have access to direct measures of participant health status, although access to mortality data would mitigate this limitation to some extent. Where possible, we will use proxy measures, such as use of acute care. Fourth, recruitment of individuals for surveys and semi-structured interviews is likely to be challenging. RAND will work with stakeholders to develop the most effective recruitment strategies and offer incentives to participants for completing interviews. However, recruiting providers who have busy schedules and patients with complex health conditions who may be poorly connected to care will be challenging.

Chapter 2. Evaluation Design for Access, Reform, and Outcomes Incentive Program

Brief overview of the Access, Reform, and Outcomes Incentive Program

The Access, Reform, and Outcomes Incentive Program (IP) is a pay-for-performance payment arrangement. BHPs that opt-in will be eligible for additional payments based on their performance on pre-specified metrics of the quality of care provided to Medi-Cal members. The IP allows BHPs to earn additional payments for positive performance, but participation does not put them at risk of losing incentive funds if they fail to meet the measure thresholds. BHPs that receive incentive payments must use those funds to support and expand Medi-Cal services that improve Medi-Cal members' service in the BH delivery system. The state is at risk of forfeiture of a portion of the total federal funding for incentive programs if the BHPs as a group fail to demonstrate progress on a select group of accountability measures on an annual basis starting in demonstration year 3. In this section, we describe the IP goals and approach, and the plan for evaluating its implementation and impact.

According to the approved STCs, the IP has the following overall goals:

- Reward BHPs for improving access to high-quality, timely BH services
- Support BHPs in establishing coverage of and implementing key EBP with fidelity
- Reward improved health outcomes among Medi-Cal members living with significant mental health conditions and SUDs
- Reduce BHP-specific gaps in BH quality improvement capabilities
- Support improved integration and care coordination across the BH and managed care delivery systems.

At the time of this writing, 45 counties had completed the prerequisites to participate in the IP. Some counties will be eligible to earn incentive payments related to mental health services only; most counties will be eligible to earn incentives payments related to both mental health and substance use disorder (SUD) treatment services. Within each county, the intended target population of the program is the entire population of Medi-Cal members who receive specialty BH services.

To achieve its goals, the IP specifies three focus areas for BHP efforts:

1. Improved Access to BH Services: BHPs can earn performance payments for improving access to specialty mental health services (SMHSs) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Access is measured in several ways, such as improving penetration and retention in behavioral health services and the ability of members to receive SMHS and DMC-ODS services in a timely manner. The IP focuses specifically on increasing access to certain specified BH services: Assertive Community Treatment (ACT), Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode

Psychosis (FEP), Supported Employment, Peer Support Specialists, Enhanced Community Health Worker (CHW) Services, Clubhouse Services, Multisystemic Therapy, Functional Family Therapy, Parent Child Interaction Therapy, High Fidelity Wraparound, and Enhanced Care Management (ECM).

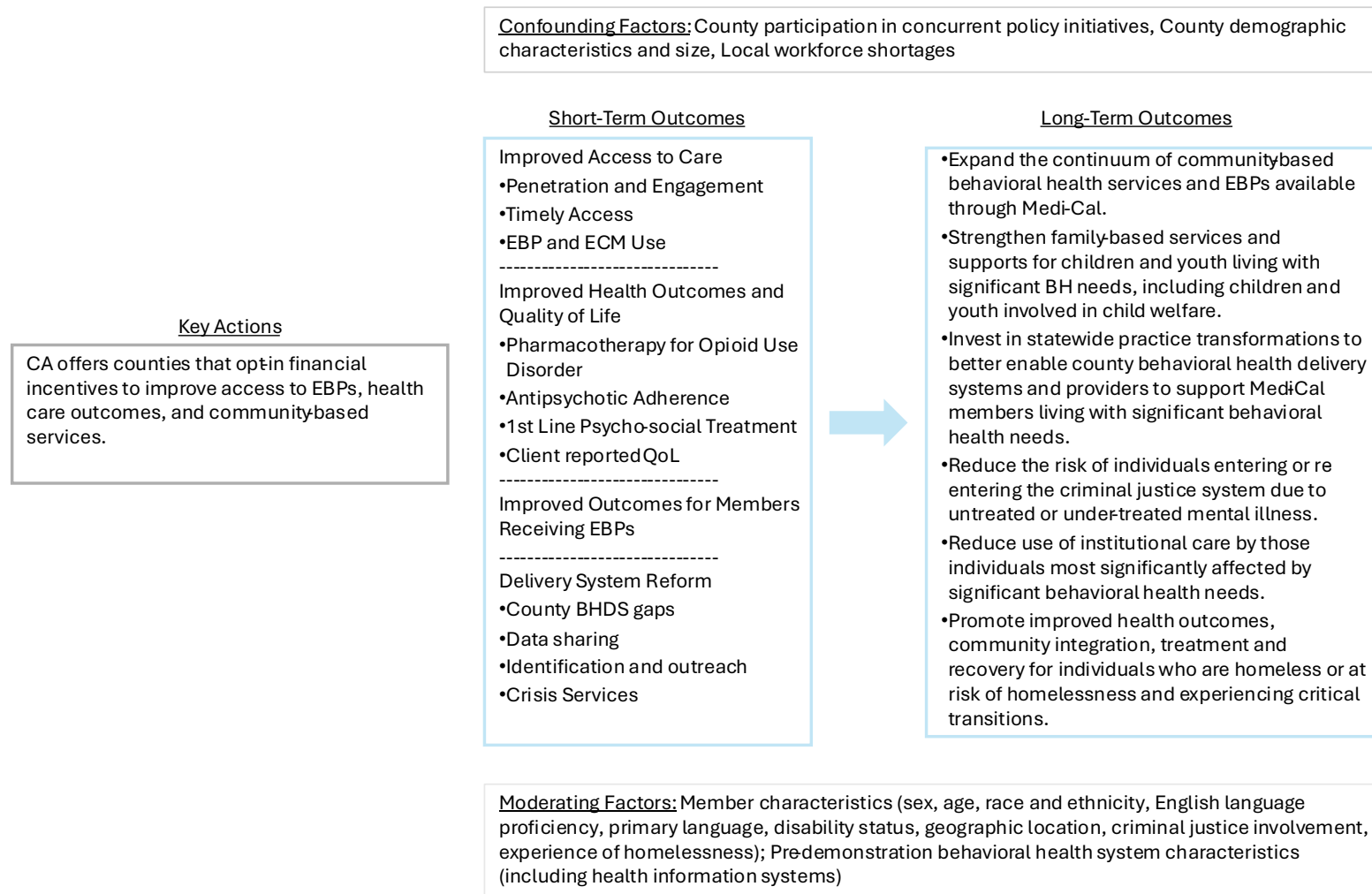
2. Improved Health Outcomes and Quality of Life (QoL): Performance payments can be earned by demonstrating improved health (measured via quality measures) and QoL outcomes for Medi-Cal members living with significant BH needs. There are specific measures for members receiving key evidence-based practices (EBPs). Measures in this focus area are derived from claims data, enrollment data, and/or patient surveys.
3. Targeted BH Delivery System Reforms: Performance payments can be earned through four delivery system reforms that BHPs can implement: 1) reducing BHP-specific gaps in quality improvement capabilities; 2) enhancing data sharing capabilities; 3) improving outreach and engagement to Medi-Cal members with BH needs who are not receiving services; and 4) increasing capacity to deliver crisis services. Where applicable, tracking of BHP performance on delivery system reforms will follow accreditation standards for managed BH organizations developed by the NCQA.

IP Evaluation Overview

The IP evaluation design is guided by the logic model in Figure 2.1. The program is driven by the financial incentives that the IP creates. In response to these incentives, BHPs are expected to make changes to county BH delivery systems across the three focus areas: improvements to access to behavioral health care, improved member health outcomes and quality of life, and targeted BH delivery system reform. Changes in each of these domains, which represent the short-term outcomes of IP, are assessed by the measure domains shown in the figure. Impacts of the IP on the short-term outcomes have impacts on the long-term outcomes, which correspond to the goals of the IP as described in the STCs (Table 1.1).³ For instance, the model theorizes that improvements in access to behavioral health care will reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness and reduce use of institutional care.

³ To avoid duplication, we refer in the model to the focus areas and the overall demonstration goals in the logic model, noting that the goals for the IP discussed in the STCs that are quoted above are subsumed under those goals.

Figure 2.1. Access, Reform, and Outcomes Incentive Program Logic Model



It is important to note that the IP does not prescribe specific reforms under the delivery system reform focus area. Rather, it enables counties to make locally strategic reforms, based on their current system needs as identified in their self-assessment, in order to meet the IP performance metrics. This means that counties may differ in the specific services they add or reforms that they introduce, whether those are specific EBPs, investments in HIT infrastructure, expansion of ECM, or other investment in community-based services. The evaluation will therefore need to assess these changes on a county-by-county basis.

To enable tracking of IP implementation, the evaluation will use two main strategies, county profiles and qualitative interviews. As described above, the county profiles will track changes made to specialty BH delivery systems, including changes in system capacity (i.e., number of people who can be treated at each level of care or with each service) across the continuum of community-based care and changes to health information sharing systems. Information on county systems will be updated using reports from counties and other documentation on at least a twice-yearly basis.

IP impacts will be examined primarily with Medi-Cal data, supplemented by additional administrative data. Our preferred analytic strategy will be a DD approach, in which trends over time in IP participating counties will be compared with concurrent trends in non-participating counties (see Chapter 1, Quantitative methods). Model assumptions, such as ‘parallel trends’ and ‘common shocks’ will be examined in preliminary analyses, as described in Chapter 1. For the IP, concurrent policies implemented in some counties may be shocks that differentially affect participating and non-participating counties. If we find that the DD approach is not appropriate we will consider alternative approaches, such as focusing on a select set of counties (participating and non-participating) that appear to meet model assumptions. Detailed county system reform profiles can help inform the study design by identifying strategic comparisons. Analyses by subgroups listed as moderators in Figure 2.1 will be conducted to examine heterogeneity of impacts and potential impacts of the demonstration on disparities in care.

Finally, we will also monitor how the IP payments, including those paid through the high-performance pool, are made—how many of the participating counties meet the criteria for the payments, how that changes over time, the size of the payments, and how the payments are used. This is important for assessing the IP because of the potential to have a design with thresholds that are too high (few or no counties meeting criteria) or too low (most or all counties meeting criteria) to effectively incentivize delivery system reforms. In addition, counties may perceive the incentive amounts to be not worth the effort required to meet the criteria and they might see the criteria as misaligned with county policy priorities. Information on the functioning of the IP will be drawn from information on payments to counties by the state and interviews with state and county officials.

Table 2.1 presents the evaluation questions (EQs), hypotheses and data sources that will be used to test the hypotheses for each of the three IP goals.

Table 2.1. Evaluation Questions, Hypotheses, and Data Sources: Access, Reform, and Outcomes Incentive Program

Goal	Evaluation Question	Hypotheses	Data Sources
1. Improve access to BH services	1. Will participating counties improve penetration and engagement with specialty BH services?	• Proportion of beneficiaries using SMHS services will increase. • Proportion of beneficiaries with 5 or more SMHS encounters will increase. • Initiation of and engagement in SUD treatment services (Drug Medi-Cal Organized Delivery System [DMC-ODS]) will improve.	• County profiles • Qualitative interviews • Medi-Cal data • SMHS Performance Dashboards
	2. Will participating counties improve timely access to services?	• Identification of Medi-Cal members with BH needs and referral to BH services will increase. • The proportion of clients meeting timely access standards for SMHS and DMC-ODS services will increase.	• County profiles • Qualitative interviews • CA Timely Access Data Tool (TADT)
	3. Will participating counties increase use of EBPs by adults and children?	• Capacity for providing EBPs to adults and children will increase. • Utilization of EBPs by adults and children will increase.	• County profiles • Qualitative interviews • Medi-Cal data

Goal	Evaluation Question	Hypotheses	Data Sources
	4. Will participating counties increase use of ECM?	• Capacity to refer to and coordinate with ECM will increase. • Utilization of ECM will increase.	• County profiles • Qualitative interviews - Claims
	5. Will participating counties reduce the risk of Medi-Cal members entering or re-entering the criminal justice system due to untreated or under-treated mental illness?	• Access to BHP-covered outpatient services by Medi-Cal members with criminal justice involvement will increase.	• Medi-Cal data • Automated Criminal History System (ACHS) data
	6. Will participating counties reduce use of institutional care by Medi-Cal members with the most significant BH needs?	• Admission to institutional care by Medi-Cal members with mental illness will decrease. • Medicaid expenditure (total and per-member and per-month) for acute BH care will decrease relative to expenditure for community based BH care, resulting overall reduction of total Medi-Cal BH expenditure.	• Medi-Cal data • HCAI Patient Discharge Data • National Substance Use and Mental Health Services Survey

Goal	Evaluation Question	Hypotheses	Data Sources
2. Improve health outcomes and quality of life (QoL)	1. Will participating counties increase the capacity of provide pharmacotherapy for opioid use disorder (OUD)?	• Capacity for providing pharmacotherapy for OUD will increase. • Utilization of pharmacotherapy for people with OUD will increase.	• County profiles • Qualitative interviews • Quality measure reports • Medi-Cal data
	2. Will counties improve on adherence to antipsychotic medication?	• Patient-centered care for Medi-Cal members prescribed antipsychotics will improve. • Performance on antipsychotic medication adherence will improve.	• County profiles • Qualitative interviews • Quality measure reports • Medi-Cal data
	3. Will counties improve first line use of psychosocial care for children and adolescents on antipsychotics?	• Patient-centered care for child and adolescent Medi-Cal members on antipsychotics will improve. • Counties will improve access to psychosocial care for children and adolescents. • Performance on use of first-line psychosocial care for children and adolescents on antipsychotics will improve.	• County profiles • Qualitative interviews • Quality measure reports • Medi-Cal data

Goal	Evaluation Question	Hypotheses	Data Sources
	4. Will counties improve member quality of life?	- Counties will field a QoL survey to Medi-Cal members receiving BH services. - QoL of Medi-Cal members receiving BH services will improve.	- Client surveys - Qualitative interviews
	5. Will counties improve health outcomes among Medi-Cal members receiving intensive community-based services?	- The number of Medi-Cal members with frequent ED visits for BH conditions (≥ 4 per year) will decrease. - ED visits for BH conditions will decrease for Medi-Cal members using specified EBPs, including those who are experiencing homelessness, justice involved, receiving CSC for FEP or supported employment.	- Qualitative interviews - Medi-Cal data - Homelessness Data Integration System - Automated Criminal History System (ACHS) data
3. Implement reforms to the BH delivery system	1. Will participating counties strengthen their quality improvement capabilities?	- Counties' capacity for quality improvement data collection and reporting will expand. - Counties' ability to use data to inform quality improvement efforts and policy change will improv.	- County profiles - Qualitative interviews

Goal	Evaluation Question	Hypotheses	Data Sources
	2. Will participating counties improve their data sharing capabilities?	• HIT systems used by community-based providers will be improved. • Capacity for data sharing among BH providers, social services providers, primary care providers, government agencies, and acute care providers (EDs and inpatient facilities) will increase. • Participation in Regional Health Information Exchanges or Health Information Organizations will increase.	• County profiles • HIT assessment • Qualitative interviews • DxF Signatory List • DxF system data

Goal	Evaluation Question	Hypotheses	Data Sources
	3. Will participating counties improve identification of and outreach to individuals in need of BH services who are not receiving services?	• Counties will use transparent data-informed methods to guide outreach and engagement efforts. • Counties will use community-based strategies, including community engagement plans and culturally and linguistically appropriate services (CLAS) to identify and address barriers to care. • Investments in outreach efforts addressing unmet needs for BH services in Medi-Cal members not receiving services will increase.	• County profiles • Qualitative interviews
	4. Will participating counties improve community-based crisis services?	• Capacity of crisis services across the continuum of crisis services will increase. • Timeliness of access to crisis services will improve. • Coordination of crisis services with local law enforcement and community services agencies will improve. • Utilization of crisis services will increase. • Data sharing systems for crisis services will improve.	• County profiles • Qualitative interviews • Medi-Cal data • HIT assessments • 988/911 data

Evaluation Methods

Study Population

The study population will include Medi-Cal members who are exposed to the SMI Program—that is, those living in counties that have opted-in to the IP, and unexposed members living in non-participating or “control” counties. The counties that will opt-in have not been determined as of this writing. A total of 40 counties have met initial eligibility criteria for participation but final decisions have not been made. The STCs specify that up to 80% of counties (which would be 43 counties) can participate. Furthermore, counties may opt-in to the IP at different points in time during the demonstration. We do not anticipate that counties will opt-out of the IP because there is no cost to participate once quality measurement infrastructure is in place. If counties opt-out they will be treated as counties that have entered the IP and failed to meet criteria for a financial incentive.

Analytic Approaches

Quantitative Methods

Descriptive Statistics

Initial analyses will describe characteristics of the Medi-Cal member population (overall and those who use specialty BH services), variation in characteristics across participating and non-participating counties and over time. Differences will be examined using statistical testing and graphical illustrations. Results from the descriptive analyses will inform decisions about the design of quasi-experimental methods.

Quasi-Experimental Methods

The overall approach to use of quasi-experimental methods, such as DD, CITS, and ITS, to assess impacts of the demonstration is described in Chapter 1. For the IP, the analyses will examine whether the outcomes of interest (Table 2.1) differ over time in the counties participating in the IP relative to non-participating counties. Where there is interest in heterogeneity of impact and we have adequate sample size, DDD models will be used to test whether IP impacts are similar across groups (e.g., age, race and ethnicity, English language proficiency, or region). We anticipate having adequate sample size from both participating and non-participating counties for DD models, but ITS models will be considered as options. In the event that counties enter the IP program at different times, methods for staggered adoption, as described in Chapter 1, will be used. To address potential confounding by concurrent policies we will include time varying adjustments for policies associated with participation in the IP and

likely to have an impact on IP outcomes. Other strategies, such as restricting the analyses to counties that do not differ with respect to concurrent policies, will also be considered.

Qualitative Methods

Semi-structured interviews will be conducted with state officials, county officials, representatives of provider agencies (including clinicians), and Medi-Cal members.

- State officials: Interviews with state officials will cover the design of the overall program, perception of implementation challenges across the counties, functioning of monitoring processes at the county and state levels, and any notable unintended or unanticipated consequences of the program. Questions about the IP will be included in interviews with state officials during each year of the demonstration.
- County officials: Interviews will aim to understand the process by which counties decide on delivery system reform(s), implementation strategies, and the factors that have aided or hindered implementation as planned. Interviews will cover how decisions related to implementation of BH-CONNECT intersect with other county policy issues, such as full-service partnerships implemented under the Behavioral Health Services Act. To reduce the burden on individual counties, we will conduct interviews with half of the participating counties in the first and third year of the demonstration and the other half in the second and fourth years of the demonstration.

Counties will be selected to represent all regions of the state in both years. This strategy will provide data on counties at different stages of implementation, while minimizing the number of interviews that county officials are asked to participate in. In addition, we will conduct interviews with a sample of non-participating counties to understand their reasons for non-participating in the IP. While the number of non-participating counties that we can interview may be limited by their willingness to participate, we will aim to select a sample that is diverse with respect to region and size.

- Providers: We will interview program directors, individuals who have supervisory or management roles in organizations responsible for direct service delivery, and clinicians in programs impacted by the IP. Based on an initial analysis of how programs are being implemented across counties, the provider interviews will be staggered across years. For instance, we may focus on enhanced care management programs in Year 1 and specific EBP programs in Year 2. Details of the sampling will be based on initial data from counties on implementation plans.
- Medi-Cal Members: Interviews with members, their family members, or caregivers will be conducted in selected cases where changes in county BH delivery systems impact a well-defined group of BH service users who can be identified and recruited for interviews. The interviews will cover the members' perspectives on the changes, focusing on the burden of seeking care, ability to access the care they want, satisfaction with care, improvement in

behavioral health and co-occurring health conditions, and the extent to which the care meets their needs. To allow for time for the changes to impact care, we will conduct Medi-Cal member interviews at least two years following the beginning of the IP.

Focus Area 1: Access to Care

EQ1: Penetration and Engagement in specialty BH services

We expect that both penetration and engagement in SMHS and DMC-ODS services will increase as BHPs increase service capacity across the continuum of care, defined as the number of available services per Medi-Cal member with SMI in the county. Increases in capacity can increase both the number of people who receive services (penetration) and the average number of services received by each service user (engagement). In addition, improvement in the continuum of care within a county in response to the IP can be expected to provide additional opportunities for service users, increasing the likelihood that services will meet actual needs and increase engagement. County-level changes in system capacity will be tracked using the county profiles described above. Outcome measures for assessing penetration and engagement are shown in Table 2.2. The penetration and engagement measures include measures specific to SUD services and SMHS to assess maintenance of continuity of care over time. Criteria for initiation and engagement with SUD treatment will be specified to match the corresponding Healthcare Effectiveness Data and Information Set (HEDIS) measure (*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*, IET) to maximize comparability. Qualitative interviews with state and county officials will add information on barriers and facilitators to expanding system capacity. Variation in penetration and engagement with respect to race/ethnicity, age, sex, county or region, or other potential modifiers identified in the qualitative interviews will also be investigated.

EQ2: Timely Access to specialty BH services

We expect that timely access to BH services will improve as BHPs increase service capacity and functioning. Qualitative interviews and county BH services profiles will be used to identify changes to BH services systems most likely to impact timely access. Interviews with provider agencies will be informative with respect to how agencies have been directly impacted by changes to referral systems. Quantitative assessments of change in timely access will draw on data from the Timely Access Data Tool (TADT), which includes standardized information on the number of referrals by referral source, the timing of the first appointment offered to new patients, and whether and when appointments were kept.

EQ3: EBP Launch and Scaling

We expect an increase in the number of Medi-Cal members receiving EBP services and in the proportion of BH service users who receive EBPs. Information on service provision will be collected in the county profiles, and qualitative interviews with county officials and EBP

providers will provide information on how policy changes have or have not impacted practice. Claims based measures of utilization of EBPs will be used to quantitatively assess impacts of the IP.

EQ4: Utilization of ECM

We expect an increase in the number of Medi-Cal members using ECM. We will track county funded ECM services in our county profiles and ask about implementation of ECM in qualitative interviews with county officials and ECM providers. Claims data on ECM use will be used to examine impacts of the IP on the number of Medi-Cal members using ECM and the average number of ECM services per ECM user.

EQ5: Criminal Justice System Involvement

We expect an increase in the proportion of people with a history of criminal justice system involvement who receive specialty behavioral health services and a decrease in re-entry into the criminal justice system by people with a history of treatment in the specialty behavioral health system. To assess these hypotheses, we will link data from the Automatic Criminal History System (ACHS) with Medi-Cal claims and enrollment data.

EQ6: Reducing Institutional Care

We expect admissions to institutional care among people with serious mental illness to decrease. We also expect that Medi-Cal BH expenditures, measured as total Medi-Cal BH costs and as per-member per-month (PMPM) BH costs, will decrease for acute BH care, i.e. hospitalizations and emergency department visits, and increase for community based BH care. Medi-Cal claims data will be used to identify admission to institutional care and to calculate expenditures.

Table 2.2. Measures for Access Outcomes

Evaluation Question	Measure Domain	Measure Descriptions	Data Source
EQ1.1	Penetration	Proportion of Medi-Cal members who access SMHS services; proportion of past-year users of SMHS services who use services in the current year	Claims
	Engagement (5 or more claims)	Proportion of Medi-Cal Enrollees with 5 or more claims for SMHS services within a 12-month period; proportion of Medi-Cal enrollees with SMHS services on 5 or more days within 12-month period	Claims

Evaluation Question	Measure Domain	Measure Descriptions	Data Source
	Initiation of SUD treatment	Proportion of Medi-Cal members with one or more claims for SUD treatment in a 12-month period; proportion of Medi-Cal members with a newly identified SUD who have one or more claims for SUD treatment	Claims
	Engagement in SUD Treatment	Proportion of members who initiate SUD treatment who meet criteria for treatment engagement	Claims
EQ1.2	Referrals to BH services	Number of referrals to SMHS services and SUD services, by referral source	TADT
	Timely Access to Care	Proportion of new contacts with care that are offered an initial appointment within 10 days; average and median time to first offered appointment; average and median time to first completed appointment; Proportion of new contacts with care with a kept appointment	TADT
EQ1.3	EBP Launch (Adults/Children)	Number of adult/child members with one or more claims for specified EBPs within a 12-month period	Claims
	EBP Scaling (Adults/Children)	Proportion of adult/child BH services users with one or more claims for specified EBPs within a 12-month period	Claims
EQ1.4	ECM Utilization (Adults/Children)	Number and proportion of adult/child BH services users who access ECM; number of ECM services received by ECM users	Claims
EQ1.5	Criminal Justice System Involvement	Number and proportion of adult/child BH services users who have contact with the criminal justice system	ACHS
EQ1.6	Institutional Care	Admissions to hospitals for BH conditions	Medi-Cal data; HCAI Hospital Data
	Medi-Cal Costs	Costs to Medi-Cal for BH services as reflected in paid Medi-Cal claims	Medi-Cal Data

Focus Area 2: Health Outcomes and Quality of Life

EQ2.1: Pharmacotherapy for OUD

We expect that improvements made to the BH services delivery system will result in an increase in the use of pharmacotherapy for OUD. We will track county-level change in pathways to pharmacotherapy for OUD and ask questions about access to these services in qualitative interviews with county officials and providers. In quantitative analysis of impacts, we will examine the number of Medi-Cal members with a diagnosis of OUD who receive pharmacotherapy as measured by the HEDIS measure *Pharmacotherapy for Opioid Use Disorder* (POD).

EQ2.2: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

We expect adherence to antipsychotic medications for individuals with schizophrenia to improve. In qualitative interviews with county officials, we will ask questions about how delivery system reforms were designed to improve this outcome. In interviews with providers, we will ask about how these changes have affected care in practice, focusing on care plans. Principles from the Person-Centered Care Planning Assessment Measure will be used to guide development of interview questions. In interviews with Medi-Cal members who receive BH services in participating counties and are prescribed antipsychotic medications, we will ask about how changes to the delivery system have impacted the care they receive. Using claims data, we will examine the number of adults with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period as a proportion of the total number of adults with schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication.

EQ2.3: Psychosocial Care for Children and Adolescents on Antipsychotic Medication

We expect that changes to the delivery system for children will result in more children receiving frontline psychosocial care prior to being prescribed antipsychotic medications. In qualitative interviews with county officials, we will ask about how delivery system reforms were designed to improve access to psychosocial care for children with BH needs, and, in qualitative interviews with child services providers, we will ask questions about how these changes have affected services in practice. Impacts of the IP will be examined through analyses of claims-based HEDIS measure of receipt of psychosocial care prior to receipt of antipsychotic medication. If this measure is available or definable using claims for the pre-demonstration period we will use DD models for this analysis. If pre-demonstration data are not available for the HEDIS measure are not available, we will explore the possibility of defining a closely related claims-based measure for which pre-demonstration data are available.

EQ2.4: Quality of Life

We expect that quality of life of Medi-Cal members using BH services will improve. Qualitative interviews with county officials and providers will focus on how delivery system reforms have improved quality of life by, for instance, addressing social determinants of health. Quantitative assessment of the impact of the IP will use data from the required client survey to assess change in quality of life among all Medi-Cal members using BH services and, where possible, change over time for the same individuals who complete multiple surveys.

EQ2.5: Improve Health Outcomes

We expect overall ED visits for BH conditions and the proportion of Medi-Cal members with frequent ED visits to decrease due to improved access to community-based services. Qualitative interviews with county officials will ask about efforts to prevent unnecessary reliance on acute care, especially among clients with high needs. The primary outcomes will be measures of high use of ED and inpatient services for any reason and for BH conditions, in particular. Measures of ED use will include the number of Medi-Cal members with one or more ED visits (for any reason or for a BH condition) as a proportion of all Medi-Cal members and the number of Medi-Cal members with four or more ED visits (for any reason or for a BH condition) as a proportion of all Medi-Cal members. Similar measures will be defined for inpatient stays, in addition to a measure of the number of Medi-Cal members who have a total number of inpatient days (potentially across multiple hospitalizations) of 30 or more in a 12-month period. Subgroup analyses will examine these outcomes among members receiving EBPs.

Table 2.3. Measures for Health Outcomes and Quality of Life

Evaluation Question	Measure Domain	Measure Descriptions	Data Source
EQ2.1	Pharmacotherapy for OUD	Proportion of BH services users with OUD who receive pharmacotherapy among BH services users with OUD Continuity of pharmacotherapy for Medi-Cal members with OUD	Claims
EQ2.2	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Proportion of BH services users who were prescribed antipsychotics who remain on antipsychotic medication for at least 80% of the treatment period	Claims
EQ2.3	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Proportion of child BH services users treated with an antipsychotic medication who received psychosocial care as a first-line treatment	Claims

EQ2.4	Quality of Life	Average QoL among BH services users; improvement in QoL over time among BH services users	Client Survey
EQ2.5	ED Visits	Number of Medi-Cal members with frequent ED use for BH condition (≥ 4 visits within 12 months)	Claims
	Hospitalizations	Number of Medi-Cal members with frequent hospitalization for BH condition (≥ 3 stays or 30 days within 12 months)	Claims

Focus Area 3: Delivery System Reform

EQ3.1 Quality Improvement Capabilities

We expect quality improvement capabilities of county BH services system to improve. Assessment of improvement will involve qualitative interviews with county officials and providers. RAND will develop a structured assessment of quality improvement capabilities based on a literature review and consultation with stakeholders. The assessment will measure changes in capabilities related to quality measure data collection and analysis, data sharing, measure selection, iteration of improvement efforts across measurement cycles and systematic follow-up assessments (e.g., implementation of Plan-Do-Study-Act Cycles).

EQ3.2 Data Sharing Capabilities

We expect data sharing capabilities to improve. Qualitative interviews with county officials will ask about changes made to health information technology across the BH services and in capacity for health data sharing. Qualitative interviews with providers will examine how these changes have impacted providing quality care in practice. Improvement in data sharing capabilities will be assessed systematically using information from the Data Exchange Framework, which includes information on county BHP participation in data exchanges.

EQ3.3 Outreach to Medi-Cal Members with BH Needs

We expect that counties will expand their outreach to Medi-Cal members with BH needs through a range of community-based efforts. Qualitative interviews with county officials will ask about community outreach activities. After an initial round of data collection about planned outreach activities and discussions with DHCS, we will select a sample of efforts for close observation and evaluation. Methods will need to be tailored to the selected events. For instance, if there are specific events in which individual participants can be identified and surveyed, we can use pre-post on-site surveys, as has been done in prior assessments of anti-stigma campaigns. For larger campaigns, we will consider county-level population surveys.

EQ3.4 Crisis Services

We expect that counties will improve their crisis services in ways that increase capacity, timely access, and utilization and improve integration with other medical and non-medical services (including law enforcement). We will track county expansions of crisis services and include questions about crisis services in interviews with county officials. Questions about crisis services will be developed to address the ACCESS TO HELP framework for quality crisis services created by the National Council for Mental Well-Being (Hopper et al., 2024). In addition, we will include questions about interactions with crisis services in interviews with providers. The evaluation team will explore data available on 988 and 911 utilization. If feasible, we will use these data sets to examine how 988 and 911 lines are interacting with crisis services. Finally, analyses of claims data will be used to assess the impact of IP on utilization of crisis services.

Chapter 3. Evaluation Design for Workforce Initiatives

Brief Overview of Workforce Initiatives

The BH-CONNECT Workforce Initiatives Program (WIP) consists of a set of five initiatives intended to increase the BH workforce that serves Medi-Cal members and uninsured individuals with significant BH needs. All five initiatives will be administered by HCAI under the direction of DHCS. The five initiatives, as described in the approval letter, are:

- Medi-Cal Behavioral Health Student Loan Repayment Program (MBH-SLRP): Provides up to \$240,000 in loan repayment for eligible behavioral health professionals, including those with prescribing privileges, individuals in training to become licensed prescribing practitioners, non-prescribing licensed or associate-level pre-licensure practitioners, and other non-prescribing providers serving Medi-Cal members in exchange for completing up to four years of service in a safety net setting. The maximum amount of loan repayment and the required period of service commitment depends on the practitioner's provider type. Loan repayment funds will be paid directly to loan services.
- Medi-Cal Behavioral Health Scholarship Program (MBH-SP): Provides up to \$240,000 in scholarship payments for future BH practitioners in exchange for completing up to four years of service in a safety net setting after graduation. The maximum scholarship amount and required service commitment period depend on the type of behavioral health degree or certification a participant is pursuing, which must lead to their ability to provide behavioral health services to Medi-Cal members. The participant must be pursuing education to become a licensed practitioner with prescribing privileges, non-prescribing licensed or associate-level pre-licensure practitioner roles, and other non-prescribing providers serving Medi-Cal members. Scholarship funds will be paid directly to educational institutions.
- Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP): Provides funds for a range of recruitment and retention bonuses, supervision support for pre-licensure and pre-certification practitioners, and certification/licensure and training aiming to recruit and retain behavioral health practitioners to serve the Medi-Cal population. Recruitment and Retention funds are paid *to Medi-Cal safety net provider organizations* to distribute the funds to eligible BH practitioners. BH practitioners are required to complete up to four years of service in a safety net setting depending on the awarded amount. Bonuses and other activities funded through the recruitment and retention program are listed below:
 - Up to \$20,000 per practitioner in recruitment bonuses
 - Up to \$4,000 per practitioner in retention bonuses
 - Up to \$50,000 per practitioner in recruitment bonuses that support a practitioner's last year of study
 - Up to \$1,500 per practitioner for gaining or maintaining licensure or certification
 - Up to \$35,000 per safety net setting provider organization per year to support pre-licensure and/or pre-certification supervision requirements
 - Up to \$750 per day to backfill BH practitioners who attend specific trainings. The maximum backfill amount is determined by the BH practitioner type.

There are restrictions in place restricting the award of multiple bonuses to an individual provider. For example, individuals may not receive retention bonuses until they fulfill the service obligations for any recruitment bonuses they received. These limitations are in addition to the maximum funding amount available for each individual practitioner.

- Medi-Cal Behavioral Health Community-Based Provider Training Program (MBH-CBPTP): Provides up to \$10,000 in funding to support training to become an Alcohol or Other Drug Counselor, Community Health Worker, or Peer Support Specialist. Participating practitioners must complete three years of service in a Medi-Cal safety-net setting. Awards will be paid directly to the training program.
- Medi-Cal Behavioral Health Residency Training Program (MBH-RTP): Provides up to \$250,000 per residency or fellowship slot per year to safety net settings for certain specialties. Three residency and fellowship programs are eligible: Psychiatry Residency, Child Psychiatry Fellowship, and Addiction Psychiatry/Addiction Medicine Fellowship. The funds to support the residency or fellowship will be paid to the certified or accredited professional training programs. Residents and fellows will automatically be enrolled in the MBH-SLRP and will be required to complete a four-year service commitment in an eligible Medi-Cal safety net setting post-residency or fellowship.

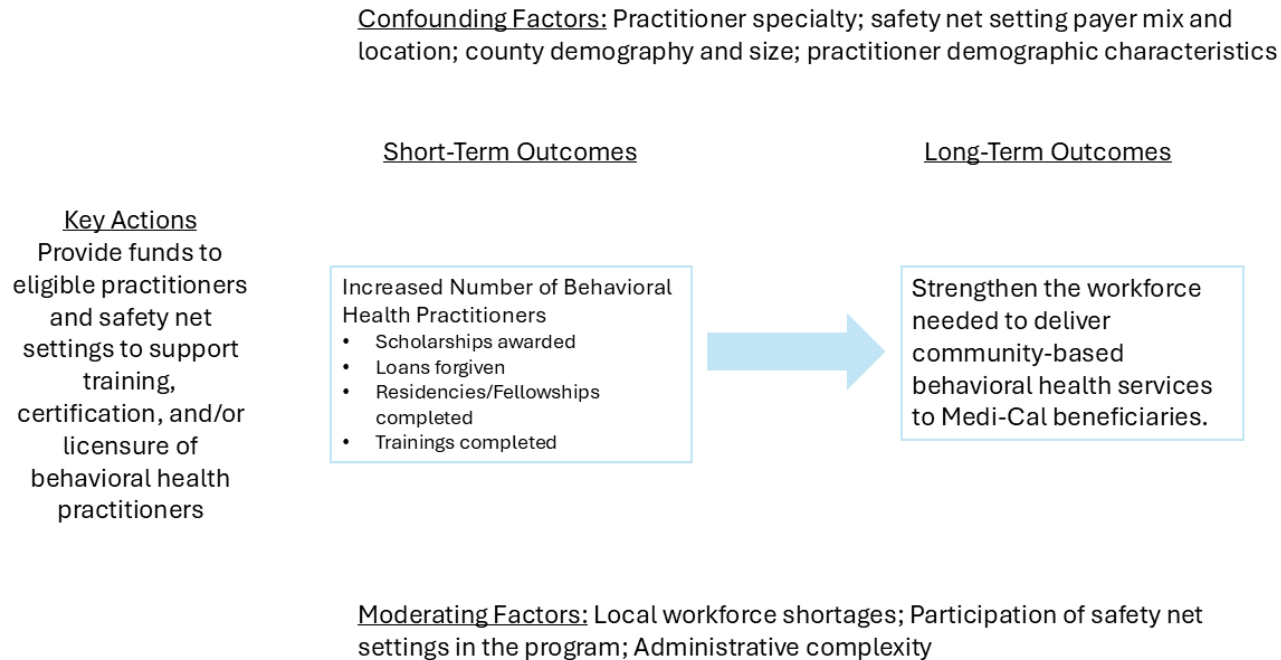
While all initiatives involve financial support for BH practitioners, the funds are disbursed differently depending on the initiative, to a mix of individual and institutional awardees. The MBH-SLRP and scholarship initiatives provide funding directly to loan services or educational institutions on behalf of the awarded individual practitioners. In exchange, individual awardees are required to complete a term of service working in a Medi-Cal safety net setting, defined and described in the approval letter as Federally Qualified Health Centers (FQHC), Community Mental Health Centers, Rural Health Clinics, or other behavioral health clinical settings with a high proportion of Medi-Cal members or uninsured individuals in their patient population. The recruitment and retention initiative provides funds to Medi-Cal safety net settings that provide BH care to Medi-Cal members and uninsured individuals. The training initiatives target practitioner types for which there are known BH workforce shortages, including community-based providers, and psychiatrists or physicians focused on addiction and/or children and adolescents. These funds are dispersed directly to the clinical training programs that provide the training. In contrast with the other demonstration programs, the WIP is targeted directly at individual awardees, behavioral health clinical care providers, and training programs, rather than BHPs.

The MBH-SLRP and the MBH-RTP are scheduled to launch in July of 2025, the scholarship and community-based provider initiatives in the first quarter of 2026, and the recruitment and retention initiative in summer 2026.

Workforce Initiatives Program Evaluation Overview

The design of the evaluation of the WIP is guided by the logic model in Figure 3.1. The WIP makes direct investments in BH care workforce development through the five programs described above. In the short term, these initiatives are expected to increase the initiatives of BH practitioners being trained, recruited into, and retained as BH staff within the safety net care system that serves Medi-Cal members and the uninsured. In addition, by reducing the costs of training in BH clinical certifications, the WIP may also incentivize awardees to work in Medi-Cal safety net clinical settings. In the long term and mediated by these short-term outcomes, the five initiatives are expected to strengthen the system's overall capacity to provide community-based BH services. Several factors may confound or modify the impacts of the WIP. Contextual factors include the characteristics of the safety net provider (size, academic, payer-mix) and its location (severity of shortages, cost of living, urbanicity), the availability of training sites and applicants at or near the safety net setting, and the administrative complexity of the WIPs, which could deter participation; other factors that might influence long-term outcomes include the specialties for which practitioners and safety net settings seek training resources and the characteristics of the practitioners (age, prior training).

Figure 3.1. Workforce Initiatives Logic Model



The evaluation will use a mixed methods approach to track implementation of the initiatives and, to the extent possible, assess the impact of the WIP and its constitutive initiatives on BH workforce capacity. We will track implementation by leveraging administrative data collected by HCAI that will describe, for instance, the number and types of practitioners who have received support through the WIP, the types of safety net providers that have benefitted from the WIP, and the setting types of places in which the WIP individual and institutional awardees are located. In addition, we will collect data through surveys and qualitative interviews of WIP awardees and institutional awardees to assess the perceived impacts of the WIP as well as facilitators and barriers to impact. Assessments of the impact of the initiatives will go beyond description of the activities to estimating longer term contributions to the workforce providing BH services in safety net settings. These analyses will use survey results and other administrative data to assess change in service capacity over time.

We plan two surveys of workforce initiative awardees, an initial survey of early awardees and a later survey of all awardees. We anticipate fielding the later survey during the second half of the waiver period. The administration timing of the final survey may vary based upon a range of factors across all WIPs including, but not limited to: WIP implementation start date, when the institutional and/or individual awardee has completed accruing initiative benefits (e.g., all scholarship payments made), and when the institutional and/or individual awardee is expected to complete WIP requirements (e.g., expected length of service period). Estimating the number of awardees based on the total dollar amounts allocated for the WIP in each year and the ranges of individual awards, the sampling frames for these surveys are anticipated to be approximately 12,500 and 33,500 awardees respectively. For each survey, we plan to field a simple random sample of 6,400 awardees. Assuming a 25 percent response rate (i.e., 1,600 responses), these samples would be sufficient to produce margins of error (MOE) of ± 2.5 percentage points (i.e., confidence intervals spanning five percentage points) on survey items with binary responses.⁴

Table 3.1 below presents the evaluation questions, hypotheses, and measures that will be used to evaluate the WIP.

⁴ The MOE of ± 2.5 percentage points is conservative in two ways. (i) It relies on a worst-case scenario based on 50 percent endorsing each category. The MOEs will reduce as the proportion selecting one of the binary responses moves toward zero or one. For example, at 75% endorsing one category, the MOE reduces to ± 2.1 percentage points. (ii) A finite population correction would slightly further reduce the MOE.

Table 3.1. Evaluation Questions, Hypotheses, and Data Sources: Workforce Initiatives

Goal	Evaluation Question	Hypotheses	Data Sources
1. Increase BH workforce recruitment and retention	1. What will be the uptake of the WIP initiatives among different types of eligible practitioners and safety net providers?	• Applications for WIP funds will exceed the available funds. • All available WIP funds will be dispersed. • Resources will be dispersed in areas of identified need based on objective criteria.	• HCAI workforce program data • Area Health Resource Files (AHRF), MH-HPSA data • Awardee Survey
	2. How many practitioners will complete their training (e.g., graduated, received a license, etc.) or employment term and complete their term of service?	• A majority of WIP participants will complete the required service commitment.	• HCAI workforce initiatives data • Qualitative interviews
2. Increased availability of BH practitioners serving Medi-Cal members and uninsured individuals	1. Will participating safety net settings strengthen their ability to serve Medi-Cal members and uninsured individuals?	• Participating safety net settings will have an increased number of BH practitioners. • Participating safety net settings will increase capacity to provide BH services.	• HCAI workforce initiatives data • Qualitative interviews • Mental Health Plan (MHP) Dashboards • Network Adequacy Certification Data • Awardee survey

Goal	Evaluation Question	Hypotheses	Data Sources
	2. To what extent do the new practitioners address the pre-existing practitioner shortages at participating safety net settings?	• Participating safety net settings' recruitment of practitioners will mitigate their local shortages. • Participating safety net settings' recruitment of practitioners will increase their capacity to provide BH care.	• HCAI workforce initiatives data • Qualitative interviews • Licensure data • MHP Dashboards • Awardee survey
	3. To what extent does the geographic distribution of participating safety net settings and providers align with pre-existing state-level provider shortages?	• Participating practitioners will be more likely to work in safety net settings as a result of their award. • Practitioners will work in areas with pre-existing provider shortages.	• HCAI workforce initiatives data • Qualitative interviews • Awardee survey • AHRF, MH-HPSA data

Evaluation Methods

Study Population

The study population will include a range of individuals and entities, including practitioners receiving funds through the WIP, safety net settings receiving funds through the WIP, and Medi-Cal members receiving treatment from those practitioners and settings. As of this writing, no awards have been made for any of the WIPs. The initial grant cycles for the Medi-Cal Behavioral Health Student Loan Repayment Program and the Medi-Cal Behavioral Health Residency Training Program closed on August 15, 2025. While it is expected that the number of participating practitioners and safety net settings will increase over time, it is also possible that participation will be low. As a result, in any given year of the demonstration, there may be different sets of WIPs, participating practitioners, and participating safety net settings.

Time Frame for the Evaluation

The evaluation will include a pre-implementation period, or baseline, of a minimum of two years, to the extent that data is available, and a post-implementation period, or post-period. The post-period will span the time between the date of implementation of each individual WIP initiative and the date of either awardee drop-out or the end of the five-year demonstration period, whichever comes first. The staggered start dates for the funding rounds of the five WIP initiatives and ability of awardees to drop out prior to completing their service requirements, as described above, will lead to varying start and end dates for the different WIP initiatives for participating practitioners and safety net settings and for variable durations for post-periods.

Analytic Approaches

We will address each of the evaluation questions using a mixed methods approach of both qualitative and quantitative methods as necessary and feasible. The planned analytic approaches are described below.

Qualitative Methods

Qualitative methods (interviews or focus groups with key stakeholders) will be used to provide context for and augment the quantitative findings, and address evaluation questions for which quantitative data are not available.

We will seek out stakeholders with ‘on the ground’ experience with the implementation of the WIP initiatives, including state officials, HCAI WIP initiative administrators, officials at safety-net settings, practitioners, and affected Medi-Cal members or their families/caregivers. The focus of the qualitative component of the evaluation will be to identify WIP initiative activities or their components or characteristics thought to be most effective in achieving the

goals of the WIP initiatives (facilitators), factors thought to hinder their effectiveness (barriers), and program-driven changes to data sharing systems, processes, or policies.

Semi-structured interview (or focus group) guides and document review abstraction forms will be developed in close consultation with DHCS. The guides will be brief and targeted, consisting of questions and probes, but flexible enough to permit follow-up questions that are responsive to interviewees' comments. The qualitative data will be analyzed with principled methods that emphasize inductive codes emerging directly from the data (Bradley, Curry, and Devers, 2007).

Quantitative Methods

Methods that may be to characterize workforce populations and trends and, whenever possible, validly quantify the impacts of the WIP initiatives include descriptive statistics, geospatial analysis, and quasi-experimental methods.

Descriptive Statistics

Descriptive statistics will be used to describe the populations of participating providers, participating safety-net settings, and Medi-Cal members served by participating providers and/or safety-net settings. The descriptive statistics will be presented overall and stratified by key characteristics (e.g. language proficiency, race/ethnicity), year-to-year, and examine trends over time, as well as regional and initiative-specific patterns. For categorical variables, a chi-square test or a McNemar's test will be used as appropriate; for continuous variables, the Analysis of Variance test or paired t-test will be used as appropriate. For selected outcomes, we will complement the presentation of results with graphical illustrations.

Geospatial Analysis

The WIP initiatives differ from the other BH-CONNECT programs in that the geographic reach of participating practitioners and safety-net settings is not necessarily a county. To the extent that data is available, we will use geospatial analysis to examine the service area of participating practitioners and safety-net settings, as well as examine the extent to which these service areas align with geographic areas experiencing workforce shortages during the baseline period.

Quasi-Experimental Methods

As described in detail in Chapter 1 (Quantitative Methods), BH-CONNECT program outcomes will be examined using quasi-experimental methods that support valid causal inferences, including DD, the most robust of these methods, CITS, and ITS. Whenever quasi-experimental methods are preferred, we will aim to implement a DD approach to examine how the difference in the outcome pre- and post- WIP initiative implementation vary by exposure to a WIP initiative. We will adjust for confounder imbalance between exposed and unexposed Medi-

Cal members living in participating and non-participating counties by implementing multivariable DD regression models.

We believe it will be possible to implement a DD approach because, as of July 2025, it appears that there is significant interest in applying for the first funding round of the LRP as evidenced by a completely booked HCAI informational webinar on the initiative. The differential timing of WIP initiative implementation and funding rounds will be addressed with methods that can handle the expected staggered adoption of the program; see Chapter 1 (*Quantitative Methods*).

We will address the possibility that concurrent policies and other initiatives may affect estimates of program impacts by examining the timing of other initiatives relative to the implementation of the BH-CONNECT programs and including controls for concurrent initiatives in the causal models.

Limitations

Our ability to evaluate the long-term impacts of the WIP is limited by the duration of the waiver demonstration period in comparison to the length of the WIP initiative service requirements. Depending on when a participant begins participating in a WIP initiative and the amount of funding they are awarded, they may not complete their service requirement within the demonstration period. This limited availability of post-service requirement data on post-WIP initiative career choices and workforce characteristics may limit our ability to use quantitative methods to examine the impacts of the WIP. Mitigation strategies include identifying related evaluation questions/hypotheses that may be addressed with the available data or informing these analyses with qualitative data, such as interviews with participants about their future career plans while they are still completing their service requirements.

For planned analyses employing quantitative methods, we may be limited by incomplete person-level secondary data (missing Medi-Cal member information, missing years) or lack of the necessary data to construct the required variables. Mitigation strategies include using data imputation methods (if feasible), switching to descriptive analyses, or identifying related evaluation questions/hypotheses that may be addressed with available data.

For quasi-experimental analyses for which a DD approach had been planned, potential limitations are the finding of non-parallel trends, and for system-level outcomes assessed at the county level, the possibility that during the demonstration, most or all regions of the state will have implemented a WIP initiative. We will mitigate these limitations by implementing a CITS model and an ITS, respectively; see Chapter 1 (*Quantitative Methods*).

EQ 1.1 Increase Behavioral Health Workforce Recruitment and Retention

The evaluation team will use administrative data from HCAI to track applications and awards for all the WIP initiatives. Specifically, we will track the numbers and types of applications, the number and types of awards made, characteristics of the applicants and individual awardees and

institutional awardees (e.g., age, prior training, professional qualifications, location in the state, language proficiency), characteristics of the safety net settings (e.g., type of facility, size, academic setting, payer mix, location), and total award amounts. To assess the extent to which the initiative is addressing specific workforce needs, we will crosswalk the awardee characteristics with county-reported workforce shortages. To assess the specific effects of the retention initiatives, we will examine the extent to which individual awardees continue serving in safety-net settings throughout the waiver period, to the extent that data is available on individual awardee's career changes after completing their service requirements. We may be able to access this data from initiative implementation data or by administering a survey to initiative graduates. However, this specific aspect of the evaluation may be limited, as there may be a small number of individual awardees who have completed the service requirements within the waiver period.

EQ 1.2 Completion of Training Programs and Service Requirements

Administrative data from HCAI will be used to track awardees' activities in the initiatives after the initial award is made. Specifically, we will track the completion of the training initiatives, completion of the service requirements, and total payments made. Surveys and qualitative interviews with awardees (individuals or safety net providers as appropriate) will ask about experiences participating in the WIP, the influence of any financial incentives on practitioners' career choices, and whether the initiatives enabled the participant to work in a setting or capacity in which they would otherwise have been unable to work. To assess the extent to which the WIP is addressing specific workforce needs, we will crosswalk the individual awardee and participating provider characteristics with county-reported workforce shortages.

EQ 2.1 Strengthening the BH Workforce

We will examine the impact of the WIP and its constituent programs on the workforce providing BH care to Medi-Cal members using initiative data from HCAI, survey results, and Medi-Cal data. First, using HCAI administrative data we will be able to track the number of practitioners and years of workforce participation covered by the award and the service requirements. Second, drawing on participants' observations about the impact of the awards on the amount of time they spend working in safety net settings, including but not limited to completion of the service requirement, we will estimate the total contribution of the programs to service capacity. Third, using Medi-Cal data we will track the volume of services provided to Medi-Cal members, testing whether predicted increases in capacity are reflected in increases in the number of services provided.

EQ 2.2 and 2.3 Addressing Shortages of Specific Practitioner Types and in Specific Geographic Regions

We will extend the analyses under EQ 2.1 to address impacts of the WIP on specific practitioner types and in specific geographic regions that are identified as areas of shortage. For

instance, we will examine whether the WIP initiatives contributed to increasing workforce capacity in mental health provider shortage areas (MH-HPSAs). For example, we will use data from California Mental Health Services Authority (CalMHSA) on peer support specialty certifications to assess whether the awards initiative has increased the peer support workforce overall and in areas that have historically had lower numbers of peers per Medi-Cal BH service user.

Chapter 4. Evaluation Design for Activity Funds Initiative

Brief Overview of Activity Funds Initiative

The activity funds initiative provides support to Medi-Cal members who are involved in the child welfare system and are diagnosed or are at risk of being diagnosed with BH conditions. This support allows them to engage in activities that facilitate their inclusion in the community and promote improved BH outcomes. To qualify as involved in the child welfare system a Medi-Cal member must meet one of the following four criteria: 1) under age 21 and received care through the child welfare system in California or another state within the past year; 2) under age 26 and aged out of the child welfare system in California or another state; 3) under age 18 and participating in or eligible for California's Adoption Assistance Program; or 4) under 18 and received services from California's Family Maintenance program in the past year. Behavioral health criteria require either a diagnosed BH condition or high risk for a BH condition with a service need, as determined by a licensed BH professional through a clinical assessment. Activity funds payments, which will be administered by DHCS through a contractor, will be paid on behalf of the participant directly to the activity provider.

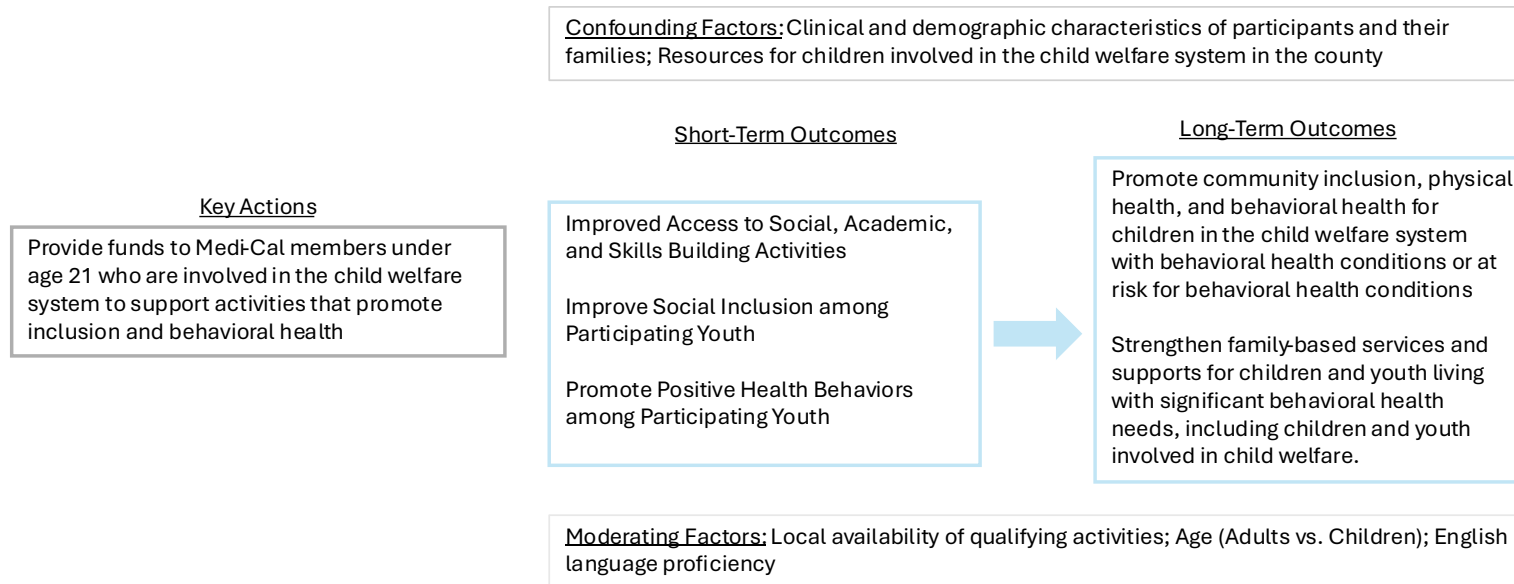
Activity funds can be used on behalf of eligible members to support purchase of goods or services that 1) promote inclusion in the community, 2) increase the member's safety in their home environment, or 3) facilitate participation or autonomy in making decisions that improve physical or BH outcomes. The purchased goods or services must be linked to a specific need documented in the member's clinical record, unavailable through other means, and non-duplicative of goods or services available through the Medicaid State Plan. Decisions about use of the funds, provided they follow these rules, are to be made by eligible members, their families, or caregivers (hereafter, families for simplicity). Examples of potential uses of activity funds include physical wellness activities, such as gym memberships or exercise gear and safety equipment, and strengths-developing activities, such as music lessons or therapeutic summer camps. Activity funds cannot be used for entertainment or recreational activities, tobacco or alcohol purchases, and multiple items of the same type for the same individual without a documented change in need.

Activity Funds Initiative Evaluation Overview

Evaluation of the activity funds initiative will examine implementation of the program through analysis of program documentation and qualitative interviews with participants, families, and activity providers, as well as outcomes of the program using program records, participant surveys, and semi-structured interviews.

The evaluation of the Activity Funds will be informed by the logic model in Figure 4.1. The key actions are the funds that are made available to support activities. The short-term outcomes are the resulting access to activities and the improvement in social inclusion and health behaviors among participants that is theorized to occur as a result. The long-term outcomes are improved inclusion in the community, improved physical health and BH outcomes, and the strengthening of family-based supports for youth involved in the child welfare system. The program is family-based in the sense that participants' families will be directly involved in decision making about use of the funds, though this may vary by the age of the participant. Notable modifying factors include the region in which a participant lives, which is likely to impact the availability of activities, whether the participant is a child or an adult, and the preferred language of the participant or their caregiver. Factors that may confound the impact of the program include clinical and demographic characteristics of participants and their families, and the availability of other types of supports services to which the participant has access.

Figure 4.1. Activity Funds Initiative Logic Model



The evaluation will involve two main components, one tracking implementation of the program and one assessing its impacts on participants and their families. Tracking implementation use administrative data on program participation, document reviews, and interviews with county officials directly administering the program. To assess the program's impact, we will conduct a survey of program participants who are 18 years of age or older and adult family members of participants who are under age 18. The surveys will address interactions with the program, motivations for using the program, and perceived benefits for the participants with respect to connectedness, social participation, social support, health and health behaviors. Follow-up semi-structured interviews with selected survey participants will be conducted to explore interactions with the program and impacts on participants in more depth. Given uncertainty about the numbers of participants, the difficulty in identifying a comparison group, and the long time frame required for detecting outcomes, we do not anticipate a controlled assessment of the impact of the program.

Table 4.1 presents the evaluation questions (EQs), hypotheses and data sources that will be used to evaluate the Activity Funds Initiative. We do not include specific EQs related to strengthening family-based supports since this goal is subsumed under Goal 1.

Table 4.1. Evaluation Questions, Hypotheses, and Data Sources: Activity Funds Initiative

Goal	Evaluation Question	Hypotheses	Data Sources
1. Promote community inclusion, physical health, and BH for children in the child welfare system with BH conditions or at risk for BH conditions.	1. Will the activity funds program engage eligible youth in activities that they would not otherwise have had access to?	Participating youth will access desired activities that they would not have been able to access without activity funds.	- Qualitative interviews - Participant survey - Program records
	2. Will the activities supported by the program improve social inclusion among participating youth?	- Activities that participants access through the activity funds program will promote a wide range of strategies for social inclusion. - Participants will report positive influences of the activities on connectedness, social participation, and social support.	- Qualitative interviews - Participant survey
	3. Will the activities supported by the program promote positive health behavior among participating youth?	- Activities that participants access through the activity funds program will promote a wide range of strategies for social inclusion. - Participants will report positive influences of the activities on connectedness, social participation, and social support.	- Qualitative interviews - Participant survey

Evaluation Methods

Study Population

The study population will include Medi-Cal members who participate in the Activity Funds Initiative and the family members of participants who are under 18 years of age. Given that information to assess the eligibility criteria is not available for non-participants, we will not attempt to sample a control group for this component of the evaluation. In addition to participants, the evaluation will also collect data from programs that provide services supported by the Activity Funds.

Time Frame for the Evaluation

The evaluation timeline will be based on the actual rollout of the program. We anticipate conducting participant-level data collection (interviews or surveys) between 90 days and six months from the participants' initiation of program-supported activities.

Quantitative Methods

In presenting the survey results we will present detailed information on the characteristics of the sample, response rate, and any weighting that is conducted to correct for non-response. Survey results will be presented as weighted proportions. Comparisons of survey responses across sample sub-groups (e.g., by age group) will be conducted using weighted chi-square tests.

Tracking Implementation

The evaluation team will collect data directly from counties on how activity funds programs are structured and how they are used through review of documents (e.g., instructions for participants and families), information from the third-party entity administering the program, and interviews with county personnel involved in decision-making about awards and oversight of the program. We do not know whether information on participants, such as individual participant demographic characteristics, clinical conditions, preferred activities, and payment amounts, will be available in standardized formats across counties, though we anticipate that detailed information will be collected by DHCS for oversight and reporting purposes. The evaluation team will work with counties, the third-party administrator, and DHCS to collect detailed data on program participants and the activities supported by the program in a format that minimizes burden on counties. In addition, the evaluation team will work with counties and DHCS to apply eligibility criteria to the enrolled Medi-Cal population to characterize the population eligible for the activity funds initiative. Qualitative interviews conducted with samples of counties in years 2 and 3 of the program will examine implementation facilitators and barriers.

Family and Participant Perspectives on Impact

Provided that the contact information can be accessed, we will field a survey to collect information on program participation. The survey sample will include participants aged 18 or older and family members or caregivers of participants who are under age 18. Based on estimates of the number of program participants, we anticipate approximately 500 participants ages 18 to 21 and 1500 participants under age 18. Given these relatively small numbers, we intend to survey all recipients of activity funds. Assuming a 25 percent response rate and employing a finite population correction, these samples would be sufficient to produce margins of error of ± 7.6 percentage points for the adult survey and ± 4.4 percentage points for the parent/caregiver survey. These calculations will be updated as the number of participants becomes clear.

The survey will ask about how difficult or easy it was to participate in the program, the perceived value of the program to the participant, and the impact of the program on participants' BH, health care service use, social engagement, social support, and social connectedness. Survey participants will be given the opportunity to provide direct contact information for a follow-up semi-structured interview that will examine program participation in greater detail, including questions about the decision to participate, use of the funds, quality of interactions with BHPs and program providers, and impacts of the program on participants. Qualitative interviews will also ask about barriers to program participation and potential improvements that could be made. RAND will explore the possibility of conducting interviews with eligible Medi-Cal members who indicated an interest in the program but did not receive activity funds to provide an additional perspective on barriers to participation.

EQ1: Engaging Youth

The evaluation team will track overall participation numbers and the proportions of eligible Medi-Cal members who participate by county over time. Working with the available data, we will develop a measure of program retention, designed to reflect long-term engagement in the selected activity, as opposed to brief episodes of participation that are unlikely to have lasting impacts. In the survey and qualitative interviews, we will ask questions about whether the program enabled participation in activities that would otherwise have been inaccessible. Analyses will examine potential barriers to participation that may impact specific subgroups, such as challenges of managing the program for participants whose preferred language is not English and participants in areas with limited access to qualifying activities.

EQ2: Promoting Social Inclusion

Survey data on the perceived impacts of the activities supported by the program will be used to assess the extent to which it is contributing to improving social inclusion of participants. Social inclusion will be measured through a combination of objective and subjective measures. Objective measures will focus on changes in time spent in social activities, including but not

limited to those directly related to the supported activity. Aspects of social inclusion in work, school, and other settings will also be assessed. We will consider including a validated measure of social inclusion, such as the Filia Social Inclusion Measure (Filia et al., 2022) or the Social Exclusion Scale for Children (Karakaya, Özsavran, and Kurt, 2024). Subjective measures will focus on perception of inclusion in meaningful activities and perceived value of participation in the supported activities. Qualitative data on these topics will provide narrative case studies to illustrate the findings and describe how the supported activities have (or have not) impacted participants.

EQ3: Promoting Positive Health Behavior

Surveys and qualitative interviews will ask about the impact of the supported activities on health behaviors, primarily sleep, physical activity, diet, and health care utilization (BH and general health care). Surveys will use validated measures where possible and feasible. Qualitative interviews will be designed to parallel content covered in validated measures.

Chapter 5. Evaluation Design for Serious Mental Illness Program

Brief Overview of SMI Program

The SMI program seeks to strengthen the BH delivery system by leveraging the SMI Section 1115 demonstration opportunity to enhance the continuum of community-based specialty mental health services and increase opportunities for early intervention for Medi-Cal members with SMI/SED. Medi-Cal members with SMI will have access to a full range of services ranging in intensity from short-term acute care in psychiatric hospitals and residential settings to ongoing care for SMI in cost-effective community-based settings.

Under BH-CONNECT's SMI program, federal financial participation (FFP) for IMD services provided to Medi-Cal members age 21 and over with SMI⁵ is available to BHPs⁶ that have received DHCS approval and have agreed to the following conditions:

4. Cover the following EBPs under State Plan authority on a timeline specified by DHCS: ACT; FACT; CSC for FEP;⁷ Individual Placement and Supports (IPS) Supported Employment; Enhanced CHW services; and Peer Support services, including a forensic specialization. Counties that have opted into the program will be required to implement these EBPs during the demonstration period on a rolling basis as follows:
 - Prior to claiming FFP for IMD Stays: Begin providing Enhanced CHW services
 - Within one year of claiming FFP for IMD Stays: Fully Implementing ACT
 - Within two years of claiming FFP for IMD Stays: Begin providing FACT and CSC for FEP
 - Within three years of claiming FFP for IMD Stays, go-live: Begin providing IPS Supported Employment
5. Reinvest FFP received for IMD services⁸ to support services and activities that benefit Medi-Cal members served by the BHP.

Additionally, the state will work to improve care coordination and care for co-occurring physical and BH conditions.

⁵ FFP will be available under this program only for IMD services provided to Medi-Cal members 21 years of age and older.

⁶ All California BHPs are eligible for participation.

⁷ Available in over half of counties funded in part through SAMHSA block grants and with training and technical assistance offered through UC Davis. The state plan amendment will cover CSC for FEP as a new bundled service at county option.

⁸ The state must achieve a statewide average length of IMD stay of no more than 30 days.

The goals of the SMI Program are aligned with those of the SMI Demonstration Opportunity and will facilitate accomplishing several goals of the BH-CONNECT demonstration (See Table 1.1). They include:

6. Reduced utilization and lengths of stay in EDs while Medi-Cal members await mental health treatment in specialized settings
1. Reduced preventable readmissions to acute care hospitals and residential settings
2. Improved availability of crisis stabilization services delivered in various settings.⁹
3. Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care
4. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

To accomplish the SMI program goals, the state has committed to undertake several actions captured in the following milestones:

5. Ensure quality of care in psychiatric hospitals and residential settings that primarily provide mental health treatment to Medi-Cal members with SMI, hereafter also referred to as *participating psychiatric settings*
6. Improving care coordination and transitions to community-based care
7. Increasing access to continuum of care including crisis stabilization services
8. Earlier identification and engagement in treatment including through increased integration.

The state already received approval for an “SMI Implementation Plan” describing actions already undertaken or planned in order to achieve these milestones, and timelines for state action on milestones not yet achieved (typically within 3–24 months of CMS approval).¹⁰ As detailed in the STCs, the activities and their status are as follows:

9. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
 - 1.a. Assurance that participating psychiatric settings (Mental Health Rehabilitation Centers, Psychiatric Health Facilities, Freestanding Acute Psychiatric Hospitals) are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medi-Cal (Partially Achieved).

⁹ These include Crisis Outreach and Response services (Call Centers, Mobile Crisis Units, Crisis Observation / Assessment Centers, and Coordinated Community Crisis Response Teams involving collaboration with trained law enforcement and other first responders); Intensive Outpatient and Partial Hospitalization services; and Crisis Stabilization services provided during acute short-term stays in public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings (residential crisis stabilization programs, small inpatient units in community mental health centers, peer-run crisis respite programs, and others).

¹⁰ The state also received approval for a Health IT Plan (“HIT Plan”) describing the state’s ability to leverage HIT, advance health information exchange(s), and ensure HIT interoperability in support of the demonstration’s goals.

- 1.b. Oversight process to ensure that participating psychiatric settings meet state's licensing or certification and accreditation requirements (Achieved).
- 1.c. Use of a utilization review process to ensure Medi-Cal members have access to the appropriate levels and types of care and to provide oversight on lengths of stay (Achieved).
- 1.d. Compliance with program integrity requirements and state compliance assurance process (Achieved).
- 1.e. State requirement that participating psychiatric settings screen Medi-Cal members for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions, e.g., with on-site staff, telemedicine, or partnerships with local providers (co-morbid physical health conditions) (Partially Achieved).
- 1.f. Other state requirements/policies to ensure good quality of care in participating psychiatric settings, including: revisions to the informed consent requirement for antipsychotic medications to permit verbal consent; requirement that SUD recovery or treatment facilities offer medications for addiction treatment (MAT) or have effective referral processes for this purpose; establishment of Psychiatric Residential Treatment Facilities, a new category of DHCS-licensed residential health facilities for individuals under 21 (the state is utilizing interim licensing regulations-final regulations expected by December 2027); and improved quality standards for certain residential psychiatric settings serving children and youth (Achieved).

10. Improving Care Coordination and Transitions to Community-Based Care

- 2.a. Actions to ensure participating psychiatric settings carry out intensive pre-discharge planning and include community-based providers in care transitions (Partially Achieved).
- 2.b. Actions to ensure participating psychiatric settings assess Medi-Cal members' housing situations and coordinate with housing services providers when needed and available (Partially Achieved).
- 2.c. State requirement to ensure psychiatric hospitals and residential settings contact Medi-Cal members and community-based providers through the most effective means possible, e.g., email, text, or phone call within 72 hours post discharge (Partially Achieved).
- 2.d. Strategies to prevent or decrease lengths of stay in EDs among Medi-Cal members with SMI prior to admission (Achieved).
- 2.e. Other State requirements/policies to improve care coordination and connections to community-based care (Achieved).

11. Increasing Access to Continuum of Care Including Crisis Stabilization Services

- 3.a. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (Achieved).
- 3.b. Commitment to implementation of the SMI financing plan (Achieved).
- 3.c. Strategies to improve the state tracking of the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible (Not Achieved).
- 3.d. State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay (Not Achieved).

3.e. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization (Achieved).

12. Earlier Identification and Engagement in Treatment and Increased Integration

4.a. Strategies for identifying and engaging Medi-Cal members with or at risk of SMI in treatment sooner, particularly adolescents and young adults (Achieved).

4.b. Plan for increasing integration of BH care in non-specialty settings, including schools and primary care practices, to improve early identification of SMI conditions and improve awareness of and linkages to specialty treatment providers (Achieved).

4.c. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI (Achieved).

4.d. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people (Achieved).

Evaluation Overview

The SMI Program evaluation will use a mixed-methods approach to examine the state's success at improving member- and system-level outcomes and achieving the program goals.

Following CMS guidance, we have proposed a logic model (Figure 5.1) that identifies connections between the actions that will be undertaken as part of the SMI Program and their expected short-term and long-term outcomes. While some of the long-term outcomes are specific to the SMI Program's five (5) goals, others are specific to the BH-CONNECT reform's goals, with some goals having overlapping domains. We have proposed additional long-term goals of high public health and policy significance. Additionally, the logic model identifies member characteristics and contextual variables that may modify or confound program impacts.

Each of the goals of the SMI Program will be addressed with evaluation questions of relevance to Medi-Cal members with SMI as well as policymakers, along with testable hypotheses. The evaluation questions include, but are not limited to, the primary and subsidiary research questions listed in CMS's SMI/SED and SUD Evaluation Design Guidance: Appendix A (CMS, 2018). See Table 5.1 for evaluation questions and hypotheses, as well as data sources.

In what follows, we describe the data sources, study population, time frame, outcomes and outcome measures, other key variables, and our analytic approach to the evaluation. Measures specific to the Mid-Point Assessment are also noted.

Figure 5.1. SMI Program Logic Model

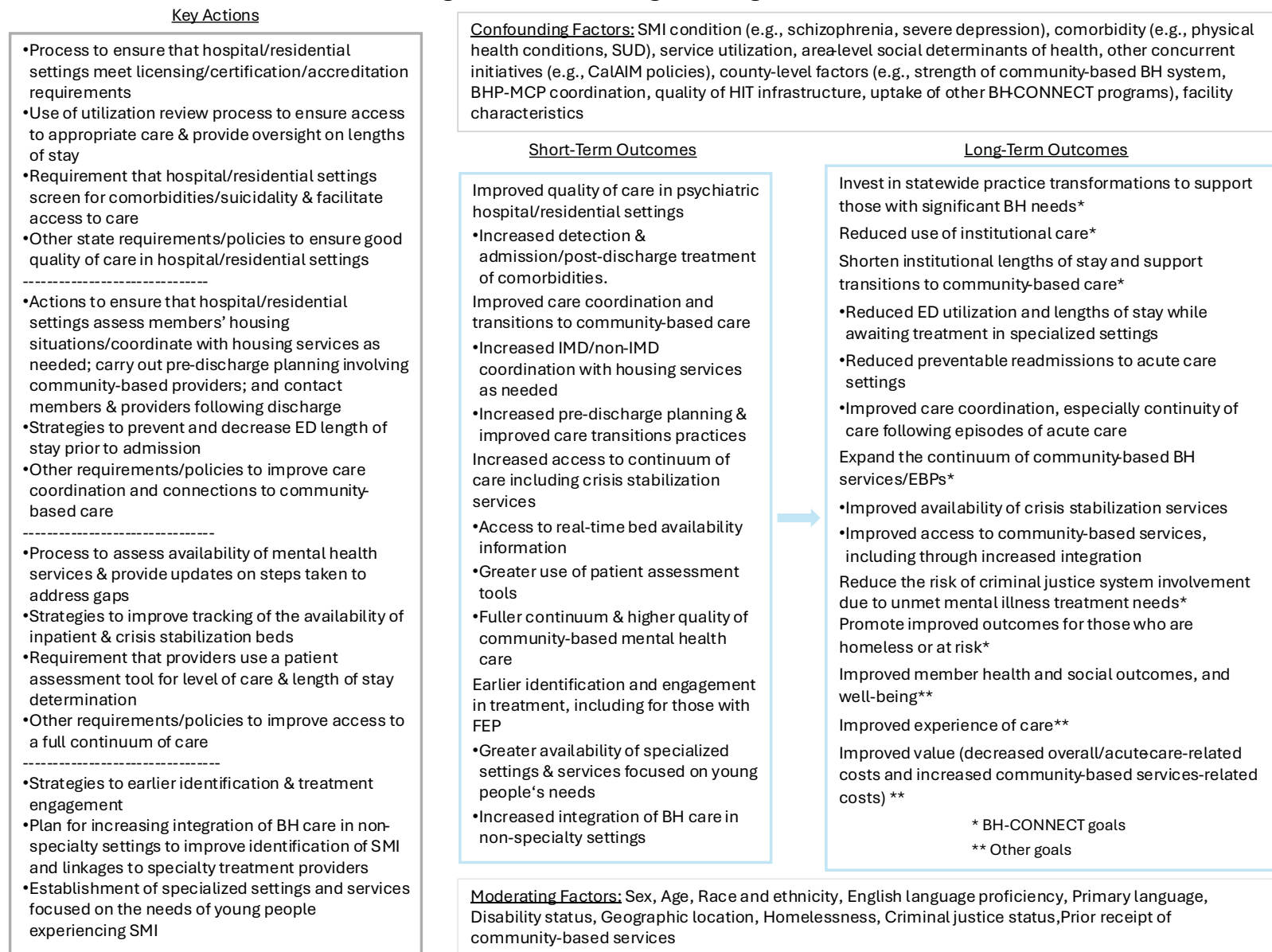


Table 5.1. Evaluation Questions, Hypotheses, and Data Sources: SMI Program

Goal	Evaluation Question	Hypotheses	Data Sources
1. Reduced utilization and lengths of stay in Emergency Departments (EDs) while Medi-Cal members await mental health treatment in specialized settings.	1. Is the SMI Program associated with reductions in ED utilization among Medi-Cal members with SMI? Are member characteristics* and prior receipt of community-based services associated with ED reduced utilization?	• All-Cause ED utilization among Medi-Cal members with SMI will be reduced under the SMI Program. • All-Cause ED utilization will be lower among Medi-Cal members with SMI receiving community-based services. • All-Cause ED utilization reductions may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). • All-Cause ED utilization and costs (PMPM/total) among Medi-Cal members with SMI will be reduced under the SMI Program. • ED utilization for mental health conditions among Medi-Cal members with SMI will be reduced under the SMI Program.	• Medi-Cal data
	2. Is the SMI Program associated with reductions in ED lengths	• ED lengths of stay among Medi-Cal members with SMI awaiting mental health	• Medi-Cal data • HCAI Patient-Level Administrative Data

Goal	Evaluation Question	Hypotheses	Data Sources
	of stay among Medi-Cal members with SMI awaiting mental health treatment in specialized settings?	treatment in specialized settings will be reduced under the SMI Program.	County BH EHR data
	3. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and the achievement of this Goal?	Changes made to systems, processes, or policies and other activities undertaken under the SMI Program will be associated with the achievement of this goal.	- Medi-Cal data - HCAI Patient-Level Administrative Data - County BH EHR data - Qualitative data
2. Reduced preventable readmissions to acute care hospitals and residential settings.	1. Is the SMI Program associated with reductions in preventable readmissions of Medi-Cal members with SMI to acute care hospitals and residential settings (IMDs and non-IMDs)? Do observed reductions vary by member characteristics* and prior receipt of community-based services?	- All-cause unplanned readmissions following acute psychiatric hospitalizations will be reduced under the SMI Program. - Reductions in all-cause unplanned readmissions may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). - All-cause unplanned readmissions following acute care hospital/residential stays for any diagnosis will be reduced for Medi-Cal members	- Medi-Cal data - HCAI Patient-Level Administrative Data - HPD

Goal	Evaluation Question	Hypotheses	Data Sources
		with SMI under the SMI Program.	
	2. Is the SMI Program associated with increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?	- Screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient/residential stays will increase for Medi-Cal members with SMI under the SMI Program. - Timely post-discharge treatment for comorbid SUD and physical health conditions identified during acute care psychiatric inpatient/residential stays will increase for Medi-Cal members with SMI under the SMI Program. - Care of diabetes for Medi-Cal members with SMI admitted to psychiatric inpatient/residential facilities will improve under the SMI Program as evidenced by fewer individuals whose most recent HbA1c level was $\geq 9.0\%$ or had a missing result or test.	- Medi-Cal data - County BH EHR data - IPFQR data
	3. What is the association between the activities undertaken	Under the SMI Program, fewer all-cause unplanned readmissions for Medi-Cal	- Medi-Cal data - HCAI Patient-Level Administrative Data

Goal	Evaluation Question	Hypotheses	Data Sources
	under the SMI Program's four (4) milestones^ and the achievement of this Goal?	members with SMI will have no evidence of receipt of timely community-based services following discharge from psychiatric hospitalizations. • The length of stay of psychiatric hospitalizations will be reduced under the SMI Program. • The activities undertaken under the SMI program will be associated with a reduction of preventable readmissions to acute care hospitals and residential settings.	• HPD • Qualitative data
3. Improved availability of crisis stabilization services throughout the state.	1. Is the SMI Program associated with improved availability of Crisis Outreach and Response services?	• The availability of Crisis Outreach and Response services will improve for Medi-Cal members with SMI under the SMI Program.	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS)
	2. Is the SMI Program associated with improved availability of Intensive Outpatient and Partial Hospitalization?	• The availability of Intensive Outpatient and Partial Hospitalization services will improve for Medi-Cal members with SMI under the SMI Program.	• County Profiles • Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)

Goal	Evaluation Question	Hypotheses	Data Sources
	3. Is the SMI Program associated with improved availability of acute short-term crisis stabilization services?	The availability of acute short-term crisis stabilization services will improve for Medi-Cal members with SMI under the SMI Program.	- County Profiles - Bed Tracking Tool - Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)
4. Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care.	1. Is the SMI Program associated with improved access of Medi-Cal members with SMI to community-based services to address their chronic mental health care needs? Do observed improvements vary by member characteristics*?	- Access to (1) outpatient, rehabilitation, and targeted case management services, (2) home and community-based services, and (3) long-term services and supports will increase for Medi-Cal members with SMI under the SMI program. - Improvements in access to community-based services may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). - Improved access to community-based mental health services for Medi-Cal members with SMI under the SMI program will be associated with increased costs associated with mental health-related community-based services and reduced mental	- Medi-Cal data - TADT

Goal	Evaluation Question	Hypotheses	Data Sources
		health-related inpatient/residential <u>and</u> overall costs. Ease and timeliness of access to community-based mental health services will improve for Medi-Cal members with SMI under the SMI program.	
	2. Is the SMI Program associated with improved availability of community-based services needed to comprehensively address the chronic mental health needs of Medi-Cal members with SMI?	The availability of community-based mental health services for Medi-Cal members with SMI will improve under the SMI program.	- County Profiles - Other (BHCIP)
	3. To what extent is the SMI Program associated with improved access of SMI Medi-Cal members to specific types of community-based services? Is quality/experience of care improved under the SMI Program? Do observed improvements	- Access to specific types of evidence-based community mental health practices will improve for SMI Medi-Cal members under the SMI program. - Quality/experience of care will improve for SMI Medi-Cal members under the SMI program. - Quality/experience of care	- Medi-Cal data - Performance data - Other (URS)

Goal	Evaluation Question	Hypotheses	Data Sources
	vary by member characteristics*?	improvements under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	
	4. To what extent does improved access to community-based services under the SMI Program vary by geographic area or member characteristics?	While access to community-based mental health services for Medi-Cal members with SMI will improve under the SMI Program, improvements may vary across geographic areas and member characteristics including age and language needs.	- County Profiles - Other (N-MHSS/N-SUMHSS)
	5. To what extent is the SMI Program associated with improved integration of primary and behavioral health care to address the chronic mental health care needs of Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	- Integration of primary and behavioral health care for Medi-Cal members with SMI will improve under the SMI Program. - The SMI program will be associated with improved efforts to identify need for mental health care among Medi-Cal members with SMI. - The SMI program will be associated with increased access to primary/preventive and chronic medical illness	- Medi-Cal and HPD/CA Medicare FFS data - County Profiles - Performance data - TADT - Other (Medi-Cal & EHR data: Child and Adult Core Set, hybrid measure)

Goal	Evaluation Question	Hypotheses	Data Sources
		care for Medi-Cal members with SMI. • The SMI program will be associated with an increase in the rate of Medi-Cal members with SMI accessing SMHSs following primary care referrals. • Improvements in integration of primary and behavioral health care under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	
	6. To what extent is the SMI Program associated with improved patient outcomes? Do observed improvements vary by beneficiary characteristics*?	• H6a. Health and social outcomes and well-being will improve for Medi-Cal members with SMI under the SMI Program. • Improvements in health and social outcomes and well-being under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	• Medi-Cal data • Other (State data, Quality of life survey)

Goal	Evaluation Question	Hypotheses	Data Sources
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	1. Is the SMI Program associated with improved care coordination for Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• The SMI program will be associated with improved care coordination for Medi-Cal members with SMI. • Improvements in care coordination under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations). • The SMI program will be associated with improved data sharing systems, processes, or policies aimed at improving care coordination.	• Medi-Cal data • Performance data • County BH EHR data • IPFQR data • Qualitative data
	2. Is the SMI Program associated with improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities among Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• The SMI program will be associated with improved continuity of care in the community for Medi-Cal members with SMI following acute care episodes. • Improvements in continuity of care in the community following acute care episodes under the SMI Program may vary across relevant subgroups of Medi-Cal members with SMI (e.g., age groups, rural vs. urban populations).	• Medi-Cal data • HCAI Patient-Level Administrative Data • HPD • Performance data

Goal	Evaluation Question	Hypotheses	Data Sources
	3. To what extent is the SMI Program associated with improved discharge planning and outcomes regarding housing for Medi-Cal members with SMI who are transitioning out of acute psychiatric care in hospitals and residential treatment facilities?	The SMI program will be associated with improved discharge planning and outcomes regarding housing for Medi-Cal members with SMI who are transitioning out of acute psychiatric care.	Facility administrative data
	4. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and improvements in the continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	The activities undertaken under the SMI program will be associated with improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	Qualitative data
NOTE: ^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased NOTE: ^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased			

Goal	Evaluation Question	Hypotheses	Data Sources
integration.of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.			

Evaluation Methods

Data Sources

The data sources for the evaluation of the SMI Program, including the SMI Mid-Point Assessment, will include qualitative data collected during the demonstration through key informant interviews or focus groups and a variety of member- and provider-level secondary data collected by DHCS and other state agencies, as well as publicly available area-level data collected by federal agencies.

Person-level secondary data include (i) health care administrative data, e.g., DHCS's Medi-Cal Claims and Eligibility data and HCAI's Health Care Payments Data (HPD, CA's All Payer Claims Database), both of which provide information on Medi-Cal member demographics, mechanism for Medicaid eligibility, diagnosed BH and physical health conditions, and service utilization including filled prescriptions drugs; HCAI Patient-Level Administrative Data which provides information related to inpatient discharges from CA-licensed hospitals, ED encounters, and ambulatory surgery encounters, including a homelessness indicator; and CA TADT, which provides information on the number of hours/days between a new patient's first contact with BHP-financed care and the offered appointment date, also capturing the source of the referral, final disposition and other information; (ii) other state administrative data, e.g., CA Homeless Data Integration System (HDIS), which provides information on individuals who have experienced homelessness, and ACHS and Juvenile Court Probation Statistical System (JCPSS), which provides information on individuals with criminal justice system involvement; (iii) performance data, e.g., data from the DHCS Mental Health CMS Core Set Measures Dashboard, which provides information on quality measures, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, which provides survey-based information on patient experience of care; (iv) other state data, e.g., CA Department of Public Health vital statistics data, which provides mortality information; (v) clinical operations data, e.g., Electronic Health Record (EHR) data from county BHPs; and (vi) other survey data, namely, the survey that will be deployed to collect information on self-reported quality of life as part of the BH-CONNECT Incentive Program.

Other secondary data include (vii) provider-level capacity/workforce data compiled into the County Profiles (described in Chapter 1) and Behavioral Health Continuum Infrastructure Program (BHCIP) data, which provide information on availability of providers or treatments; (viii) provider-level performance data, e.g., CMS's Inpatient Psychiatric Facility Quality Reporting (IPFQR); and (ix) publicly available area-level data sources, e.g., Area Health Resources File (AHRF), which provide county-level information on social determinants of health, including sociodemographic and health care infrastructure characteristics. See Tables 5.1

and 5.2 for potential data sources for the evaluation of the SMI Program and Appendix A for details on all available data sources.

Study Population

The study population will include Medi-Cal members meeting MHP/BHP criteria for SMI/SED who are exposed to the SMI Program—that is, those living in participating counties (counties that expressed interest in participating, received DHCS approval, and implemented the SMI Program, hereafter also referred to as implementer, opt-in, or “intervention” counties), and unexposed Medi-Cal members living in non-participating or “control” counties.

As of July 2025, in a non-binding survey DHCS released in early 2025, 15 counties expressed interest in implementing the SMI Program. While it is expected that the number of participating counties will grow over the course of the demonstration, it is also possible although unlikely, that some participating counties may opt out before the end of the demonstration (historically counties have rarely opted out of programs that were already launched). As a result, in any given year of the demonstration, there may be different sets of intervention and control counties. Counties that opt out of the SMI Program will not be allowed to serve as control counties; therefore, control counties will only include those that never participate in the SMI Program or are yet to opt in.

Time Frame for the Evaluation

The evaluation period will include a pre-implementation period, hereafter pre-period or baseline, of a minimum duration of two years, and a post-implementation period, hereafter post-period. The post-period will span the time between the date of implementation of the SMI Program (start date) and the date of opt-out or end of the five-year demonstration (end date), whichever comes first. The opt-in and opt-out flexibility afforded to counties, described above, may lead to variable start and end dates for participating counties and variable durations of post-implementation periods.

CMS Outcomes and Outcome Measures

A range of outcomes will be assessed as part of the evaluation. Medi-Cal member-level outcomes include hospital/residential, ED, and outpatient utilization; access to care; quality of BH and physical health care assessed with Core Set and other measures (see Appendix B for an inventory of routinely collected quality and service utilization measures); patient experience with care; and member outcomes, including health outcomes (suicidal behavior, death), social outcomes (homelessness, criminal justice system involvement), and well-being (self-reported quality of life). System-level outcomes include availability of specialized mental health services, i.e., treatment capacity; Medi-Cal costs; and value of Medi-Cal-financed care. We define value as decreasing overall costs over the course of the demonstration, with costs associated with mental health inpatient/residential services also decreasing, and costs associated with mental

health community-based services increasing (we will assess both per-member-per-month (PMPM) and total costs). Other system outcomes include the extent of changes to critical systems, processes, or policies, and barriers to and facilitators of the effectiveness of actions undertaken under the SMI program's four (4) milestones.

Outcomes will be assessed with measures selected based on their relevance to the specific evaluation question and hypothesis being tested, as well as their validity and feasibility. Outcome measures will include but will not be limited to the monitoring metrics required by the Section 1115 SMI/SED Demonstration (CMS, 2019), hereafter CMS monitoring metrics, as well as any recommended metrics that may be feasibly constructed (see Table 5.2 for details on outcome measures, including the monitoring metrics required for the Mid-Point Assessment).

Other Key Variables

We will address the potential confounding effects of relevant member characteristics and contextual factors with variables that will be assessed at baseline. Member characteristics include sex, age, race and ethnicity, English language proficiency, primary language, dual Medicaid-Medicare eligibility, Medicaid eligibility based on disability, geographic location (e.g., ZIP code, rurality), criminal justice status, homelessness, physical health comorbidity, SUD comorbidity, SMI diagnosis (e.g., schizophrenia, bipolar I disorder, severe major depressive disorder), and service utilization (including use of EBPs). Contextual factors include area-level social determinants of health such as household income and quality of housing stock; county-level factors such as strength of the community-based BH system, quality of coordination between BHPs and Medi-Cal managed care plans MCP, quality of the HIT infrastructure, and uptake of other BH-CONNECT programs; ownership and other characteristics of IMDs and other acute care (hospital/residential) facilities; and concurrent multicounty, state, or federal initiatives with the potential to impact outcomes, e.g., CalAIM programs (see Appendix C for a list of multicounty and state-level initiatives). Several of these variables, including those describing contextual factors, may modify program effects and lead to outcome disparities. In keeping with the STCs, we will pay particular attention to outcome moderation by key member characteristics including sex, age, race and ethnicity, English language proficiency, primary language, disability status, geographic location, homelessness, criminal justice status, and prior receipt of community-based services (see Figure 5.1, SMI Program Logic Model and Table 5.2).

Analytic Approaches

We will address each of the evaluation questions using quantitative and qualitative methods as necessary and feasible. See Table 5.2 for planned analytic approaches.

Quantitative Methods

Methods that may be used to characterize populations and trends and, whenever possible, validly quantify the impacts of the SMI Program include:

- Descriptive statistical analyses
- Quasi-experimental methods.

Descriptive Statistics

This method will be used to describe the Medi-Cal member population, overall and stratified by key member characteristics, year-to-year, and examine trends over time as well as regional patterns. For categorical variables, a chi-square test or a McNemar's test will be used as appropriate; for continuous variables, the Analysis of Variance test or paired t-test will be used as appropriate. For selected outcomes, we will complement the presentation of results with graphical illustrations.

Quasi-Experimental Methods

As described in detail in Chapter 1 (*Quantitative Methods*), BH-CONNECT program outcomes will be examined using quasi-experimental methods that support valid causal inferences, including DD, the most robust of these methods, CITS, and ITS.

As described in Chapter 1, whenever quasi-experimental methods are preferred, we will aim to implement a DD approach to examine how the difference in the outcomes pre- and post-SMI Program implementation vary by exposure to the SMI Program. We will adjust for confounder imbalance between exposed and unexposed Medi-Cal members living in participating and non-participating counties by implementing multivariable DD regression models. Additionally, following stratified descriptive analyses to examine potential outcome differences across Medi-Cal member subpopulations defined by key member characteristics (see Other Key Variables), we will implement a DDD approach to assess for effect moderation and identify outcome disparities as described in Chapter 1.

We believe it will be possible to implement a DD approach because, as of July 2025, it appears that there will be an adequate number of participating and non-participating counties providing adequate samples of contemporaneous exposed and unexposed Medi-Cal members with SMI throughout the demonstration (see Study Population).

The flexibility afforded to counties regarding the timing for opting in and the rare eventuality that counties may opt out (see Study Population and Time Frame for the Evaluation) sets up several scenarios for analysis, with the first two (2) thought to be most likely:

- Counties that implemented the SMI Program at the start of the BH-CONNECT demonstration and remained in the SMI Program throughout the demonstration
- Counties that implemented the SMI Program at a later date and remained in the SMI Program throughout the demonstration
- Counties that implemented the SMI Program at the start of the demonstration and opted out before the end of the demonstration
- Counties that implemented the SMI Program at a later date and opted out before the end of the demonstration.

The differential timing of county participation in the SMI Program will be addressed with methods that can handle the expected staggered adoption of the program as described in Chapter 1.

We will address the possibility that concurrent policies and other initiatives may affect estimates of program impacts by examining the timing of other initiatives relative to the implementation of the BH-CONNECT programs and including controls for concurrent initiatives in the causal models.

Qualitative Methods

The focus of the qualitative component of the evaluation will be to identify SMI Program activities or their components or characteristics thought to be most effective in achieving the goals of the SMI Program (facilitators), factors thought to hinder their effectiveness (barriers), and program-driven changes to data sharing systems, processes, or policies. Semi-structured interviews will be conducted with individuals who have ‘on the ground’ experience with the implementation of the SMI Program, including state and county officials, MCP officials, IMD/other provider administrators, direct care providers (ED, hospital/residential, and outpatient provider staff), and affected Medi-Cal members or their families/caregivers.

Table 5.2. SMI Program: Evaluation Questions, Data Sources, Outcome Measures, and Analytic Approach, by Goal

Goal 1: Reduced utilization and lengths of stay in EDs) while Medi-Cal members await mental health treatment in specialized settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI)			
Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with reductions in ED utilization among Medi-Cal members with SMI? Are member characteristics* and prior receipt of community-based services associated with ED reduced utilization?	Medi-Cal Data	<i>All-cause ED utilization rate for Medi-Cal members with SMI who may benefit from integrated physical and BH care (MM3@):</i> - Count (N) of all-cause ED visits per 1,000 member-months for Medi-Cal members with SMI aged ≥18,^{&} all and by prior receipt of community-based services, by annual period - Percentage of Medi-Cal members with SMI who use ED services for mental health (MM16@) or any condition, by annual period - Mean all-cause ED utilization and costs (PMPM and total), Medi-Cal members with SMI, by annual period	- Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models) - Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
2. Is the SMI Program associated with reductions in ED lengths of stay among Medi-Cal members with SMI awaiting mental health treatment in specialized settings?	- Medi-Cal data - HCAI - Other (EHR data, ED/ inpatient facility administrative data)	<i>Time from ED arrival to ED departure for patients discharged from ED (NQF-0496-adapted):</i> Median time (minutes) from ED arrival to ED departure for Medi-Cal members with SMI who are admitted or transferred from an ED	- Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models)

Goal 1: Reduced utilization and lengths of stay in EDs) while Medi-Cal members await mental health treatment in specialized settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI)			
Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		to inpatient psychiatric treatment, by annual period	
3. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and the achievement of this Goal?	• Medi-Cal data • Other (ED/inpatient facility administrative data)	• Percentage of Medi-Cal members with SMI with housing instability <u>and</u> prior ED use for mental health/any condition who use enhanced Community Supports, by annual period • Percentage of psychiatric inpatient/residential facilities utilizing the Bed Tracking Tool, by annual period • Number of acute psychiatric admissions following ED visits per 1,000 member-months (with SMI) for which a Patient Assessment Tool was used to determine appropriate level of care and length of stay, by annual period	• Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer counties only
	• Qualitative data (interviews or focus groups with ED/county demonstration staff; interviews	• Barriers/facilitators of the effectiveness of SMI Program activities • Barriers/facilitators of the effectiveness of efforts to track psychiatric beds in real time	• Qualitative methods

Goal 1: Reduced utilization and lengths of stay in EDs) while Medi-Cal members await mental health treatment in specialized settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI)			
Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	or focus groups with Medi-Cal members or significant others)	Changes made to systems, processes, or policies related to real-time psychiatric bed-tracking	
NOTE: @ Monitoring Metric used for Mid-Point Assessment & For selected Evaluation Questions using CMS monitoring metrics focused on specific age groups, metrics may be adapted for use with additional age groups. * Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others. ^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.			

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, beneficiaries with SMI)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with reductions in preventable readmissions of Medi-Cal members with SMI to acute care hospitals and residential settings (IMDs and non-IMDs)? Do observed reductions vary by member characteristics* and prior receipt of community-based services?	• Medi-Cal Data • HCAI Patient-Level Administrative Data • HPD	• Thirty-day all-cause unplanned readmissions following psychiatric hospitalization (NQF-2860-adapted) (MM4@): Percentage of acute psychiatric hospitalizations for Medi-Cal members with SMI with an unplanned acute readmission for any diagnosis within 30 days after discharge, all and by receipt of community-based services in the 7 and 30 days prior to readmission, by annual period • <i>Plan All-Cause Readmission</i>: Percentage of acute care inpatient/residential and observation stays followed by an unplanned acute readmission for any diagnosis within 30 days after discharge, Medi-Cal members with SMI aged ≥18 years, by annual period	• Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> – Unadjusted Analyses – Adjusted analyses (DD models) – Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
2. Is the SMI Program associated with increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?	• Other (EHR data, IPFQR)	• <i>SUD Screening & Brief Intervention Provided or Offered</i> (NQF-1663-adapted): Percentage of Medi-Cal members with SMI admitted to psychiatric inpatient/ residential facilities who are screened for SUDs and, if indicated, offered an intervention during the hospital stay (MM1@), by county and annual period	• Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), implementer and non-implementer counties

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, beneficiaries with SMI)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	Other (EHR data)	Percentage of Medi-Cal members with SMI admitted to psychiatric inpatient/residential facilities who are screened for comorbid physical health conditions and, if indicated, offered an intervention during the hospital stay, by annual period	- Descriptive quantitative analysis for two periods during the <u>post-period</u>: - Between start date and mid-point - Between start and end dates
	Medi-Cal & EHR data	<i>Diabetes Care for Patients with SMI: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)</i>: Percentage of Medi-Cal members with SMI admitted to psychiatric inpatient/residential facilities whose most recent HbA1c level was $\geq 9.0\%$ or had a missing result or test (MM23@), by annual period	- Descriptive quantitative analysis for two periods during the <u>post-period</u>: - Between start date and mid-point - Between the start and end dates
	Medi-Cal data	Percentage of Medi-Cal members who receive outpatient treatment for SUDs and physical health conditions within 30 days of discharge from a psychiatric inpatient/residential facility, by annual period	- Analyses over <u>pre-period</u> (≥ 2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models)
3. What is the association between the activities undertaken under the SMI Program's four (4) milestones [^] and the achievement of this Goal?	- Medi-Cal data - HCAI Patient-Level Administrative Data - HPD	Percentage of Medi-Cal members with SMI with 30-day, all-cause unplanned readmissions following psychiatric hospitalization who received community-based services in the 7 and 30 days prior to readmission, by annual period	- Analyses over <u>pre-period</u> (≥ 2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models)

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, beneficiaries with SMI)

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		• Mean length of stay per psychiatric hospitalization (MM19a@, MM19b) and annualized (MM13@), Medi-Cal members with SMI, by annual period	
	• Qualitative data (interviews or focus groups with inpatient/residential staff and community-based service providers; interviews or focus groups with Medi-Cal members or significant others)	• Barriers/facilitators of the effectiveness of SMI Program activities	• Qualitative methods

NOTE:

@ Monitoring Metric used for Mid-Point Assessment.

* Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others.

^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.

Goal 3: Improved availability of crisis stabilization services throughout the state. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).			
Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with improved availability of Crisis Outreach and Response services?	County Profiles	- Count (N) of providers, by county and annual period: - Crisis Call Centers - Mobile Crisis Units - Crisis Observation /Assessment Centers - Coordinated Community Crisis Response Teams	Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties
		- Ratio of Medi-Cal members with SMI to count (N) of providers, by county and annual period: - Crisis Call Centers - Mobile Crisis Units - Crisis Observation/Assessment Centers - Coordinated Community Crisis Response Teams	State map depicting the outcome measures each year of the SMI Program (between the start and end dates)
	- County Profiles - Other (BHCIP, N-MHSS/N-SUMHSS)	Count (N) of mental health facilities that accept Medi-Cal and offer a crisis intervention team that handles acute mental health issues, by county and annual period	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), comparing implementer vs. non- implementer counties
2. Is the SMI Program associated with improved availability of Intensive Outpatient and Partial Hospitalization?	County Profiles	Count (N) of Medi-Cal-enrolled Intensive Outpatient and Partial Hospitalization providers, by county and annual period	Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties

Goal 3: Improved availability of crisis stabilization services throughout the state. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).			
Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	County Profiles	Ratio of Medi-Cal members with SMI to Medi-Cal-enrolled intensive outpatient/partial hospitalization providers, by county and annual period	State map depicting the outcome measure each year of the SMI Program (between the start and end dates)
	- County Profiles - Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)	- Count (N) of mental health facilities that accept Medi-Cal and offer partial hospitalization/day treatment, by county and annual period - Count (N) of hospitals with psychiatric partial hospitalization programs, by county and annual period	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), comparing implementer vs. non- implementer counties
3. Is the SMI Program associated with improved availability of acute short-term crisis stabilization services	- County Profiles - Other (Bed Tracking Tool)	- Count (N) of psychiatric hospitals, by county and annual period - Total count (N) of residential mental health treatment facilities and beds (adults), by county and annual period - Count (N) of Medi-Cal-enrolled psychiatric residential treatment facilities and beds (child), by county and annual period - Count (N) of Medi-Cal-enrolled general hospital psychiatric units (acute care/critical access hospitals), by county and annual period - Count (N) of licensed psychiatric	Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties

Goal 3: Improved availability of crisis stabilization services throughout the state. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		hospitals and psychiatric unit beds, by county and annual period Count (N) of crisis stabilization units (e.g., residential crisis stabilization programs, small inpatient units in community mental health centers, peer-run crisis respite programs), by county and annual period	
	- County Profiles - Other (Bed Tracking Tool)	- Ratio of Medi-Cal members with SMI to count (N) of providers, by county and annual period: - Psychiatric hospitals - Medi-Cal-enrolled psychiatric units in acute care and critical access hospitals - Licensed psychiatric hospital and psychiatric unit beds - Crisis stabilization units - Ratio of Medi-Cal members with SMI to count (N) of Medi-Cal-enrolled providers, by county and annual period: - Residential mental health treatment facilities and beds (adult) - Psychiatric residential mental health treatment facilities and beds (child)	State map depicting the outcome measures each year of the SMI Program (between the start and end dates)
	County Profiles	Count (N) of mental health	Descriptive quantitative

Goal 3: Improved availability of crisis stabilization services throughout the state. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)	facilities offering 24-hour inpatient/residential treatment, by county and annual period: - Total - Public psychiatric hospital - Private psychiatric hospital - Residential treatment facility - General hospital psychiatric unit - Community-based inpatient setting	analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), comparing implementer vs. non- implementer counties
	- County Profiles - Bed Tracking Tool - Other (AHRF)	- Count (N) of inpatient beds, by county and annual period: - Total - Public psychiatric hospital - Private psychiatric hospital - Residential treatment facility (adult) - Psychiatric residential treatment facility (child) - General hospital psychiatric unit - Crisis stabilization units or other community-based inpatient setting	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), implementer and non-implementer counties
	- County Profiles - Other (BHCIP, N-MHSS/N-SUMHSS, AHRF)	- Count (N) of mental health facilities offering 24-hour inpatient/residential treatment, by county and annual period: - By age groups accepted for treatment (children, adolescents, young adults, adults, seniors)	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), comparing implementer vs. non- implementer counties

Goal 3: Improved availability of crisis stabilization services throughout the state. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).			
Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		– By whether mental health services are available in languages other than English	

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with improved access of Medi-Cal members with SMI to community-based services to address their chronic mental health care needs? Do observed improvements vary by member characteristics*?	• Medi-Cal data	• Percentage of Medi-Cal members with SMI who use mental health-related (1) outpatient, rehabilitation, and targeted case management services, (2) home and community-based services, and (3) long-term services and supports (MM15@), by annual period • Percentage of Medi-Cal members with SMI with ≥ 1 mental health-related outpatient visits per quarter, by annual period • Percentage of Medi-Cal members with SMI who use mental telehealth services (MM17@), by annual period • Amount of mental health-related (1) outpatient, rehabilitation, and targeted case management services, (2) home and community-based services, and (3) long-term services and supports used by Medi-Cal members with SMI, by annual period • Ratio of non-inpatient/non-residential costs (PMPM and total) associated with mental health services for Medi-Cal members with SMI (MM32, MM34) to	• Analyses over <u>pre-period</u> (≥ 2 years) and <u>post-period</u> – Unadjusted Analyses – Adjusted analyses (DD models) – Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		inpatient/residential costs for the same (MM33, MM35, MM39, MM40), by annual period Ratio of non-inpatient/non-residential costs (PMPM and total) associated with mental health services for Medi-Cal members with SMI (MM32, MM34) to overall costs for the same, by annual period	

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	TADT	Percentage of Medi-Cal members with SMI whose SMHS appointment met DHCS timely access standards, by county and annual period	Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties
2. Is the SMI Program associated with improved availability of community-based services needed to comprehensively address the chronic mental health needs of Medi-Cal members with SMI?	County Profiles	- Number of Medi-Cal-enrolled providers, by county and annual period: - Community mental health centers - Psychiatrists and other mental health practitioners authorized to prescribe - Mental health practitioners (other than psychiatrists) who are certified and licensed by the state to independently treat mental illness	Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties
	County Profiles	Number of mental health facilities that offer outpatient mental health treatment and accept Medicaid, by county and annual period	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), implementer and non-implementer counties
	County Profiles	Number of community mental health centers, outpatient mental health facilities, and multi-setting mental health facilities that accept Medicaid and offer specific types of	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), implementer and non-

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		mental health treatment approaches, services, and practices, by county and annual period	implementer counties
	County Profiles	Ratio of Medi-Cal members with SMI to count (N) of Medi-Cal-enrolled outpatient mental health professionals, by type (psychologists, social workers, psychiatrists & other prescribers, counselors, others), by county and annual period	Descriptive quantitative analysis during the <u>post-period</u>, comparing the start year with each post-period year, implementer and non-implementer counties
	- County Profiles - Other (BHCIP)	Number and capacity of CCBHCs, by annual period	- Descriptive quantitative analysis for two periods during the <u>post-period</u>: - Between start date and mid-point - Between the start and end dates

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
3. To what extent is the SMI Program associated with improved access of SMI Medi-Cal members to specific types of community-based services? Is quality and experience of care improved under the SMI Program? Do observed quality or experience of care improvements vary by member characteristics*?	• Medi-Cal data • Other (URS)	• Percentage of Medi-Cal members with SMI with ≥ 1 visit to specific services listed by CMS by county and annual period:	• Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), implementer and non-implementer counties
	• Medi-Cal data • Performance data (Child and Adult Core Set)	• <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>: Percentage of children and adolescents aged 1-17 with SMI who had a new prescription for antipsychotic medication and had documentation of psychosocial care as first-line treatment (MM2@), by annual period • <i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents</i>: Percentage of children and adolescents who were on ≥ 2 concurrent antipsychotic medications for an extended period during the year, by annual period • <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i>: Percentage of children and adolescents aged 1-17 with SMI who ≥ 2 antipsychotic prescriptions and had metabolic monitoring	• Analyses over <u>pre-period</u> (≥ 2 years) and <u>post-period</u> – Unadjusted Analyses – Adjusted analyses (DD models) – Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		(MM29@), by annual period • <i>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</i>: Percentage of Medi-Cal members with SMI aged ≥18 years with schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for ≥80% of their treatment period, by annual period • <i>Follow-up Care for Beneficiaries who are Newly Prescribed an Antipsychotic Medication</i> (NQF-3313): Percentage of new antipsychotic prescriptions for Medi-Cal members with SMI aged ≥18 years who have completed a follow-up visit with a provider with prescribing authority within four (4) weeks of prescription of an antipsychotic (MM30@), by annual period • <i>Antidepressant Medication Management</i>: Percentage of Medi-Cal members with SMI aged ≥18 years with a diagnosis of major depression who were newly treated with antidepressant medication and	

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		remained on their antidepressant medications	
	Performance data (CAHPS)	Percentage of Medi-Cal members with SMI aged ≥18 years who self-report overall satisfaction with mental health care, by annual period	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), implementer and non-implementer counties
4. To what extent does improved access to community-based services under the SMI Program vary by geographic area or member characteristics?	County Profiles	- Ratio of Medi-Cal members with SMI to Medi-Cal-enrolled providers, by county and annual period: - Community mental health centers - Psychiatrists and other mental health practitioners authorized to prescribe - Mental health practitioners (other than psychiatrists) who are certified and licensed by the state to independently treat mental illness - Ratio of Medi-Cal members with SMI to count (N) of Medi-Cal-enrolled outpatient mental health professionals, by type (psychologists, social workers, psychiatrists & other prescribers, counselors, others), by county and	State map depicting the outcome measures each year of the SMI Program (between the start and end dates)

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		annual period	
	- County Profiles - Other (N-MHSS/N-SUMHSS)	Count (N) of mental health facilities that provide outpatient mental health treatment, accept Medicaid, and (1) serve children, adolescents, or geriatric populations or (2) provide mental health services in languages other than English	Descriptive quantitative analysis of trends over time during the evaluation period (<u>pre-period</u> and <u>post-period</u>), implementer and non-implementer counties
5. To what extent is the SMI Program associated with improved integration of primary and behavioral health care to address the chronic mental health care needs of Medi-Cal members with SMI? Do observed improvements	County Profiles	- Count (N) of FQHCs that offer BH services, by annual period - Ratio of Medi-Cal members with SMI to FQHCs that offer BH services, by county and annual period	- Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties - State map depicting the outcome measure each year of the SMI Program

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
vary by member characteristics*?			(between the start and end dates)
	• Medi-Cal data[#] • HPD/CA Medicare FFS data[#]	• Count (N) and percentage of Medicare FFS or Medicaid providers providing BH integration services	• Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> – Unadjusted Analyses – Adjusted analyses (DD models)
	• TADT	• Percentage of Medi-Cal members with SMI whose first contact with SMHSs resulted from a primary care referral, by county and annual period	• Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties
	• Medi-Cal & EHR data (Child and Adult Core Set, hybrid measure)	• <i>Depression Screening and Follow-up</i>: Percentage of Medi-Cal members with SMI screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the positive screen, by age group (6-17 years, ≥18) (MM24, MM25), by annual period	• Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> – Unadjusted Analyses – Adjusted analyses (DD models) – Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	Performance data (Adult Core Set)	<i>Adults' Access to Preventive/Ambulatory Health Services:</i> Percentage of Medi-Cal members with SMI aged ≥20 years who had an ambulatory or preventive care visit (MM26®), by annual period <i>Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia:</i> Percentage of Medi-Cal members with SMI aged 18–64 years with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year, by annual period <i>Diabetes Monitoring for People with Diabetes and Schizophrenia:</i> Percentage of Medi-Cal members with SMI aged 18–64 years with schizophrenia or schizoaffective disorder and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year, by annual period.	- Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models) - Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Goal 4: Improved access to community-based services to address Medi-Cal members' chronic mental health care needs, including through increased integration of primary and BH care. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
6. To what extent is the SMI Program associated with improved patient outcomes? Do observed improvements vary by member characteristics*?	- Medi-Cal data - Other (state data)	Percentage of Medi-Cal members with SMI aged ≥18 years who experience poor outcomes: (a) require mental health care for suicidal behavior, (b) are newly diagnosed with Type 2 Diabetes or Cardiovascular Disease (c) die, (d) become homeless, or (e) become involved with the criminal justice system, by annual period	- Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models) - Adjusted analyses to assess effect modification by selected member characteristics (DDD models)
	Other (quality of life survey)	Percentage of Medi-Cal members with SMI aged ≥18 years who self-reported good quality of life, by annual period	Descriptive quantitative analysis of trends over time during the <u>post-period</u>, implementer and non-implementer counties

NOTE:

@ Monitoring Metric used for Mid-Point Assessment,

* Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others.

Procedure codes for BH integration services

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
1. Is the SMI Program associated with improved care coordination for Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	• Medi-Cal data • Performance data (Child and Adult Core Set)	• <i>Alcohol Screening and Follow-up for People with SMI</i> (NQF-2152-adapted): Percentage of Medi-Cal members with SMI aged ≥18 years who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user (MM28), by annual period • <i>Follow-Up After Emergency Department Visit for Substance Use</i>: Percentage of Medi-Cal members with SMI aged ≥18 years with follow-up after ED visit for alcohol and other drug abuse (MM9@), by annual period • <i>Follow-Up After Emergency Department Visit for Mental Illness</i>: Percentage of Medi-Cal members with SMI aged ≥18 years with follow-up after ED visit for mental illness (MM10@), by annual period	• Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> – Unadjusted Analyses – Adjusted analyses (DD models) – Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
	EHR data	<i>Medication Reconciliation on Admission</i> (NQF-3317) (MM5): Percentage of Medi-Cal members with SMI for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization, by annual period	- Descriptive quantitative analysis for two periods during the <u>post-period</u>: - Between start date and mid-point - Between start and end dates
	- EHR data - Other (IPFQR)	<i>Timely Transmission of Transition Record</i> (NQF-0648): - Percentage of discharges of Medi-Cal members with SMI (any age) from an inpatient facility to home or other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary physician or other health care professional designated for follow-up care, by annual period <i>Transition Record with Specified Elements Received</i>	- Analyses over <u>pre-period</u> (≥2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models)

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		<i>by Discharged Patients</i> (NQF-0649): Percentage of Medi-Cal members with SMI (any age) discharged from an inpatient facility to home or other site of care, or their caregivers, who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all the specified elements, by annual period	
	Qualitative data (interviews or focus groups with county demonstration staff, and/or inpatient/residential and outpatient provider staff)	- Barriers/facilitators regarding data sharing systems, processes, or policies that staff identify as most effective for improving care coordination - Changes made to data sharing systems, processes, or policies to improve care coordination	Qualitative methods
2. Is the SMI Program associated with improved continuity of care in the community following episodes of acute care in hospitals and	- Medi-Cal data - HCAI Patient-Level Administrative Data	<i>Medication continuation following inpatient psychiatric discharge</i> (NQF-3205) (MM6): Percentage of biennial discharges from inpatient	- Analyses over <u>pre-period</u> (≥ 2 years) and <u>post-period</u> - Unadjusted Analyses - Adjusted analyses (DD models)

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
residential treatment facilities among Medi-Cal members with SMI? Do observed improvements vary by member characteristics*?	- HPD - Performance data (Child and Adult Core Set)	psychiatric facilities for Medi-Cal members with SMI (or schizophrenia, bipolar disorder, or major depressive disorder) for which a prescription for evidence-based medication was filled within 2 days prior to and 30 days post-discharge, by period <i>Follow-Up After Hospitalization for Mental Illness (children):</i> Percentage of Medi-Cal members with SMI aged 6-17 years with follow-up after hospitalization for mental illness (MM7@), by annual period <i>Follow-Up After Hospitalization for Mental Illness (adults):</i> Percentage of Medi-Cal members with SMI aged ≥18 years with follow-up after hospitalization for mental illness (MM8@), by annual period - Amount of mental health–related (1) outpatient, rehabilitation, and targeted case management services,	Adjusted analyses to assess effect modification by selected member characteristics (DDD models)

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		(2) home and community-based services, and (3) long-term services and supports used by Medi-Cal members with SMI within 30 days after discharge from a psychiatric inpatient/residential facility, by annual period	
3. To what extent is the SMI Program associated with improved discharge planning and outcomes regarding housing for Medi-Cal members with SMI who are transitioning out of acute psychiatric care in hospitals and residential treatment facilities?	Facility administrative data	- Among Medi-Cal members with SMI transitioning out of acute psychiatric care in inpatient/ residential facilities, percentage who are screened for housing needs, by annual period - Among Medi-Cal members with SMI receiving acute psychiatric care in inpatient/residential facilities who lack housing, percentage who meet with housing services agencies/providers before discharge, by annual period - Percentage of Medi-Cal members with SMI who are released from acute psychiatric care in inpatient/residential facilities to a homeless shelter	- Descriptive quantitative analysis for two periods during the <u>post-period</u>: - Between start date and mid-point - Between start and end dates

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
		or no fixed address, by annual period Among Medi-Cal members with SMI who are released from acute psychiatric care in inpatient/ residential facilities to a homeless shelter or no fixed address, percentage who before discharge had an appointment scheduled with a housing services agency/ provider for within 7 or 30 days after discharge	
4. What is the association between the activities undertaken under the SMI Program's four (4) milestones^ and improvements in the continuity of care in the community following episodes of acute care in hospitals and	Qualitative data (interviews or focus groups with county demonstration staff, and/or inpatient/ residential and outpatient	Barriers/facilitators of the effectiveness of SMI Program continuity-of-care-related activities	Qualitative methods

Goal 5: Improved coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. MM=SMI/SED Monitoring Metric (MM21/MM22: monthly/annual counts, Medi-Cal members with SMI).

Evaluation Question	Data Source	Outcome Measure	Analytic Approach
residential treatment facilities?	provider staff; interviews or focus groups with Medi-Cal members or significant others)		

NOTE:

@ Monitoring Metric used for Mid-Point Assessment

* Member characteristics of interest include age, SUD or physical health comorbidity, race and ethnicity, geographic location, and others.

^ Milestones: (1) Ensuring quality of care in IMDs; (2) Improving care coordination and transitions to community-based care; (3) Increasing access to continuum of care including crisis stabilization services; (4) Earlier identification and engagement in treatment including through increased integration.

Chapter 6. Evaluation Design for Community Transition In-Reach Services

Brief Overview of Community Transition In-Reach Services

Community Transition In-Reach Services are transitional care management services to support Medi-Cal members age 21 year or older (or emancipated minors) with significant behavioral health needs who are returning to the community after extended stays in inpatient, subacute, and residential facilities, including in facilities that meet the definition of an Institution for Mental Diseases (IMD). Members who are experiencing or at risk of experiencing lengths of stay of 120 days or more are eligible to receive In-Reach Services, for up to 180 days prior to discharge. In-Reach Services are additive to services offered in inpatient, subacute, or residential settings, and are provided by community-based multi-disciplinary teams, not the inpatient, subacute, or residential settings themselves, to improve connections to community-based services and providers.¹¹

BHPs may opt in to provide Community Transition In-Reach Services at any point during the demonstration.

The goal of this program is to improve care coordination and facilitate transitions to community-based care for Medi-Cal members with the most complex and significant behavioral health needs. The state envisions Community Transition In-Reach Services as a critical intervention in the pursuit of improved access to high-quality community-based treatments for Medi-Cal members living with significant behavioral health needs.

Specific objectives include:

1. Reducing extended stays in institutional settings
2. Supporting individuals to establish connections with community-based providers
3. Addressing barriers such as housing instability, particularly those due to disparities
4. Promoting continuity of care and reducing readmissions to acute care settings
5. Providing comprehensive pre-discharge planning and transitional care management.

Transition services aimed at addressing both clinical and social barriers to community reintegration can be initiated up to 180 days prior to discharge from qualifying facilities. Services include comprehensive assessments, individualized care planning, referrals to needed services, and monitoring to ensure care plans are implemented effectively, and identifying and addressing other system barriers, including social and financial issues, and facilitating linkages to social supports necessary to support successful reintegration of members into their communities.

¹¹ [BH-CONNECT Section 1115\(a\) Demonstration Special Terms and Conditions](#), (STC 9.1 p.40).

Transition services are delivered by community-based multidisciplinary teams, which include at a minimum:

1. a licensed mental health professional as team lead,
2. a certified peer support specialist or other SMHS practitioner with lived experience,
3. an occupational therapist, unless the BHP meets criteria for exemption,
4. at least one additional mental health specialty practitioner, and
5. access to a medical prescriber (included on the team or linked externally), such as a psychiatrist, psychiatric nurse practitioner, or physician) to manage any medications during the discharge process and community reintegration.

In addition to establishing the multidisciplinary care transition teams described above and financing services for Medi-Cal members, BHPs that participate in the Community Transition In-Reach Services program must meet the following criteria:

- BHPs must submit a plan to the DHCS detailing how they will assess the availability of mental health and/or SUD services and housing options within the county. The plan must include a process for assessing the BH continuum of care and outline action steps to address identified gaps.
- BHPs must track and regularly report data to DHCS on trends in the number and utilization of beds across inpatient, subacute, and residential facilities, including IMDs, in which the county places Medi-Cal members.
- BHPs are required to monitor the compliance of facilities delivering Community Transition In-Reach Services.

Community Transition In-Reach Services Evaluation Methods Overview

The evaluation of the Community Transition In-Reach Services program will have two components: a rapid-cycle assessment to provide timely feedback to counties, the state, and CMS on how the program is functioning, and an overall evaluation that is integrated into the evaluation of the other demonstration components. Both the rapid-cycle assessment and the overall evaluation will use a mixed-methods approach. The rapid-cycle assessment will cover implementation of the program, data on utilization of the services, and preliminary data on health-related outcomes, such as discharges from residential services and readmissions. The overall evaluation, guided by the logic model depicted in Figure 6.1, will analyze the impact of the program on the short-term program outcomes and the long-term demonstration outcomes. Table 6.1 below presents the evaluation questions (EQs), hypotheses, and data sources that will be used in the comprehensive evaluation.

Figure 6.1. Community Transitions In-Reach Services Logic Model

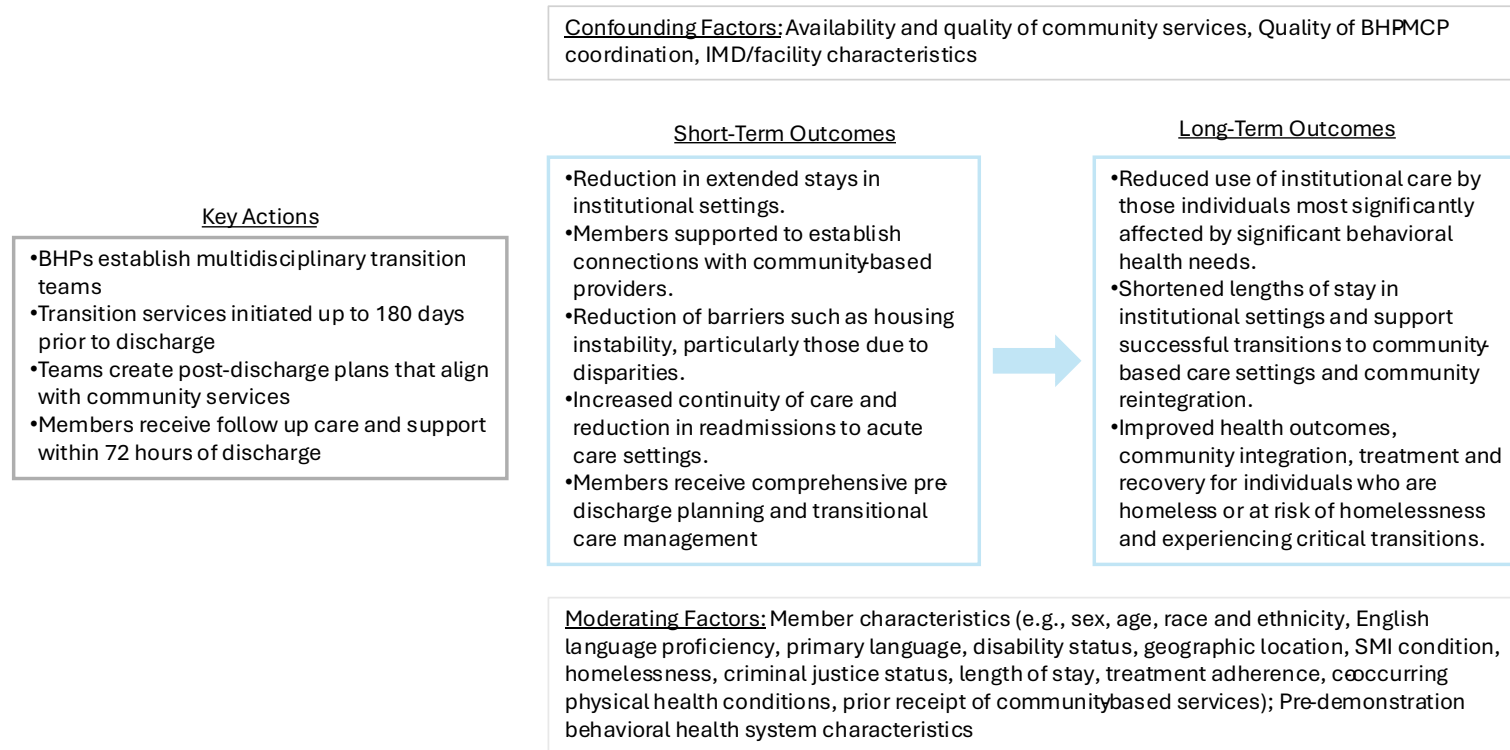


Table 6.1. Evaluation Questions, Hypotheses, and Data Sources: Community Transition In-Reach Services (CTIRS)

Goals	Evaluation Questions	Hypotheses	Potential Data Sources
1. Reduce extended stays in institutional settings	Is CTIRS associated with reduced extended stays in institutional settings?	CTIRS will be associated with reduced length of stay and extended stays in institutional settings.	- County BH EHR Data - HCAI Patient-Level Administrative Data - Medi-Cal Claims and Eligibility data
2. Support individuals to establish connections with community-based providers	Is CTIRS associated with improved connections to community-based care among discharging Medi-Cal members?	- CTIRS will be associated with increased referrals to community-based providers within 72 hours of discharge. - CTIRS will be associated with greater awareness of and plans to access community treatment and service options. - CTIRS will be associated with increased use of behavioral health and primary care services (at follow up timepoints).	- County Behavioral Health EHR data; Medi-Cal data; HCAI HPD - Referral data from CTIRS team - Medi-Cal member interviews

Goals	Evaluation Questions	Hypotheses	Potential Data Sources
3. Address barriers to health care access particularly those due to disparities (e.g. housing instability)?	Does CTIRS reduce barriers to health care access, particularly those due to disparities (e.g. housing instability)?	- Medi-Cal members will report a reduction in perceived barriers to care.¹² - CTIRS will be targeted to individuals experiencing or at risk of experiencing stays of 120 days or more in institutional settings and other characteristics that can be barriers to successful community tenure such as diagnosis of SMI, poor treatment adherence, homelessness, and/or co-occurring physical health conditions.	- County Behavioral Health EHR data; Medi-Cal data; HPD claims; - Medi-Cal member interviews
4. Promote continuity of care and reduce readmissions to acute care settings	Is CTIRS associated with increased continuity of care and reduced readmissions to acute care settings?	- CTIRS will be associated with reduced readmissions to institutional settings. - CTIRS will be associated with increased continuity of care. - CTIRS will be associated with increased implementation of strategies to enhance data sharing and interoperability among providers.¹³	- HCAI Patient-Level Administrative Data; County BH EHR Data; Medi-Cal data; HCAI HPD - Provider interviews

¹² Rapid cycle evaluation and comprehensive evaluation. All other hypotheses pertain to comprehensive evaluation only.

Goals	Evaluation Questions	Hypotheses	Potential Data Sources
5. Provide comprehensive pre-discharge planning and transitional care management	Is CTIRS associated high quality, comprehensive pre-discharge planning and transitional care management?	- Medi-Cal members will be satisfied with the quality and comprehensiveness of their pre-discharge planning and transitional care management. ¹³_{[OBJ][OBJ][OBJ]}¹²_[OBJ] - Transition teams will adhere to best practice strategies for community transitions. ¹³¹² - CTIRS will be associated with reduction in discharges homelessness, including discharges to unstable or unsuitable housing. - CTIRS will be associated with a reduction in days spent experiencing homelessness.	- HCAI inpatient discharge data; HMIS data; - Provider and Medi-Cal member interviews - Document review

Evaluation Methods

Rapid Cycle Evaluation

The rapid-cycle evaluation will focus on understanding implementation factors (such as fidelity and satisfaction), as well as preliminary information about outcomes where available. We will use guidance from implementation science frameworks, such as the Consolidated Framework for Implementation Research 2.0 (CFIR) (Damschroder, Reardon, Widerquist and Lowery, 2022), to develop qualitative interview protocols and analysis plans. CFIR provides a structured approach to understanding the multilevel factors that influence implementation, including intervention characteristics, organizational context, external influences, individuals involved in implementation, and the implementation process itself.

Overall Evaluation

The overall evaluation of CTIRS will include quantitative analyses of administrative data and an additional wave of interviews with stakeholders to serve as a follow-up to the interviews included in the rapid cycle evaluation. Qualitative and quantitative analyses will follow procedures outlined in Chapter 1. Data sources and methods are described below as they pertain to each evaluation question.

Study Population

The study population will include Medi-Cal members meeting MHP/BHP criteria for SMI/SED who are exposed to the CTIRS program—that is, those living in participating counties (counties that expressed interest in participating, received DHCS approval, and implemented the program, hereafter also referred to as “intervention” counties), and unexposed Medi-Cal members living in non-participating or “control” counties. The rapid cycle evaluation will include data from the intervention counties only, and the overall evaluation will include both the intervention and control counties.

As with the SMI program, while it is expected that the number of participating counties may increase over the course of the demonstration, it is also possible that some participating counties may opt out before the end of the demonstration; therefore there may be different sets of intervention and control counties during different years of the demonstration. The overall evaluation will include data from all participating counties, as well as corresponding data from selected comparison counties.

Time Frame for the Evaluation

The time frame for the overall evaluation will include a baseline period prior to implementation of a minimum duration of two years and a post-implementation period. The post-implementation period will span the time between the date of implementation of the CTIRS

program (start date) and the date of opt out or end of the five-year demonstration (end date), whichever comes first. As with the SMI program, the opt-in and opt-out flexibility afforded to counties will likely lead to variable start and end dates for participating counties and variable durations of post-implementation periods.

The rapid cycle evaluation will employ two waves of data collection, in Q1 of 2026 and Q1 of 2027. This will enable us to compare earlier and later stages of implementation to understand how the process and outcomes changed over time.

Qualitative Methods

To capture implementation experiences, we will conduct multiple waves of structured interviews with key program stakeholders, including Medi-Cal members, transition team staff (e.g., clinicians, peer specialists), county BH leads, and community-based service providers. These conversations with transition team members and community-based providers will explore barriers to and facilitators of implementation, fidelity to program design, workforce challenges, cross-system coordination and data sharing practices, and strategies for engaging individuals in transition. Member interviews will cover topics such as barriers and facilitators to accessing care, and satisfaction with quality and comprehensiveness of pre-discharge and transition planning.

Table 6.2. In-Reach Transition Services Rapid Cycle Assessment Qualitative Interviews

In-Reach Transition Services Rapid Cycle Assessment Qualitative Interviews		
Informant Type	Estimated number of Interviews	Topics
Transition Team Members	2–5 per county	Barriers and facilitators to implementation, adherence to best practices (fidelity), workforce challenges, data sharing practices, strengths and weaknesses of cross system coordination, strategies used to engage individuals in transition, use of best practices in transition planning (e.g. peer support)
Community Based Providers	2–5 per county	Workforce challenges, data sharing practices, strengths and weaknesses of cross system coordination, strategies used to engage individuals in transition
Participants	2–5 per county	Barriers to and facilitators of care, perceived quality and comprehensiveness of services

Quantitative Methods

RAND will use data reported by the programs to assess patterns of service utilization, such as the volume and timing of in-reach engagement, characteristics of individuals served, duration of services, and initial outcomes such as hospital readmissions, emergency department (ED) visits, and post-discharge community tenure. These data will also be used to examine variation across participating counties and identify emerging trends in program reach and intensity. Where data allow, we will construct and analyze patient pathways, mapping individual trajectories from institutional settings into community-based services. As described in Chapter 1, we will explore the relationship between outcome variables and potential moderators, including factors such as length of stay, diagnosis, treatment adherence, co-occurring physical health conditions, and/or homelessness. More details about proposed data sources and methods are included in the descriptions by evaluation question, below.

Where possible, preliminary findings from these sources will be included in the rapid cycle evaluation. The results will provide DHCS and CMS with early insights into program performance, inform continuous quality improvement, and meet federal requirements for a rapid-cycle evaluation that incorporates both qualitative and quantitative analysis of implementation progress, service utilization, and preliminary outcomes (CMS, 2024).

EQ1: Reduction in extended stays in institutional settings

To test the hypothesis that CTIRS is associated with a reduction in extended stays in institutional settings, we will analyze HCAI Patient Level Administrative Data to examine trends in length of stay in the institutional settings served by In-Reach teams and institutional care settings without In-Reach teams. Outcomes will be length of stay, measured in days, and stays of over 120 days, measured as a yes/no outcome. Preliminary analyses will examine trends in outcomes using pre-demonstration data to establish baselines and compare trends. Tests of the impact of In-Reach services will use ITS or DD models, depending on the outcomes of the preliminary analyses, as described in Chapter 1. Information from qualitative interviews on program implementation, community integration outcomes, and perception of program effectiveness from clinicians and participants will assist in interpreting the quantitative results.

EQ2: Improved connections to community-based care.

To assess the impact of CTIRS on connections to community-based care we will use a combination of quality measure and claims data to compare post-discharge service use prior to the demonstration with post-discharge service use during the demonstration in the counties that have transition teams. In addition, we will also compare trends in these outcomes between the counties with and without transition teams. The major outcomes will be follow-up after hospitalization at 30 and 90 days and frequency of outpatient behavioral health care visits following discharge. Additional measures of service utilization will include:

- Structured clinical interventions within step-down care
- Appointments with primary care or other medical follow-up
- Arranged access to prescriptions
- Family and support system engagement
- Psychoeducation
- Peer support engagement
- Vocational or education support
- Crisis response and safety planning
- Suitable, stable housing.

These analyses will be supplemented by semi-structured qualitative interviews with participants discharging from institutional settings to assess their awareness of services, plans to access community-based care, and any follow-up received. In qualitative interviews with transition team members, we will ask about barriers and facilitators to successfully establishing and maintaining connections to community-based care. Qualitative data may help guide selection of quantitative variables and inform subgroup comparisons and moderators. Data will be integrated using the methods described in Chapter 1.

EQ3: Reduction in barriers to health care access.

We will analyze HCAI inpatient discharge data, County Behavioral Health EHRs, and claims data to assess whether CTIRS mitigates barriers to care—particularly disparities related to housing instability, geography, race/ethnicity, and income. The evaluation will investigate whether the program contributes to more equitable outcomes and access to services across diverse populations, and the extent to which CTIRS has been targeted towards individuals with relatively long lengths of stay in institutional settings and other characteristics that can be barriers to successful community tenure such as diagnosis of SMI, poor treatment adherence, homelessness, and/or co-occurring physical health conditions. To the extent possible, as sample sizes allow, we will investigate the extent to which the impact of CTIRS on health outcomes varies by these factors. We will also interview Medi-Cal members to understand self-reported barriers to care and the impact of CTIRS on them; information from the interviews will be used to inform both the rapid cycle evaluation and the overall evaluation.

EQ4: Increased continuity of care and reduced readmissions to acute care settings

To test that hypotheses that CTIRS will be associated with increased continuity of care and decreased readmissions to acute care, we will analyze HCAI inpatient discharge data, County Behavioral Health EHRs, and Medi-Cal and HPD claims data. Readmissions to acute care will be defined as visits to an ED for a mental health condition or an inpatient stay for a mental health condition. We will examine use of acute services in the 90 days immediately following discharge as well as frequency of use of acute services. Continuity of care will be defined using information on outpatient services. Measures of continuity, such as number of months in which a

person has a visit in the 12 months following discharge, will be developed based on preliminary data analyses. Qualitative interviews with In-Reach team members, community-based clinicians, and participants will provide information on the perceived effectiveness of community-based support services in reducing the need for acute care.

Results from the analysis of the impact of the In-Reach services on acute care utilization will also be used in cost analyses. We will use Medi-Cal claims and encounter data to estimate the costs of the program to Medi-Cal, the costs saved by Medi-Cal through reduction in acute care utilization, and total cost offsets from the expenditure on In-Reach services.

To understand whether CTIRS has resulted in increased interoperability among providers, we will conduct interviews with acute care and community-based care providers; information from these interviews will be used to inform both the rapid cycle evaluation and the overall evaluation.

EQ5: Increased comprehensive pre-discharge planning and transitional care management

This question pertains to both the rapid cycle evaluation and the overall evaluation. To determine whether Medi-Cal members receive high quality, comprehensive pre-discharge planning and transitional care management, we will use qualitative interviews with participants and providers. Perceived quality will include perceptions of effectiveness, timeliness, clarity, coordination, respectfulness, and client-centeredness of the pre-discharge and transition process. Perceived comprehensiveness will assess the extent to which all relevant needs were considered in the plan. These methods will explore both the fidelity of transition teams to best practices and Medi-Cal member satisfaction with the process, providing information about the consistency and perceived quality of CTIRS-supported transition processes. We will also investigate the extent to which CTIRS is associated with a reduction in discharges to homelessness, using available HCAI discharge data, and whether it is associated with a reduction in days spent experiencing homelessness following discharge, using data from HDIS and/or HMIS.

RAND will develop a fidelity assessment semi-structured interview protocol to assess fidelity to best practices for transition planning as established in the literature, including early discharge planning (NASMHPD, 2016), comprehensive and strengths-based planning (SAMHSA, 2014), rapid and consistent follow-up (NCQA, n.d.), warm hand-offs (NCBH, 2016; NRI 2012), secure housing (USICH, 2019), and medication planning prior to discharge (Bazelon Center for Mental Health Law, 2020), among others. We will interview members of the transition team to complete the fidelity assessment protocol.

Chapter 7. Evaluation Design for Transitional Rent Program

Brief overview of the Transitional Rent program

The Transitional Rent program, also described as the short-term rental assistance program, is designed to address the impact of housing, as a health related social need, on health by providing up to six months of rental assistance or temporary housing for Medi-Cal members who are experiencing or at risk of homelessness at key points of transition and meet specific clinical and social eligibility criteria. By creating a bridge from homelessness or institutional care to stable, permanent housing, the program aims to improve access to health care, reduce costly use of acute health care services and improve members health and well-being. The Transitional Rent program is one of six programs of the BH-CONNECT waiver, but DHCS implemented it as a Community Supports Service as part of the broader CalAIM initiative.

The Transitional Rent program's delivery model relies on Medi-Cal Managed Care Plans (MCPs), which are required to contract with a network of transitional rent providers. These providers may include county behavioral health agencies, affordable or supportive housing providers, Continuum of Care (CoC) entities, social service agencies, public housing authorities, or other organizations serving people experiencing homelessness. Transitional rent providers are responsible for issuing payments to landlords or property owners or, in some cases, directly providing housing. MCPs must ensure that members have an individualized housing support plan before authorizing transitional rent. The individualized housing support plan outlines the members' permanent housing strategy, identifies necessary supports to sustain tenancy, and must be culturally appropriate, trauma-informed, and responsive to the member's preferences and needs.

Eligibility for transitional rent is based on meeting all of the following three sets of criteria:

1. Inclusion in one of the following 7 'transitioning populations':
 - a. transitioning out of institutional or congregate residential settings
 - b. transitioning out of carceral settings
 - c. transitioning out of interim housing
 - d. transitioning out of recuperative care
 - e. transitioning out of foster care
 - f. unsheltered homeless
 - g. eligible for Full Service Partnership (FSP).

AND

2. One or more qualifying clinical risk factor related to behavioral health (qualifying for Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or the Drug Medi-Cal Organized Delivery System (DMC-ODS); or physical health (having one or more serious chronic physical health conditions; having a physical, intellectual, or developmental disability; or being pregnant or up to twelve months postpartum)

AND

3. Homelessness or risk of homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) with certain modifications.¹³

Beginning in January 2026, coverage of Transitional Rent is required for Medi-Cal members who meet the Behavioral Health Population of Focus criteria. Coverage will be required for members with physical health risk factors no earlier than January 2027. A member is eligible for up to six months of Transitional Rent total under the BH-CONNECT waiver, though they may receive room and board services from multiple community supports programs, provided they do not exceed six months of coverage for these services in a single year.

Transitional rent covers both permanent and interim housing settings. Permanent settings include apartments, single-family homes, multi-family homes, shared housing, accessory dwelling units, housing in mobile home communities, project-based or scattered site permanent supportive housing, and supportive housing, while interim settings may include hotels, motels, tiny homes, or transitional recovery housing. MCPs must not exclude any allowable setting type and are expected to prioritize placements that lead to long-term housing stability. The Department of Health Care Services (DHCS) will reimburse MCPs for the actual cost of rent or temporary housing paid to landlords or property owners, up to a specified reimbursable ceiling based on a percentage of the U.S. Department of Housing and Urban Development's Small Area Fair Market Rents (SAFMR), which vary by ZIP code and unit size.

In addition to rent or housing costs, DHCS will pay MCPs an administrative fee to cover the reasonable costs associated with delivering the Transitional Rent service. This fee supports

¹³ Members must meet the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (CFR), with the following three modifications:

- » If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that 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; and
- » For the at risk of homelessness definition at 24 CFR section 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply.

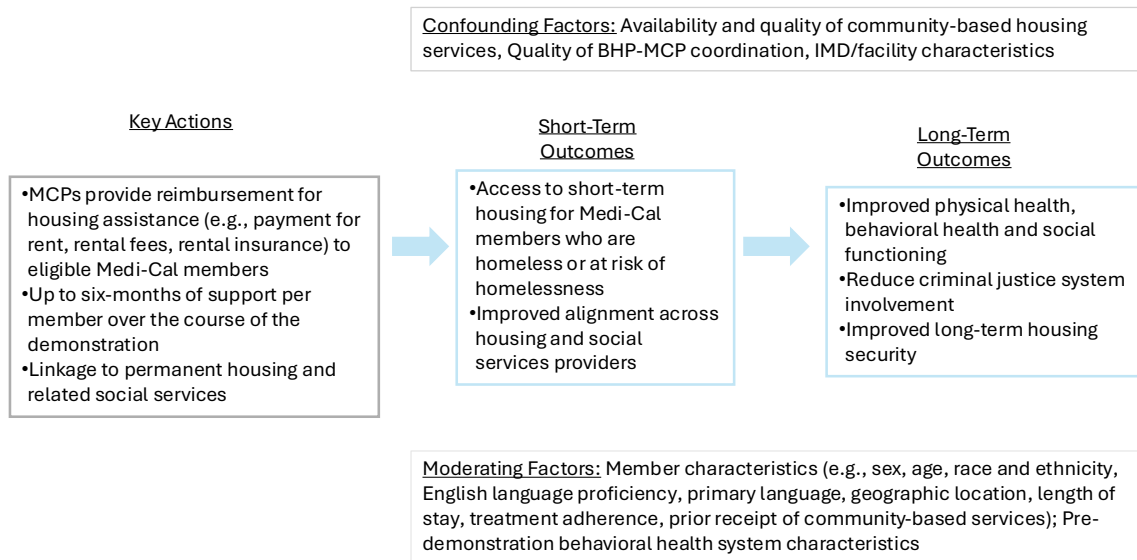
activities such as confirming appropriate housing units, ensuring habitability, assisting members with lease agreements, structuring rent payment arrangements, issuing timely payments, and coordinating with supportive service providers. The administrative fee structure includes two components: a standard monthly fee and a higher one-time fee for the first month a member is placed in a permanent setting, reflecting the additional effort required to secure long-term housing.

The Transitional Rent program also promotes coordinated partnerships between Medi-Cal Managed Care Plans (MCPs) and a diverse network of local entities that address housing and social needs. MCPs are expected to establish formal agreements with Transitional Rent Providers—including county behavioral health agencies, Continuums of Care (CoCs), public housing authorities, affordable and supportive housing providers, and community-based organizations—to ensure that members receive timely and appropriate housing assistance. These partnerships must extend beyond contracting to include shared operational protocols, referral pathways, and data exchange mechanisms that support coordinated care. MCPs are required to develop or leverage secure information technology systems that enable real-time communication and data sharing among partners while maintaining compliance with HIPAA and state privacy regulations. This includes the use of shared care management platforms, data dashboards, and standardized reporting templates to track member eligibility, housing placements, and service utilization.

Transitional Rent Program Evaluation Overview

The evaluation of the Transitional Rent program will use a mixed-methods approach guided by the logic model in Figure 7.1. The key actions of the program are payments from MCPs to Transitional Rent providers for up to six months of housing services for eligible Medi-Cal members. The payments are supplemented by requirements for individualized housing support plans, which describe a pathway to permanent housing, and linkage to related housing and social services. The evaluation will examine how the Transitional Rent program impacts two short-term and three long-term outcomes. In the short term, the program aims to provide interim housing that addresses the immediate needs of people in the transitioning population and improve integration and coordination among health care, housing and social services agencies serving this population. The system improvements include alignment across health, social services, and housing sectors through development of data sharing systems to support coordinated health and housing services. The long-term goals of the program are to improve the health and well-being of Transitional Rent recipients, reduce their likelihood of criminal justice involvement, and improve their housing security beyond the six-month assistance period.

Figure 7.1. Transitional Rent Program Logic Model



The Transitional Rent program is centered on MCPs, which not only provide reimbursement for services to members, but must also assemble a network of Transitional Rent providers that is adequate to meet the needs of their Medi-Cal populations and submit encounter data to the state through existing reporting mechanisms. In addition, MCPs are required to ensure that the Transitional Rent services are provided with fidelity, and to report on implementation of Transitional Rent services to DHCS on a quarterly basis. It is also important to note that the Transitional Rent services are designed to fit into a complex existing web of medical, housing, and social services without duplication of efforts. The existing web of services provides a wealth of resources, including behavioral health care and support for permanent housing. These additional services strengthen the Transitional Rent program's role as a bridge to permanent housing, and also require significant effort from Transitional Rent providers to coordinate with diverse partner agencies and support robust data sharing.

The evaluation of the Transitional Rent program will make use of the quarterly reports submitted and encounter data by MCPs, along with Medi-Cal data, Transitional Rent participant data reported by DHCS, and additional state-level data on criminal justice involvement, crisis

services, and mortality. Our quantitative analyses will utilize these data to provide a description of the Transitional Rent program, its participants, reach into the target population, coordination activities, and outcomes. Because of the simultaneous state-wide rollout of the program, we anticipate that we will not be able to identify an ‘unexposed’ comparison group. Consequently, our analyses will focus on pre-post comparisons, matching on time of year, clinical, and demographic information. Medi-Cal encounter data will be used to supplement the MCP utilization data. Quantitative analyses will be accompanied by qualitative interviews with MCPs as well as program participants. The specific hypotheses and research questions are presented in Table 7.1.

Table 7.1. Evaluation Questions, Hypotheses, and Data Sources: Transitional Rent Program

BH CONNECT Goals	Evaluation Questions	Hypotheses	Data Sources
Promote improved health outcomes, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.	EQ1: Does the Transitional Rent program provide short-term housing support to the intended target population?	MCPs will provide Transitional Rent program, including individualized housing support plans, to eligible Medi-Cal members.	• MCP Quarterly Reporting • Medi-Cal Data • Homeless Data Integration System • DHCS Public Reporting - Qualitative Interviews with Transitional Rent providers and participants
	EQ2: Does the Transitional Rent program improve alignment of MCPs with medical and housing services provider agencies?	MCPs will improve integration between medical services, specialty behavioral health care and a variety of housing services, including Transitional Rent providers, ECM providers, Community Supports providers, Continuums of Care and Public Housing Authorities	• MCP Quarterly Reporting - Qualitative Interviews with County Officials, Transitional Rent providers, and participants
	EQ3: Does the Transitional Rent program Improve health and wellbeing outcomes?	Transitional Rent participants will show increased engagement in services, increased engagement in meaningful activities, and improved self-reported health and wellbeing outcomes during and after participation compared to their pre-period and, where feasible, compared to eligible non-participants	• Medi-Cal Data - Qualitative Interviews with Transitional Rent participants

Reduce the risk of individuals entering or re-entering the criminal justice system due to untreated or under-treated mental illness.	EQ4: Does the Transitional Rent program reduce use of crisis services and justice-system involvement?	Transitional Rent participants will have reduced incarceration and other justice-system involvement during and after participation compared to their pre-period and, where feasible, compared to eligible non-participants.	• Medi-Cal Data • Automated Criminal History System (ACHS) • Juvenile Court Probation Statistical System (JCPSS)
Shorten lengths of stay in institutional settings and support successful transitions to community-based care settings and community reintegration.	EQ5: Does the Transitional Rent program Serve as a bridge to permanent housing?	Transitional Rent participants will be more likely to exit institutional settings into stable housing and remain connected to services.	• MCP Quarterly Reporting • Qualitative Interviews with Transitional Rent providers and participants

Evaluation Methods

Study Population

Since the Transitional Rent program is mandatory for MCPs, the study population includes all MCP-enrolled Medi-Cal members who would meet the eligibility criteria described above. The criteria change slightly over time. In calendar year 2026, the study population will be restricted to members meeting eligibility through the behavioral health risk factors. Starting as early as January 2027, the study population will expand to include members meeting the physical health risk factors. However, it is not possible to identify all members meeting criteria independently of their entry into the Transitional Rent program. Some subsets of the study population, such as Medi-Cal members currently identified as homeless in the Homeless Management Information System, may be identifiable for analysis. We will explore the possibility of using these data to define a population that is eligible for Transitional Rent services that can be followed prospectively or compared across time. For most analyses, however, we will focus on the population that is found to be eligible for Transitional Rent services through the MCP eligibility assessment process.

Time Frame for the Evaluation

The time frame for the Transitional Rent program evaluation will include a baseline period prior to the start of the program in January 2026 of a minimum duration of two years and a post-implementation period. For the interim report, the post-implementation period will span the time between January 2026 and December 2027. The post-implementation period will extend through the end of the waiver period in the final summative report. The baseline, pre-implementation, period will be described using Medi-Cal claims and encounter data, while the implementation period will be described using MCP and DHCS reports as described below.

Data Sources

The Transitional Rent evaluation will make use of available data sources used in other components of the evaluation, including Medi-Cal claims and encounter data, the Homeless Data Integration System, Criminal Justice System Involvement data, and mortality data. In addition, the Transitional Rent evaluation will use some data sources that are unique to this program, including:

MCP Quarterly Reports: MCPs will be required to submit quarterly reports on the Transitional Rent program to DHCS, using the format and procedures already in place for ECM and Community Supports. These reports will include information on referrals to the program, eligibility among enrolled members, numbers of Transitional Rent recipients, linkage to

permanent housing, Transitional Rent denials, grievances and appeals, Transitional Rent provider networks data, and connections to state and federal housing assistance programs.

DHCS Public Reports: DHCS is required by state law to publish an annual report on utilization of ECM and Community Supports that will apply to the Transitional Rent program. The required reporting includes information on demographics of the members served by the program.

Quantitative Methods

As noted above, the simultaneous statewide implementation of the Transitional Rent program and the complex eligibility criteria will make identification of a contemporaneous control group difficult and limit our analytic options to pre-post comparisons. Where we are able to identify comparable groups who would have been eligible for the Transitional Rent program in the pre-implementation period, i.e. prior to January 2026, we will apply ITS methods to Medi-Cal claims and encounter data as described in Chapter 1. However, given the difficulty in identifying these members in the available data, we may be further restricted to pre-post comparisons among Transitional Rent recipients and descriptive analyses of outcomes among Transitional Rent recipients. Analyses based on the MCP and DHCS reports on the Transitional Rent program will necessarily be limited to the implementation period.

The descriptive analyses will provide valuable information for understanding implementation of the program. For instance, we can compare information on program utilization with estimates of the size of the eligible population at the county level. This will allow us to estimate the reach of the program, i.e. the proportion of the eligible population that has received services. Similarly, we can compare costs of the Transitional Rent services, calculated from encounter data, with publicly reported costs of housing people at risk for homelessness in other settings. Results will be presented for the state as a whole and, where possible, separately for each of the five types of MCP in California (Two-Plan Model, County Organized Health Systems, Geographic Managed Care, Regional Model, and Single-Plan Model).

Qualitative Methods

We will conduct semi-structured interviews with participating MCP staff and providers, and Medi-Cal members receiving transitional rent services. MCP interviews will focus on understanding barriers and facilitators to implementation, including reaching the target audience and serving as a bridge to permanent housing, and program outcomes, including participant health, wellbeing, and service utilization outcomes. Interviews with members will explore perceived impacts of the program on outcomes such as permanent housing and health and wellbeing outcomes.

We will use purposive, maximum-variation sampling to recruit semi-structured interview participants across three groups: participating MCP staff, service delivery providers and partners, and Medi-Cal members receiving Transitional Rent Services. Sampling will be informed by the

county profiles we are developing and will be structured to maximize variability across California geography and urbanicity, county housing-system context, and MCP characteristics as well as implementation maturity and service volume. MCP and provider participants will be recruited through MCP points of contact, and members will be recruited through provider participants. Providers will provide informational flyers to interested members advertising the interviews and offering a phone number and/or email address to contact the study team. We will offer flexible interview modalities offered in English and Spanish, with recruitment designed to include participants at different points in the service trajectory and with a range of housing and health/wellbeing experiences. Members who complete the interview with us will be asked for their consent to be contacted for follow up interviews. Participating members will receive a gift card for their participation in the interview, with increasing amounts for each follow up interview to encourage participant retention.

EQ1: Does the Transitional Rent program provide short-term housing support to the intended target population?

To address EQ1 we will use MCP quarterly reports, DHCS data, and Medi-Cal data to examine the extent to which the Transitional Rent program is reaching the intended population and providing effective housing support services. Specifically, we will examine data on the numbers of people referred to the program or determined to be eligible by the MCPs and the proportions of these who are assessed for eligibility, found to be eligible, offered Transitional Rent services, received Transitional Rent services (i.e. moved into a short-term housing situation using Transitional Rent), had individualized housing support plans, and were in stable or permanent housing at discharge. To the extent that data on specific eligibility criteria are available, we will examine the proportions of each category of eligible members who receive services (e.g., unsheltered homeless, FSP-eligible). To focus on the members who are homeless, we will use data from the Homeless Management Information System to independently examine the proportion of homeless Medi-Cal members receiving Transitional Rent services. Medi-Cal encounter and claims data will be used to corroborate MCP reports and estimate per person costs of Transitional Rent to the Medicaid program. Variations across MCPs, regions, and demographic characteristics will be examined. Interviews with MCP providers will explore barriers and facilitators to reaching the intended target populations. Interviews with Transitional Rent recipients will explore the process of accessing services, benefits of participation, and challenges faced while using the program.

EQ2: Does the Transitional Rent program improve alignment of MCPs with medical and housing services provider agencies?

As mentioned, the Transitional Rent program requires integration of health care and housing services through the Transitional Rent provider network as well as integration with a broader range of services that contribute to successful long-term housing tenure, such as

specialty behavioral health services and other social services that address health related social needs. Through analyses of quarterly report data and interviews with MCPs and Transitional Rent providers, we will examine integration, including data sharing and adequacy of information technology, of MCPs with:

- The Transitional Rent provider network
- County Behavioral Health Systems
- ECM providers
- Other health and social services providers
- Continuums of Care
- Public Housing Authorities

The Transitional Rent program explicitly requires MCPs to develop information technology infrastructure to collect and share information on closed loop referrals and to effectively collect data from Transitional Rent providers to submit encounter data to the state. These information systems will be examined as part of the assessment of alignment with provider agencies.

EQ3: Does the Transitional Rent program Improve health and wellbeing outcomes?

To test the hypothesis that Transitional Rent is associated with improved health and wellbeing outcomes, we will examine changes in three outcome areas as a result of program participation, using interviews with Transitional Rent recipients and Medi-Cal data. We will also examine variation in outcomes across the five types of MCP in California.

1. Engagement in services (physical, behavioral, substance use). We will use Medi-Cal claims to measure engagement in physical health, behavioral health, and substance use services. Outcomes will include service utilization and measures of quality of care (for example, outpatient visits, follow-up after acute events, adherence with psychiatric medication, and ongoing treatment engagement) assessed in defined pre- and post-enrollment windows.
2. Engagement in meaningful activities (employment, school, family, community). We will assess engagement in meaningful activities primarily through participant self-report during semi-structured qualitative interviews. Interviews will examine experiences related to job-seeking and attainment, school or training participation, family and caregiving experiences (such as reconnection), and community involvement. These interviews will be repeated during the study period to examine how self-reported outcomes may change as housing stabilizes.
3. Suicidality and mortality. We will use Medi-Cal healthcare utilization data to identify use of acute care related to suicide attempts and CA Department of Public Health vital statistics data to examine all-cause mortality.

EQ4: Does the Transitional Rent program reduce use of crisis services and justice-system involvement?

To test the hypothesis that Transitional Rent program is associated with reduced avoidable use of crisis services and justice-system involvement, we will analyze Medi-Cal claims and other

available administrative data to examine changes in high-acuity utilization before, during, and after receipt of Transitional Rent, and compare trends to a group of eligible non-participants where feasible. Outcomes will include incarceration, emergency department utilization, IMD inpatient stays, and other crisis response services. Analyses will use pre-enrollment periods to establish baselines and assess existing trends; impact analyses will use ITS or DD models, depending on data availability and the feasibility of constructing an appropriate comparison group. Outcomes will be examined for the state as a whole and separately by type of MCP.

EQ5: Does the Transitional Rent program Serve as a bridge to permanent housing?

To test the hypothesis that Transitional Rent functions as a bridge to stable, longer-term housing, we will analyze program and housing outcomes data to examine member trajectories during and after the assistance period. Outcomes will include (1) housing stability during the subsidy period, (2) transitions to permanent housing or longer-term housing subsidies or placements by a defined follow-up point after assistance ends, and (3) rates of returns to homelessness or housing instability. Preliminary analyses will use pre-enrollment periods to establish baselines and compare trends over time; impact analyses will use pre-post comparisons, depending on data availability and comparison group feasibility. Qualitative interviews with members and providers will inform interpretation of quantitative results by describing how Transitional Rent impacts housing stability, and barriers and facilitators to successful transitions to permanent housing.

Appendix A. Secondary Data Sources

Person-Level Data Sources

Medi-Cal Data

DHCS will provide Medi-Cal claims and eligibility files, which include information about encounters with the health care system that were billed to Medi-Cal, such as demographic information (age, sex, race/ethnicity), service date, place of service, type of service, units of service provided, primary and secondary diagnosis code, procedure code, aid codes, provider type, provider specialty, prescription information, and billing information. Data elements for inpatient stays include date of admission, date of discharge, length of stay, admission necessity code, and discharge status. Eligibility files are available monthly and include demographic information (age, sex, race/ethnicity, language), county code, aid code, eligibility status code, other coverage code, and share of cost amount.

HCAI Health Care Payments Data (HPD)

HCAI's Health Care Payments Data (HPD) is California's All Payer Claims Database, which contains administrative data for health care encounters and claims submitted to California payers by providers. The data come from DHCS (Medi-Cal), CMS (Medicare fee-for service plans), and health plans for employer-based, individual, or Medicare Advantage coverage, as well as private, self-insured companies that voluntarily submit their data. The HPD contains information on eligibility, medical, pharmacy, and dental claims as well as provider information. Non-public data are available to researchers whose application has been approved.

HCAI Patient-Level Administrative Data

HCAI collects abstracted health care data from individual patient records for inpatient discharges from California-licensed hospitals, ED encounters, and ambulatory surgery encounters. Patient Discharge Data (inpatient) include information on patient location, facility type and location, birth date, preferred language, race, ethnicity, homelessness indicator, sex, type of admission, patient disposition, admission source, route of admission, age at admission, admission and discharge dates, length of stay, diagnoses, procedures, total charges, and expected sources of payment. ED encounter data and ambulatory surgery data include information on patient location, facility type and location, birth date, preferred language, race, ethnicity, homelessness indicator, sex, patient disposition, service date, diagnoses, procedures, total charges, and expected sources of payment. Non-public data are available to researchers whose application has been approved by the Committee for the Protection of Human Subjects (CPHS).

County Behavioral Health EHR records

County BH plans maintain electronic health records for patient encounters that include information about patient diagnoses, procedures, services provided, and billing information. These data may provide more insight into the types of services and treatments provided than claims data; however, variation in the structure and quality of the data across counties may complicate comparisons.

California Outcomes Measurement System Treatment

DHCS collects data from SUD treatment providers who receive funding from DHCS, including data on new admissions, discharges, and annual updates for patients who have been in treatment for longer than 12 months. Reportable services and modalities include outpatient, intensive outpatient, partial hospitalization, additional MAT, opioid treatment program/narcotic treatment program, withdrawal management or detox, and all levels of residential services (non-reportable services and modalities include recovery residence, recovery services, psychiatric services, screening and referral, and DWI/DUI programs). The data collected include information on patient demographics, facility location, level of care, type of service, disability, Proposition 36 participation, Medi-Cal eligibility, other funding programs (such as drug court), field-based services, personal responsibility assessment, alcohol and drug use data, employment data, criminal justice data, medications, recent medical history, Naloxone use/education, communicable diseases, mental health, social support, living arrangements, family and children, dates of admission and discharge, discharge status, level of care referred/transferred to, and services used during treatment. These data are submitted to DHCS monthly.

California Homeless Data Integration System

The Homeless Data Integration System (HDIS) is a collection of data from 44 individual local homelessness response systems in California, or continuums of care (COCs). These 44 COCs each maintain local homeless management information systems (HMIS) that feed data to the statewide HDIS. The individual entities follow common federal standards for data collection established by the U.S. Department of Housing and Urban Development and include elements such as demographics, disabling conditions, dates of program participation, destination, family structure, housing move in dates, prior living situation, income and sources, health insurance, disability, chronic health conditions, mental health conditions, substance use disorder, domestic violence, current living situation, dates of engagement in services, bed nights in night-by-night shelters, and coordinated entry activity. The data contain social security numbers (SSN) and name and can be linked to Medi-Cal data.

Automated Criminal History System (ACHS) and Juvenile Court Probation Statistical System (JCPSS)

The California Department of Justice, per Penal Code 13202, maintains the Automated Criminal History System (ACHS), a repository of Criminal Offender Record Information data, and makes it available for research purposes. These data, compiled by criminal justice agencies to identify people who have had contact with the criminal justice system, include information about arrests, pretrial proceedings, criminal charges, sentencing, incarceration, rehabilitation, and release. The California Department of Justice also maintains the Juvenile Court Probation Statistical System (JCPSS), which is similar to the Automated Criminal History System but includes criminal justice information for juveniles. The data contain name and date of birth and can be linked to Medi-Cal data.

California Department of Public Health Vital Statistics Death Data

The California Department of Public Health Vital Statistics provides the California Comprehensive Master Death File to approved researchers. These data contain information about deaths occurring in California as well as deaths of California residents that occur outside of California. The data are available ten months after the end of the calendar year, starting in 2014. Data elements include name, date of birth, date of death, place of death, and cause of death.

Provider-Level Capacity/Workforce Data

California Department of Public Health (CDPH), Center for Health Care Quality, Licensing and Certification (L&C) Program Data

The California Department of Public Health maintains a data system of licenses and certifications for more than 30 different types of health care facilities. These data include information on facility type, location, bed type, and bed capacity (Center for Health Care Quality, California Department of Public Health, 2018) and services associated with those facilities (Center for Health Care Quality, California Department of Public Health, 2025-b). These data are updated monthly. A crosswalk is available to link records in the CDPH L&C data to identification numbers to records that use the HCAI facility identification numbers (Center for Health Care Quality, California Department of Public Health, 2025-a).

DHCS Licensing and Certification Division Data

The DHCS Licensing and Certification Division (LCD) maintains a database of license and location information for several types of facilities, including the following facilities that are relevant to this evaluation.

Licensed Mental Health Rehabilitation Centers and Psychiatric Health Facilities

This data set is maintained by DHCS and includes license and location information for all Mental Health Rehabilitation Centers and Psychiatric Health Facilities for all California counties, as well as information about the target population and client/patient capacity (Center for Health Care Quality, California Department of Public Health, 2025-c). These data are updated monthly.

DHCS SUD Recovery Treatment Facilities

This data set is maintained by the DHCS Substance Use Disorder Compliance division Licensing and Certification Branch and includes license and location information for all non-medical alcoholism and drug abuse recovery or treatment facilities, as well as information about the facilities' resident capacities, total occupancy, and target populations (Center for Health Care Quality, California Department of Public Health, 2025-d). This dataset was created in May 2025 and is updated on an irregular basis.

DHCS Institution for Mental Diseases List

DHCS publishes a list of Institution for Mental Disease (IMD) facilities on a quarterly basis (Center for Health Care Quality, California Department of Public Health, undated). The list includes information on the facility location, program type, number of licensed beds, number of special treatment program beds, and dates of license effectiveness/expiration. DHCS notes that this list is not exhaustive.

Certified and Approved Residential Mental Health Programs

DHCS Community Services Division maintains a database of Mental Health Short-Term Residential Therapeutic Programs, Social Rehabilitation Programs, Community Treatment Facilities, and Special Treatment Programs in California (Center for Health Care Quality, California Department of Public Health, 2025-e). The data include information about the program location, program type, bed capacity, certificate number, and expiration date. This table is updated quarterly.

DHCS Subacute Contracting Unit Adult Medi-Cal Provider List

DHCS published a table of 120 subacute facilities by county that contains the location, facility type, and number of contracted beds for each adult facility (Center for Health Care Quality, California Department of Public Health, 2021).

California Department of Social Services (CDSS) Facility Data

CDSS maintains a database of information about facilities licensed by the Community Care Licensing Division, including foster family agencies and sub-agencies, 24-hour residential care for children, adult residential and day care, elderly assisted living, childcare, home care organizations, and adoption agencies (California Department of Social Services, undated). These

data include information about facility type, location, capacity, status (licensed or closed), inspections and complaints. The data are updated weekly.

California Department of State Hospitals Data

The California Department of State Hospitals website contains information on the state hospital facilities in California (California Department of State Hospitals, undated), including patient demographics through 2020 (California Department of State Hospitals, 2024-a) and counts of patients by reason for admission (forensic or civil commitments) through 2023 (California Department of State Hospitals, 2024-b).

National Substance Use and Mental Health Services Survey (N-SUMHSS)

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducts the National Substance Use and Mental Health Services Survey (N-SUMHSS), an annual survey of substance use disorder and mental health treatment facilities in the United States to understand the availability of these facilities, what services are provided, operation of the facility, facility ownership status, client counts by service type, number of beds, payment options, licensure, certification, and accreditation of the facilities. Information about mental health treatment and substance use disorder treatment were previously collected separately via the National Mental Health Services Survey (N-MHSS) and the National Survey of Substance Abuse Treatment Services, respectively.

CCBHC Locator

The National Council for Mental Wellbeing maintains a list of CCBHCs that includes 22 facilities in California. The data were most recently updated in January 2024.

Behavioral Health Continuum Infrastructure Program (BHCIP) Data Dashboards

DHCS has implemented the Behavioral Health Continuum Infrastructure Program (BHCIP) that awards competitive grants to qualified entities expand the community continuum of BH treatment resources by constructing, acquiring, and rehabilitating real estate assets or investing in mobile crisis infrastructure. Advocates for Human Potential, Inc. is administering BHCIP on behalf of DHCS and maintains a data dashboard for the grants program that contains preliminary, grantee-reported estimates of beds, individuals served annually, and type and location of facility (California Department of Health Care Services, 2025). The data dashboards are updated monthly, and the data are available for download.

Medi-Cal Network Adequacy Certification Tool

DHCS is required to report to CMS on network adequacy for specialty mental health plans, Medi-Cal managed care plans, DMC-ODS, and dental managed care plans pertaining to provider

to member ratios, mandatory provider types, and Time or Distance standard requirements (California Department of Health Care Services, undated), which are monitored for compliance. The tool includes data about the size and composition of California's county BH safety net workforce. The data have been collected since 2018; the most recent data are from 2023.

National Center for Education Statistics Integrated Postsecondary Education Data System

The National Center for Education Statistics collects data for the Integrated Postsecondary Education Data System, which is a survey of academic institutions with an agreement with the Office of Federal Student Aid. The data include information about admissions, completions, enrollment, graduation rates, and outcome measures for postsecondary education programs, which can be used to monitor trends in the number of graduates from programs educating BH professionals.

Data Exchange Framework

The California Health and Human Services Agency (CalHHS) Center for Data Insights and Innovation publishes a list of facilities and county behavioral health plans that have agreed to participate in the Data Exchange Framework (DxF).

Transitional Rent Quarterly Reports

Managed Care Plans are required to submit quarterly reports to DHCS on implementation of the Transitional Rent program. The reports will include information on the Transitional Rent provider network, the numbers referred to, assessed, and provided Transitional Rent services, and numbers referred to federal and state programs for permanent housing options.

DHCS Community Supports Public Reporting

DHCS is required to report on the demographic characteristics of Transitional Rent recipients.

Performance Data

Annual Availability Assessment of Mental Health Services

As part of the section 1115 demonstration, CMS requires collection of information such as the number of beneficiaries (adult, children, and total), the number of psychiatrists or other practitioners authorized to prescribe (overall, Medicaid-enrolled, Medicaid-enrolled and accepting new patients), the number of other practitioners certified and licensed to independently

treat mental illness (overall, Medicaid-enrolled, Medicaid-enrolled and accepting new patients), the number of community mental health centers, the number of intensive outpatient or partial hospitalization providers, the number of residential mental health treatment facilities, the number of inpatient psychiatric units, the number of inpatient psychiatric beds, the number of IMDs (residential facilities or psychiatric hospitals), the number of crisis stabilization services (crisis call centers, mobile crisis units, crisis observation/assessment centers, crisis stabilization units, community crisis response teams), and the number of FQHCs that offer behavioral health services. This information will be collected by CMS annually throughout the demonstration period.

BHSA Required Reports and Data

The BHSA requires counties to submit three-year Integrated Plans for Behavioral Health Services and Outcomes. These reports include information on planned activities and projected expenditures for Medi-Cal behavioral health programs, federal block grants, BHSA funds, and other funding for county behavioral health department services. The report template will include information on County Demographics and Behavioral Health Needs, Plan Goals and Objectives, Community Planning Process, Comment Period and Public Hearing, County Behavioral Health Care Continuum Capacity, Services by Total Funding Source, Behavioral Health Services Fund Programs, Workforce Strategy, and Budget and Prudent Reserve. The first submission is due June 2026, and updates are required annually and intermittently as needed.

Counties are also required to submit BHOATRs to DHCS annually, with the first report covering FY 2026-27 due January 30, 2029. These reports will contain information similar to what is included in the Integrated Plans.

Katie A. Specialty Mental Health Datasets

DHCS collects and publishes data on utilization of services used by children and youth (under 21) who are Katie A. Subclass members¹⁴ or use Katie A. SMHS, which include Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care. Service utilization measures for each of the services include the number of members receiving the service, the number of days, hours, or minutes of service utilization, and the cost of service

¹⁴ As a result of the December 2011 Katie A. court settlement, county MHPs are required to provide Intensive Care Coordination and Intensive Home Based Services to Katie A. subclass members, defined as children 1. Under age 21 with full-scope Medi-Cal eligibility, 2. Meet medical necessity criteria, 3. Have an open child welfare case, and 4. Are either a. in or considered for wraparound services, therapeutic foster care, therapeutic behavioral services, crisis stabilization, crisis intervention, or assigned a specialized care rate, or b. are currently in or being considered for a foster care group home, a psychiatric hospital, 24-hour mental health treatment facility, or experienced third placement within 24 months due to behavioral health needs.

delivery in dollars. Data are reported monthly at the state level and bimonthly at the county level, starting in 2018. The most recent data are from April 2025.

Inpatient Psychiatric Facility Quality Measure Data - by Facility

CMS publishes hospital-level data for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program as part of Care Compare and Hospital Quality Initiative Public Reporting initiatives. Snapshot data are available quarterly starting in 2018; the most recent snapshot is from April 2025.

Timely Access Data Tool

To assist in monitoring network adequacy for managed care plans, DHCS requires BHPs to report standardized data on timely access to care through the TADT. The TADT captures data on the number of days or hours between a new patient's first contact with care and the earliest time at which an appointment is offered. Counties report the proportion of new patients who are offered an appointment within ten days of first contact. The system also captures data on the source of the referral, the type of appointment offered, whether the appointment was kept, referrals made, and final disposition (closure reason).

DHCS Specialty Mental Health Services (SMHS) Performance Dashboards

The DHCS Behavioral Health Reporting website contains data for several reporting efforts. This includes the Specialty Mental Health Services Performance Dashboard data, which contains counts of Medi-Cal members utilizing and eligible for SMHS and penetration rates by state fiscal year (overall and by age group, race group, and sex). From 2014 through 2022, DHCS collected state- and county-level data on children and youth receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-a), children and youth in foster care (California Department of Health Care Services, 2024-b), children and youth with an open child welfare case (California Department of Health Care Services, 2024-c), and adults receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-d). For each of these groups, DHCS publishes a dataset that includes counts of patients discharged from inpatient care without stepdown service; counts of patients discharged from inpatient care and followed by a stepdown service within seven days, between eight and 30 days, and more than 30 days; counts of unique Medi-Cal members; and mean, minimum, maximum, and median number of days for stepdown service. Another includes state- and county-level utilization service counts of Medi-Cal members; the total number of days, hours, or minutes of service utilization; and the total cost of service delivery in dollars. The performance dashboard data also includes county- and state-level data with unique counts of Medi-Cal members receiving Medi-Cal Specialty mental health services (arrivals, exits, or receipt of continuous service), overall and by age group, sex, and race.

The DHCS Behavioral Health Reporting Data Hub also contains data for the AB470 Dashboards for Adults and Children/Youth. The AB470 Dashboards display counts of eligible Medi-Cal members, Medi-Cal members with one or more visits, Medi-Cal members with five or more visits, and the penetration rate for individuals by health care delivery system (mental health plan, fee for service, or managed care), health plan, mental health type (mental health services, SMHS), demographic category and group (age group, race group, sex, written language), and fiscal year (2019-2022). There are separate dashboards for adults and children/youth. From 2014 to 2022, DHCS also published service utilization and time from inpatient discharge to step down care data by age group, sex, and race for adults (California Department of Health Care Services, 2024-e) and children from 2014 to 2022 (California Department of Health Care Services, 2024-f).

Mental Health Plan Dashboard

The Mental Health Plan Dashboard contains measures of access (capacity and composition, time and distance), timeliness of appointment, and translation/interpretation (language capacity) by MHP, fiscal year (2022–2024), Medi-Cal member age group (adult, children/youth), and SMHS type (outpatient, psychiatric).

Substance Use Disorder Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Penetration Rate Dashboard

This dashboard, maintained by DHCS, displays the percentage of Medi-Cal members who are eligible for services and actively utilize SUD treatment relative to the total number of eligible Medi-Cal members, by state and by county, during the FY 2022–2023 timeframe.

Mental Health CMS Core Set Measures Dashboard

The Mental Health CMS Core Set Measures Dashboard contains data on five quality metrics (AMM-AD, APP-CH, FUH-AD, FUH-CH, and SAA-AD) by county, measurement year (2020–2021), measure denominator (MHP, MCP, and Core Set), as well as Core Set Measure subcategory (e.g., 7 day or 30 day).

Medi-Cal Managed Care Performance Dashboard

The Medi-Cal Managed Care Performance Dashboard is produced by DHCS Managed Care Quality and Monitoring Division and includes data on enrollment, health care utilization, appeals and grievances, network adequacy and quality of care (HEDIS Aggregated Quality Factor Score). The data are available quarterly from March 2016 through April 2024.

From 2014 through 2021, DHCS collected state- and county-level data on children and youth receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-a), children and youth in foster care (California Department of Health Care

Services, 2024-b), children and youth with an open child welfare case (California Department of Health Care Services, 2024-c), and adults receiving Medi-Cal Specialty Mental Health Services (California Department of Health Care Services, 2024-d). For each of these groups, DHCS published a dataset that includes counts of patients discharged from inpatient care without stepdown service; counts of patients discharged from inpatient care and followed by a stepdown service within seven days, between eight and 30 days, and more than 30 days; counts of unique Medi-Cal members; and mean, minimum, maximum, and median number of days for stepdown service. Another includes state- and county-level utilization service counts of Medi-Cal members; the total number of days, hours, or minutes of service utilization; and the total cost of service delivery in dollars. The performance dashboard data also included county- and state-level data with unique counts of Medi-Cal members receiving Medi-Cal Specialty mental health services, overall and by age group, sex, and race. From 2014 to 2018, DHCS also published service utilization and time from inpatient discharge to step down care data by age group, sex, and race for adults (California Department of Health Care Services, 2024-e) and children from 2014 to 2020 (California Department of Health Care Services, 2024-f). These data were collected annually, but this data collection effort has been discontinued.

Dual-Eligible Special Needs Plan and Cal MediConnect Enrollment Dashboard

The Dual Eligible Special Needs Plan (D-SNP) Dashboard displays data pertaining to dually eligible members receiving both Medicare and Medi-Cal benefits. Information displayed includes enrollment (Exclusively Aligned Enrollment and Non-Exclusively Aligned Enrollment), enrollment by plan, enrollment by demographics (race/ethnicity, age group, language, gender), percent of members with a health risk assessment completed within 90 days of enrollment by plan, percent of members unable to be located within 90 days to complete a health risk assessment by plan, percent of members with an individualized care plan completed within 90 days by plan, percent of members unable to be located to complete an individualized care plan by plan, community-based adult services member referrals per 100 members by plan, Multipurpose Senior Services Program referrals by plan, members residing in long term care per 100 members by plan, members referred to county for in-home supportive services by plan, statewide percentage of members willing to participate and who the plan was able to locate with an assessment completed within 90 days of enrollment, and percentage of D-SNP members with documented discussions of care goals. Dashboard information is available from 2018–2024.

California Children's Services Whole Child Model Dashboards

DHCS maintains data dashboards to show trends in enrollment in California Children's Services (CCS) among CCS Whole Child Model (WCM) and Classic counties. The dashboard includes information about CCS-eligible and Medical Therapy Program beneficiaries. The current version of the dashboard contains information about demographics and enrollment (by age, sex, race/ethnicity, population density, county status, health places index quartile, delivery

system, and foster care). The dashboard also has information about enrollment by county by month and health plan. Data are available from July 2023–June 2024. Future iterations of the dashboard will contain quality measures.

Previous versions of the dashboard include quality of care metrics for the CCS and WCM populations (childhood immunization status, ED visits per 1000 member months, COVID-19 vaccination rate), and utilization metrics (outpatient visits per 1000 member months, inpatient admissions per 1000 member months, ER visits per 1000 member months, prescriptions per 1000 member months, non-specialty mental health visits per 1000 member months, etc). Managed Care WCM Dashboards are available for September 2020, April 2021, and June 2021. Integrated CCS/WCM dashboards are available for 2022–2024.

Dental Fee for Service and Managed Care Utilization and Performance

DHCS monitors performance of Medi-Cal Dental Fee for Service (FFS) and Dental Managed Care (DMC) through reporting of annual dental visits, preventive dental services, and use of sealants for children and adults. Data are reported by plan from June 2022 through March 2025. Statewide data and data for FFS and DMC are available from 2016 through 2022. Statewide utilization data and performance measures are available for Medi-Cal Dental FFS and DMC (geographic managed care and prepaid health plans) from 2014–2024 by age group.

Medi-Cal Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Data

DHCS reports on perceptions and experiences of members of Medi-Cal managed care plans, fee-for-service programs, or population-specific plans using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey. DHCS reports on survey results, including global ratings (rating of health plan, rating of all health care, rating of personal doctor, rating of specialist seen most often) and composite measures (getting needed care, getting care quickly, how well doctors communicate, customer service, advising smokers and tobacco users to quit, discussing cessation medications, discussing cessation strategies). Scores are reported by health plan for 2021, 2023, and 2024.

Area-Level Data

Area Health Resource Files (AHRF)

The Area Health Resource Files (AHRF) contain state- and county-level information from several sources on health facilities, health care professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics. These publicly available data are maintained by HRSA, Bureau of Health Workforce, National Center for Health Workforce Analysis.

Health Professional Shortage Areas in California

The Health Resources and Services Administration (HRSA) maintains national data for identification of geographic regions that meet the federal designations for shortage areas in primary care, mental health, and dental health. HCAI maintains a California specific subset of these data, and the most recent version was updated on August 28, 2024 (California Department of Health Care Services, 2024-g).

Other Data

SAMHSA Uniform Reporting System (URS)

The Uniform Reporting System is part of SAMHSA's Community Mental Health Services Block Grant and is used by State Mental Health Agencies to report annual data used in decision support and planning for public mental health systems. The state-level data include utilization measures, demographics of clients served by the states, outcomes of care, use of evidence-based practices (ACT, Supported Housing, Supported Employment, Family Psychoeducation, Integrated Treatment for Co-occurring Disorders, Illness Self-Management and Recovery, Medications Management, Therapeutic Foster Care, Multisystemic Therapy, and Functional Family Therapy), consumer assessments of care, information on insurance status, living situation, employment, and readmission to state psychiatric hospitals within 30 and 180 days. URS output tables for California are available from 2010 to 2023.

911/988 Data

If available, we would analyze utilization data from 911/988 systems for behavioral health calls.

Appendix B. Existing Quality and Service Utilization Measures

Table B.1. Availability of Existing Quality and Service Utilization Measures

Measures	Measure Steward	Geographic Unit (Years Available)
Behavioral Health Accountability Set		
<i>County MHP Priority Measures</i>		
Follow-Up After Emergency Department Visit for Mental Illness—30 days	NCQA	State (2017-2026), County (2020-2021)
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17	NCQA	State (2022-2026)
Follow-Up After Hospitalization for Mental Illness—30 days (FUH-AD)	NCQA	State (2013-2026), County (2020-2021)
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	NCQA	State (2010-2026), County (2020-2021)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	State (2017-2026), County (2020-2021)
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	NCQA	State (2013-2026), County (2020-2021)
<i>DMC-ODS Priority Measures</i>		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30 days	NCQA	State (2017-2026)
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17	NCQA	State (2022-2026)
Pharmacotherapy for Opioid Use Disorder (POD)	HEDIS	County (2024-2026)
Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS/SAMHSA	State (2020-2026)
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	NCQA	State (2013-2026)

Measures	Measure Steward	Geographic Unit (Years Available)
Medi-Cal Managed Care Accountability Set For Health Care Delivery Systems		
<i>Children's Health Domain Measures</i>		
Child and Adolescent Well-Care Visits	NCQA	State (2010-2026)
Childhood Immunization Status	NCQA	State (2010-2026)
<i>Chronic Disease Management Domain Measures</i>		
Asthma Medication Ratio: Ages 5 to 18	NCQA	State (2018-2026)
Controlling High Blood Pressure	NCQA	State (2013-2026)
Glycemic Status Assessment for Patients with Diabetes	NCQA	State (2025-2026)
<i>Reproductive Health Domain Measures</i>		
Chlamydia Screening	NCQA	State (2013-2026)
Prenatal and Postpartum Care: Postpartum Care	NCQA	State (2013-2026)
Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA	State (2013-2026)
<i>Cancer Prevention Domain Measures</i>		
Breast Cancer Screening	NCQA	State (2013-2026)
Cervical Cancer Screening	NCQA	State (2013-2026)
<i>Report Only Measures to DHCS</i>		
Adults' Access to Preventive/Ambulatory Health Services	NCQA	To be determined
Colorectal Cancer Screening	NCQA	State (2022-2026)
Depression Remission or Response for Adolescents and Adults	NCQA	To be determined
Depression Screening and Follow-up for Adolescents and Adults	NCQA	To be determined
Low-Risk Cesarean Delivery	CMS	To be determined
Plan All-Cause Readmissions	NCQA	State (2013-2026)
Postpartum Depression Screening and Follow Up	NCQA	To be determined

Measures	Measure Steward	Geographic Unit (Years Available)
Prenatal Depression Screening and Follow Up	NCQA	To be determined
Prenatal Immunization Status	NCQA	To be determined
Mandatory Adult Core Set Measures for Medicaid		
Antidepressant Medication Management (AMM-AD)	NCQA	State (2013-2025), County (2020-2021)
Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0%	NCQA	State (2017-2026)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	NCQA	State (2017-2025)
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	State (2013-2026)
Screening for Depression and Follow-Up Plan: Age 18 and Older	CMS	State (2013-2026)
Voluntary Adult Core Set Measures for Medicaid		
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate	AHRQ	State (2013-2026)
Concurrent Use of Opioids and Benzodiazepines	PQA	State (2018-2026)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid)	AHRQ	State (2013-2026)
Diabetes Short-Term Complications Admission Rate	AHRQ	State (2013-2026)
Mandatory Child Core Set Measures for Medicaid		
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items	NCQA	State (2010-2026)

Measures	Measure Steward	Geographic Unit (Years Available)
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication	NCQA	State (2010-2026)
Immunizations for Adolescents	NCQA	State (2010-2026)
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	State (2020-2026)
Screening for Depression and Follow-Up Plan: Ages 12-17	CMS	State (2018-2026)
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NCQA	State (2016-2019)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	State (2010-2026)

Medi-Cal Specialty Mental Health Services (SMHS) Performance Dashboard

Children and Youth in Foster Care	DHCS	State/County (2014-2022)
Children and Youth with an Open Child Welfare Case	DHCS	State/County (2014-2022)
Time to Step Down (Children and Youth in Foster Care)	DHCS	State/County (2014-2022)
Time to Step Down (Children and Youth with an Open Child Welfare Case)	DHCS	State/County (2014-2022)
Utilization of SMHS (Children and Youth in Foster Care)	DHCS	State/County (2014-2022)
Utilization of SMHS (Children and Youth with an Open Child Welfare Case)	DHCS	State/County (2014-2022)

Behavioral Health Reporting Data Hub

Median Time Adult Residential Treatment Services Utilized (Adults)	DHCS	State/County (2015-2021)
Median Time Case Management/Brokerage Utilized (Adults)	DHCS	State/County (2015-2021)
Median Time Crisis Intervention Utilized	DHCS	State/County (2015-2021)

Measures	Measure Steward	Geographic Unit (Years Available)
Median Time Crisis Residential Treatment Services Utilized	DHCS	State/County (2015-2021)
Median Time Crisis Stabilization Utilized	DHCS	State/County (2015-2021)
Median Time FFS Inpatient Utilized	DHCS	State/County (2015-2021)
Median Time Full-Day Rehabilitation Utilized	DHCS	State/County (2015-2021)
Median Time Full-Day Treatment Intensive Utilized	DHCS	State/County (2015-2021)
Median Time Inpatient Administrative Utilized	DHCS	State/County (2015-2021)
Median Time Intensive Care Coordination Utilized	DHCS	State/County (2015-2021)
Median Time Intensive Home-Based Services Utilized	DHCS	State/County (2015-2021)
Median Time Medication Support Services Utilized	DHCS	State/County (2015-2021)
Median Time Mental Health Services Utilized	DHCS	State/County (2015-2021)
Median Time Psychiatric Health Facility Utilized	DHCS	State/County (2015-2021)
Median time Short-Doyle/Medi-Cal Hospital Inpatient Utilized	DHCS	State/County (2015-2021)
Median Time Therapeutic Behavioral Services Utilized	DHCS	State/County (2015-2021)
Penetration in SMHS	DHCS	State/County (2015-2022)
Engagement in SMHS	DHCS	State/County (2015-2022)
Received one or more SMHS visits: proportion of beneficiaries eligible for SMHS who received one or more SMHS visits	DHCS	State/County (2015-2022)
Time between Inpatient Discharge and Step Down Service	DHCS	State/County (2015-2022)

Measures	Measure Steward	Geographic Unit (Years Available)
MHP Dashboard Measures (Network adequacy)		
Identifies whether the County Mental Health Plan met the requirement to provide language assistance services, such as interpretation, translation, American Sign Language, and hearing impaired 24 hours a day/seven days a week.	DHCS	County MHP (2018-2023)
Measures whether the county Mental Health Plan (MHP) has a sufficient number of providers to serve Medi-Cal beneficiaries.	DHCS	County MHP (2018-2023)
Measures whether the county Mental Health Plan (MHP) has providers located within time and distance standards for Medi-Cal beneficiaries.	DHCS	County MHP (2018-2023)
Provides the percentage of appointment requests a county Mental Health Plan receives that results in a first offered appointment within timely access standards.	DHCS	County MHP (2018-2023)
Timely Access Data Tool		
Proportion of new patients offered an appointment within 10 days of first contact with BHP	DHCS	County BHP (unknown)
Dual-Eligible Special Needs Plan Measures		
Percent of beneficiaries referred to county for in-home supportive services	DHCS	State/Plan (2014-2024)
Percent of beneficiaries residing in long term care	DHCS	State/Plan (2014-2024)
Percent of beneficiaries with a health risk assessment completed within 90 days of enrollment	DHCS	State/Plan (2014-2024)
Percent of beneficiaries with an individualized care plan completed within 90 days of enrollment	DHCS	State/Plan (2014-2024)

Measures	Measure Steward	Geographic Unit (Years Available)
Percent of beneficiaries with documented discussions of care goals	DHCS	State/Plan (2014-2024)
Katie A. Specialty Mental Health Reports		
Utilization of Intensive Care Coordination	DHCS	State/County (2018-2025)
Utilization of Intensive Home-Based Services	DHCS	State/County (2018-2025)
Utilization of Therapeutic Foster Care	DHCS	State/County (2018-2025)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Measures		
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset, Alcohol and Other Drug Use Disorder Treatment at Discharge	CMS	Facility, State (2018-2025)
Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention	CMS	Facility, State (2018-2025)
Facility Commitment to Health Equity	CMS	Facility, State (2018-2025)
Follow-Up After Psychiatric Hospitalization	CMS	Facility, State (2018-2025)
Hours of Physical Restraint Use	CMS	Facility, State (2018-2025)
Hours of Seclusion Use	CMS	Facility, State (2018-2025)
Influenza Immunization	CMS	Facility, State (2018-2025)
Medication Continuation Following Inpatient Psychiatric Discharge	CMS	Facility, State (2018-2025)
Modified COVID-19 Vaccination Coverage Among Healthcare Personnel	CMS	Facility, State (2018-2025)
Screen Positive Rate for Social Drivers of Health* (Screen Positive)	CMS	Facility, State (2018-2025)
Screening for Metabolic Disorders	CMS	Facility, State (2018-2025)

Measures	Measure Steward	Geographic Unit (Years Available)
Screening for Social Drivers of Health*	CMS	Facility, State (2018-2025)
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	CMS	Facility, State (2018-2025)
Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge	CMS	Facility, State (2018-2025)
Transition Record with Specified Elements Received by Discharged Patients	CMS	Facility, State (2018-2025)
Medi-Cal Dental Measures		
Annual Dental Visit	DHCS	State/Plan (2014-2024)
Continuity of care	DHCS	State/Plan (2014-2024)
Count of Fluoride Varnishes	DHCS	State/Plan (2014-2024)
Count of Sealants	DHCS	State/Plan (2014-2024)
Exams/Oral Health Evaluations	DHCS	State/Plan (2014-2024)
Overall Utilization of Dental Services	DHCS	State/Plan (2014-2024)
Preventive Services to Fillings	DHCS	State/Plan (2014-2024)
Treatment/Prevention of Caries	DHCS	State/Plan (2014-2024)
Use of Dental Treatment Services	DHCS	State/Plan (2014-2024)
Use of Diagnostic Services	DHCS	State/Plan (2014-2024)
Use of Preventive Services for Adults Ages 21+	DHCS	State/Plan (2014-2024)
Use of Preventive Services for Children Ages 1 – 20	DHCS	State/Plan (2014-2024)
Use of Sealants	DHCS	State/Plan (2014-2024)
Usual source of care	DHCS	State/Plan (2014-2024)
Section 1115 SUD Demonstration Metrics		
Metric 3: The number of Medicaid Beneficiaries with SUD diagnosis	CMS	State (2023)

Measures	Measure Steward	Geographic Unit (Years Available)
Metric 6: Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.	CMS	State (2023)
Metric 7: Number of beneficiaries who used early intervention services.	CMS	State (2023)
Metric 8: Total Beneficiaries that received Outpatient Services.	CMS	State (2023)
Metric 9: Total Beneficiaries receiving Intensive Outpatient and Partial Hospitalization Services.	CMS	State (2023)
Metric 10: Total Beneficiaries who use residential and/or inpatient services for SUD.	CMS	State (2023)
Metric 11: Total Beneficiaries who use withdrawal services.	CMS	State (2023)
Metric 12: Number of beneficiaries who have a claim for Medication-Assisted Treatment (MAT) for SUD during the measurement period.	CMS	State (2023)
Metric 23: Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.	CMS	State (2023)
Metric 24: Inpatient stays for SUD per 1,000 Medicaid Beneficiaries.	CMS	State (2023)
Metric #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	NCQA	State (2023)
Metric #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	NCQA	State (2023)
Metric #17(2): Follow-Up After Emergency Department Visit for Mental Illness	NCQA	State (2023)
Metric #18: Use of Opioids at High Dosage in Persons Without Cancer	NCQA	State (2023)

Measures	Measure Steward	Geographic Unit (Years Available)
Metric #21: Concurrent Use of Opioids and Benzodiazepines	NCQA	State (2023)
Metric #22: Continuity of Pharmacotherapy for Opioid Use Disorder	NCQA	State (2023)
Metric #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	HEDIS	State (2023)

Appendix C. Description of Other Initiatives

Table C.1. Other CA/Medi-Cal Programs

Program	Reference	Time Frame	Description
Behavioral Health Bridge Housing	Assembly Bill 179	2022 through June 2027	Funds county behavioral health agencies and Tribal entities to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions.
Behavioral Health Quality Improvement Program	BHIN 24-006	FY2021 through FY2023	Incentivized county BH delivery systems to improve data exchange capabilities to improve quality and coordination of care. Participating entities directly shared data with MCPs (signed the California Health and Human Services Data Exchange Framework Data Sharing Agreement) and/or onboarded to a Health Information Exchange (signed the California Data Use and Reciprocal Support Agreement and California Trusted Exchange Network).
Behavioral Health Continuum Infrastructure Program (BHCIP)	WIC Section 5960	2021-2027	Awards competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets, or to invest in mobile crisis.
Behavioral Health Integration Incentives Program	Proposition 56	2020-2022	Incentivized improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed health care plan's (MCP) network.

Program	Reference	Time Frame	Description
Behavioral Health Virtual Services Platform	WIC Section 5961	Jan 2024-	Part of the CYBHI - supports the delivery of equitable, appropriate, and timely behavioral health services from prevention to treatment to recovery, provides support and resources, such as interactive digital education, self-monitoring tools, application-based games, and mindfulness exercises, and offers access to free, on-demand one-on-one coaching and counseling supports.
CA Bridge Program	Budget Act of 2019, American Rescue Plan Act of 2021	2018-fall 2027	Trains staff to screen for OUD & other SUD, start MAT and MH care in the ED, and facilitate access/referrals to community-based providers for follow-up care.
CalAIM Justice-Involved Initiative	BHIN 23-059	Oct 2024-	Requires coordination of BHPs and MCPs with correctional facilities to support reentry for Medi-Cal members transitioning from incarceration to the community and managed care setting.
CalAIM No Wrong Door Policy	BHIN 22-011	July 2022-	Allows Medi-Cal members to receive MH services regardless of delivery system where they seek care (SMHS, MCP, FFS).
CalAIM Behavioral Health Payment Reform	BHIN 23-036	July 2022-	Moves counties away from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal members.
CalAIM Screening and Transition of Care Tools for Medi-Cal Mental Health Services	BHIN 22-065	Jan 2023-	Supports BHPs and MCPs in determining the most appropriate MH delivery system referral for Medi-Cal members who are not currently receiving MH services and ensure that Medi-Cal members receive timely and coordinated care when transitioning to/adding a service from other delivery system to their existing MH treatment.

Program	Reference	Time Frame	Description
California's Contingency Management Program (Recovery Incentives)	BHIN 22-056	2023-	Complements SUD treatment services and other evidence-based practices for stimulant use disorders with structured 24-week outpatient contingency management service and six months or more of additional treatment and recovery support services without incentives.
California Youth Behavioral Health Initiative (CYBHI)	WIC Section 5961	2021-	Provides school-linked partnership and capacity grants to county offices of education, local education agencies and institutions for higher education to support institutional readiness and promote utilization of the CYBHI statewide all-payer fee schedule for school-linked BH services including screening and assessment.
Care Coordination	BHIN 23-056	2023-	BHPs are contractually required to conduct care coordination (audited by DHCS for compliance)
Community Assistance, Recovery and Empowerment (CARE) Act	BHIN 25-012	2023-	Uses a civil court process (voluntary engagement, approved CARE agreement, or 24-month maximum court-ordered CARE plan) to connect people with untreated schizophrenia/other psychotic spectrum disorders to county BH treatment services which can include medication, a housing plan, and supportive services (eligibility: people at risk of relapse or deterioration that would be likely to result in grave disability or serious harm).
Community-Based Mobile Crisis Intervention Services	BHIN 23-025	April 2022-March 2027	Addresses MH, SED, SUD crises in the community, mitigating the need for ED visits.
Community Health Worker (CHW) Services	TN No. 22-0001	July 2022-	Development and training of CHWs.

Program	Reference	Time Frame	Description
Community Supports Services	A.B. 133 14184.206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021)	2022-	Addresses Medi-Cal members' health-related social needs through housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing and recuperative care.
Complex Care Capacity Building	BHIN 21-055	Oct 2021-	Supports 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.
Comprehensive Quality Strategy	42 CFR 438.340	Feb 2022-	Requires BHPs and MCPs to meet minimum performance levels
DMC-ODS SUD service expansion	MHSUDS IN 19-032	2019	Participating counties offer all levels of care along American Society of Addiction Medicine criteria.
Dyadic Care Services	WIC Section 5961	Jan 2023-	Part of CYBHI - New Medi-Cal preventive benefit targeting family well-being as a mechanism to support healthy child development and mental health in a dyad with the child's caregiver.

Program	Reference	Time Frame	Description
Earlier Identification and Engagement in Treatment	BHIN 21-073	Jan 2022-	For members under 21 meeting certain eligibility requirements, SMHS criteria do not require a diagnosed MH health disorder (criteria for children and youth are different than for adults). Qualifying criteria: if at high risk for a MH disorder due to the experience of trauma, e.g., being child-welfare involved, juvenile-justice involved, or experiencing homelessness (ACL 24-35 released July 2024 requires that child welfare and juvenile probation submit SMHS referrals within 3 business days of opening a case), or if they have a need for SMHS prior to a formal diagnosis being established).
Early Psychosis Intervention	WIC Section 5961	2018 -	Part of the CYBHI – supports provision of high-quality early psychosis care.
Enhanced Care Management (ECM)	CalAIM DHCS ECM Policy Guide	Jan 2022-	Addresses clinical and nonclinical needs through intensive coordination of health and health-related services, including providing connections to housing and other resources.
Family Urgent Response System	BHIN 21-013	March 2021-	Coordinated statewide, regional, and county-level system designed to provide collaborative and timely response during situations of instability for current and former foster youth and their caregivers.
Full Service Partnership programs	WIC Section 5600.3	1990s-	Provides wraparound or “whatever it takes” services to unserved or underserved people who may be homeless or at risk of homelessness.
Housing and Homelessness Incentive Program	APL 24-005	2022-	Allows MCPs to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed.

Program	Reference	Time Frame	Description
MAT Expansion Program	BHIN 21-024	Dec 2021-	Increases MAT access/reduces opioid OD-related deaths through prevention, harm reduction, treatment, and recovery activities.
MOU Guidance for Serving Children and Youth in Foster Care	BHIN 19-053	2020-	Requirement for each county to develop and implement a MOU outlining the roles and responsibilities of local entities that serve children and youth in foster care to establish a more comprehensive Children and Youth System of Care.
Peer Support Services	BHIN 25-010	2021-	Service provided by peer support specialists to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and educate beneficiaries and their families about their conditions and the process of recovery.
Semi-Statewide Electronic Health Record (EHR) System	CalMHSA initiative	2023	Encourages counties to implement new semi-statewide EHR that allows for tracking of referrals to non-BH agencies and services and encourages follow-up care.
Statewide e-consult platform	WIC Section 5961	Jan 2024-	Part of the CYBHI - offers provider access to remote and real-time consultation support with behavioral health professionals.
Student Behavioral Health Incentive Program	WIC Section 5961	Jan 2022-	Part of the CYBHI - supports partnerships between Medi-Cal managed care plans and schools to increase access to preventative behavioral health services.
Suicide and Crisis Lifeline (988)	AB 988	2022-	988 hotline for people seeking help during a BH crisis.

Program	Reference	Time Frame	Description
Targeted Case Management	BHIN 24-023	2023-	BHP requirement to provide TCM for people at risk of institutionalization or negative health or psycho-social outcomes, including beneficiaries with SMI; includes coordination of all medically necessary services.
Transitional Care Services	DHCS Transitional Care Services Technical Assistance Resource	August 2023-	Set of requirements for beneficiaries transferring from one setting/LOC to another that include (i) enforcing Admissions, Discharge, and Transfer (ADT) notifications and (ii) discharge planning for benes in acute care hospitals, EDs, and skilled nursing facilities, until benes have been successfully connected to all needed services and supports.

Table C.2. Initiatives to Address Housing Needs

Program	Time Frame	Description
Senate Bill 1152 (Chapter 981, Statutes of 2018)		Requires acute psychiatric hospitals to comply with discharge planning requirements for homeless patients.
Assembly Bill 531 (Chapter 789, Statutes of 2023)		Provide additional resources to care for and house people with the most severe MH needs and SUD, including through a bond to fund new beds and supportive housing settings and updates to the Mental Health Services Act (MHSA) to expand resources for housing and workforce and increase accountability for community-based services for prevention and early intervention services.
Bills enacting Prop 1	March 2024	Require counties to allocate BH funding for housing interventions for beneficiaries of all ages with significant BH needs who are experiencing or at risk of homelessness. This funding can be used for rental subsidies, operating

Program	Time Frame	Description
		subsidies, shared housing, project-based housing assistance, other housing supports, and capital development projects, including affordable housing.

Abbreviations

ACHS	Automated Criminal History System
ACT	Assertive Community Treatment
AHRF	Area Health Resources File
AMM-AD	Antidepressant Medication Management
APP-CH	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
BH	behavioral health
BHCIP	Behavioral Health Continuum Infrastructure Program
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHOATR	Behavioral Health Outcomes, Accountability, and Transparency Report
BHP	behavioral health plan
BHSA	Behavioral Health Services Act
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalAIM	California Advancing and Innovating Medi-Cal
CalHHS	California Health and Human Services Agency
CalMHSA	California Mental Health Services Authority
CARE	Community Assistance, Recovery and Empowerment
CCBHC	Certified Community Behavioral Health Clinic
CCS	California Children's Services
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CFIR	Consolidated Framework for Implementation Research
CHW	community health worker
CITS	comparative interrupted time series
CMS	Centers for Medicare & Medicaid Services
COC	continuum of care
CPHS	Committee for the Protection of Human Subjects
CSC	Coordinated Specialty Care
CTIRS	Community Transition In-Reach Services
CYBHI	California Youth Behavioral Health Initiative
DD	difference-in-differences
DDD	difference-in-difference-in-differences
DHCS	Department of Health Care Services
DMC	Dental Managed Care

DMC-ODS	Drug Medi-Cal Organized Delivery System
DSHP	Designated State Health Programs
D-SNP	Dual Eligible Special Needs Plan
DxF	Data Exchange Framework
EBP	evidence-based practices
ECM	Enhanced Care Management
ED	emergency department
EHR	electronic health record
EQ	evaluation question
FACT	Forensic Assertive Community Treatment
FEP	First Episode Psychosis
FFP	Federal Financial Participation
FFS	fee-for-service
FQHC	Federally Qualified Health Centers
FSP	Full Service Partnership
FUH-AD	Follow-Up After Hospitalization for Mental Illness—30 days
FUH-CH	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17
FY	fiscal year
HBA1c	hemoglobin A1c
HCAI	Department of Health Care Access and Information
HDIS	Homeless Data Integration System
HEDIS	Healthcare Effectiveness Data and Information Set
HIT	health information technology
HMIS	Homeless Management Information System
HPD	Health Care Payments Data
HRSA	Health Resources and Services Administration
IET-AD	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMD	Institution for Mental Diseases
IP	Access, Reform and Outcomes Incentive Program
IPFQR	Inpatient Psychiatric Facility Quality Reporting
ITS	interrupted time series
JCPSS	Juvenile Court Probation Statistical System
L&C	licensing and certification
LRP	Medi-Cal Behavioral Health Student Loan Repayment Program
MAT	Medications for Addiction Treatment
MATTR	Mental Health and Addiction Treatment Tracking Repository
MCP	managed care plans
MH-HPSA	Mental Health Provider Shortage Area

MHP	mental health plan
MHSA	Mental Health Services Act
MOE	margin of error
NCQA	National Committee on Quality Assurance
NMD	nonminor dependent
N-MHSS	National Mental Health Services Survey
N-SUMHSS	National Substance Use and Mental Health Services Survey
OD	opioid use disorder
PMPM	per-member-per-month
POD	Pharmacotherapy for Opioid Use Disorder
PTA	prior to admission
QoL	quality of life
SAA-AD	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	serious emotional disturbance
SMHS	Specialty Mental Health Service
SMI	serious mental illness
SSD-AD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
STCs	Special Terms and Conditions
SUD	substance use disorder
TADT	Timely Access Data Tool
URS	Uniform Reporting System
WCM	Whole Child Model
WIP	Workforce Initiatives Program

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ATTACHMENT G
HRSN Services Protocol

Attachment G
Protocol for Assessment of Member Eligibility and Needs, Infrastructure Planning, and Provider
Qualifications for HRSN services

In accordance with the state’s Section 1115 Demonstration and Special Terms and Conditions (STCs) this protocol provides additional detail on the requirements for the delivery of services for Transitional Rent, as specifically required by STC 10.6. Updates to the HRSN services (duration, scope, and definitions) are subject to the restrictions in STC 10.7.

DHCS intends to phase in coverage for the eligible populations identified in Section 2 of this protocol as described in Table 1 immediately below.

Table 1: Plan for Implementation of Transitional Rent

Timeline	Program Coverage Details
No sooner than July 2025	- Optional launch for Medi-Cal managed care plans (MCPs) to cover Transitional Rent. - Managed Care Plans (MCPs) electing to launch at this time may select one or more Transitional Rent-eligible populations to cover with DHCS approval.¹ - MCPs electing to launch at this time will be required to continue to cover Transitional Rent for all Transitional Rent-eligible populations they elected to cover for the duration of the demonstration. MCPs will be required to display on their websites all populations they have optionally elected to cover for Transitional Rent, as well as the associated eligibility requirements. Members and the public have access to the complete listing of MCPs by county, along with a link to each of their websites, on the Medi-Cal managed care health plan directory page of the DHCS website here: https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx Since the MCPs will elect to use only some of the eligibility criteria approved in this protocol, in line with STC 10.7, the state will send a letter to CMS 30 days prior to implementation notifying CMS of the eligibility criteria being used for each MCP. This requirement will take effect prior to the commencement of coverage in July 2025, and will remain in effect for the duration of the demonstration.

¹ DHCS will develop a list of optional populations that MCPs may voluntarily cover; optional coverage will be limited to the identified populations. All of the optional populations will fall within the universe of members eligible for Transitional Rent as set forth in Section 2 of this protocol.

Timeline	Program Coverage Details
No sooner than January 2026	• Mandatory launch for all MCPs to cover Transitional Rent. From this point in time, all MCPs <u>will be required</u> to cover Transitional Rent for members meeting the Behavioral Health Population of Focus criteria. • The Behavioral Health Population of Focus will be comprised of MCP members who are eligible for Transitional Rent and who have one of the qualifying behavioral health clinical risk factors for Transitional Rent provided in Section 2 of this protocol (“Eligibility”). • In addition, MCPs <u>may</u> elect to cover Transitional Rent for other Transitional Rent-eligible populations, with DHCS approval. Since the MCPs will elect to use only some of the eligibility criteria approved in this protocol, in line with STC 10.7, the state will send a letter to CMS 30 days prior to implementation notifying CMS of the eligibility criteria being used for each MCP. • MCPs electing to launch earlier than this mandatory launch phase will be required to continue covering Transitional Rent for all Transitional Rent-eligible populations they previously elected to cover for the duration of the demonstration.
No sooner than January 2027	• MCPs must cover Transitional Rent for all populations who meet the eligibility criteria for Transitional Rent.

1. Description of the Covered Service

Provided in the table below is a service description for Transitional Rent (Short-term rental assistance).

Service Title	Transitional Rent
Service Description	Transitional Rent may include: • Temporary housing; • Prospective rental assistance; • Retrospective rental assistance (“back rent”) • Rent and housing fees necessary to secure and maintain the unit, including: ○ Storage fees, ○ Amenity fees, ○ Renter’s insurance ○ Landlord-paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments
Frequency/Duration	Up to six months per demonstration. The six months are not required to be continuous. The combination of retrospective and prospective rent cannot exceed the six months. As stipulated in STC 10.3, the state may only offer transitional rent to beneficiaries who have not reached the 6-month global cap, within any rolling 12-month period, for HRSN housing interventions that include room and board supports across all of California’s section 1115(a) demonstrations. If the beneficiary received additional HRSN housing interventions providing room and board supports under another one of California’s section 1115(a) demonstrations, the state may only provide the remaining balance of month(s) under the 6-month global cap for HRSN housing interventions that include room and board supports within a rolling 12-month period.
Covered Settings	Covered settings may include: • Single-family and multi-family homes (e.g., apartments, duplexes) • Housing in mobile home communities • Accessory dwelling units (ADUs)

Service Title	Transitional Rent
	• Project-based or scattered site supportive housing • Shared housing • Single room occupancy units • Recovery housing • Hotels/motels when it is serving as the member's primary residence • Interim settings with a small # of individuals per room (e.g., not large dormitory sleeping halls) • Transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming.
Habitability Requirements	Payment may only be made in connection with dwellings that meet HUD quality standards or are habitable as defined by State law. ²
Provider Requirements	• Experience providing this unique service in a culturally and linguistically appropriate and trauma-informed manner; • Knowledge of the principles, methods, and procedures of providing rental assistance or temporary housing; and • Screened and enrolled/credentialed in accordance with All Plan Letter 19-004 or superseding APL.
Exclusions	As stated in STC 10.4, this service cannot be provided in the following settings: • Congregate sleeping space, • Facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), • Facilities where sleeping space are not available to residents 24 hours a day, • Facilities without private sleeping space.

2. Eligibility

Transitional Rent will be provided through the Medi-Cal managed care delivery system and only available to Medi-Cal members enrolled in MCPs. Transitional Rent will not be a covered service for members enrolled in Medi-Cal Fee-for-Service.

² See e.g., California Civil Code §§ 1941, 1941.1, 1941.3

Medi-Cal members enrolled in MCPs may be eligible for Transitional Rent if they meet the following four eligibility requirements:

- (A) Inclusion in one of the transitioning populations;**
- (B) Satisfaction of the clinical risk factor requirement;**
- (C) Satisfaction of the social risk factor requirement; and**
- (D) Has not reached their 6-month global cap for room and board-only supports.**

All of the eligibility requirements, including the list of transitioning populations and clinical and social risk factor requirements, will be publicly posted for transparency for members, managed care plans, providers, and stakeholders. In addition, MCPs will be required to display on their websites all populations they have optionally elected to cover for Transitional Rent, as well as the associated eligibility requirements. Members and the public have access to the complete listing of MCPs by county, along with a link to each of their websites, on the Medi-Cal managed care health plan directory page of the DHCS website here:

<https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx>.

During implementation phases where MCPs will elect to use only some of the eligibility criteria approved in this protocol, in line with STC 10.7, the state will send a letter to CMS 30 days prior to implementation notifying CMS of the eligibility criteria being used for each MCP.

This requirement will take effect prior to the commencement of coverage in July 2025, and will remain in effect for the duration of the demonstration.

(A) Transitioning Populations

To be eligible for Transitional Rent, individuals must fall within one or more of the seven transitioning populations set forth in the table below.

Covered Populations	Definition
(1) Transitioning out of an <u>institutional or congregate residential setting</u>	Individuals transitioning out of an institutional or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use disorder treatment facility, an inpatient or residential mental health facility, or nursing facility.
(2) Transitioning out of a <u>carceral setting</u>	Individuals transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities.

Covered Populations	Definition
(3) Transitioning out of <u>interim housing</u>	Individuals transitioning out of transitional housing, rapid rehousing, a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing.
(4) Transitioning out of <u>recuperative care or short-term post-hospitalization housing</u>	Individuals transitioning out of short-term post-hospitalization housing or recuperative care, whether the stay was covered by Medi-Cal managed care, or another source. When covered by Medi-Cal managed care, coverage of recuperative care, short-term post-hospitalization housing, and Transitional Rent will be limited to a combined duration of six months of coverage every 12 months (assessed on a rolling basis).
(5) Transitioning out of <u>foster care</u>	Individuals up to age 26 who transitioned out of foster care either in California or in another state.
(6) <u>Unsheltered homeless as described in 24 CFR part 91.5</u>	Individuals or families 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 (as provided in part (1)(i) of the definition of homeless at 24 CFR § 91.5).
(7) <u>Eligible for Full-Service Partnership (FSP)</u>	FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services. Until July 1, 2026, the eligibility criteria for FSP are set forth in Cal. Code Regs. Tit. 9, § 3620.05 and require a significant mental health condition as described in Welfare & Institutions Code § 5600.3 and the presence of at least one qualifying risk factor (as identified in Cal. Code Regs. Tit. 9, § 3620.05), such as experiencing or a risk of homelessness. Under the criteria that will take effect on July 1, 2026, set forth in Welfare & Institutions Code § 5887(d), to be eligible for FSP a person 25 and under must (1) meet the criteria for a mental health condition specified in Welfare & Institutions Code § 14184.402(d), notwithstanding the age limitations provided therein, or have an SUD as defined in Welfare & Institutions Code § 5891.5(c) and (2) be in one of the priority populations identified in Welfare & Institutions Code § 5892(d), which includes those who are experiencing or at risk

Covered Populations	Definition
	of homelessness, among other groups. For those 26 and over, the eligibility requirements are the same as for those 25 and under except that the criteria for a qualifying mental health condition are set forth in Welfare & Institutions Code § 14184.402(c).

(B) Clinical Risk Factor Requirement

To meet the clinical risk factor requirement, a member must have one or more of the five qualifying clinical risk factors provided in the table below.

Clinical Risk Factors	
(1) Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS), as set forth in the table below; or	Behavioral Health Risk Factors ³
(2) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS), as set forth in the table below; or	
(3) One or more serious chronic physical health conditions; or	Physical Health Risk Factors
(4) One or more physical, intellectual, or developmental disabilities; or	
(5) Individuals who are pregnant up through twelve months postpartum.	

SMHS, DMC, and DMC/ODS Access Criteria by Program and Age Group	
DMC and DMC/ODS Adults	Medi-Cal members age 21 or older meet access criteria for DMC-ODS or DMC services if they meet <u>at least one</u> of the following criteria: 1) Have at least one diagnosis from the most current version of the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders <u>OR</u>

³ In determining whether a member may access Transitional Rent based on one or more behavioral health clinical risk factors, DHCS intends to apply the policy approach that governs whether a member may access SMHS, or DMC/DMC-ODS services more generally, which are set forth in [APL 22-005](#), [BHIN 22-011](#), and [BHIN 24-001](#).

SMHS, DMC, and DMC/ODS Access Criteria by Program and Age Group	
	2) Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
DMC and DMC/ODS Children	Medi-Cal members under 21 are eligible for DMC-ODS or DMC if they meet the medical necessity standard for one or more SUD services provided through these delivery systems, as recommended by a licensed behavioral health practitioner.
SMHS Adults	Medi-Cal members aged 21 or older qualify for SMHS if they meet <u>both</u> of the following criteria: 1) The individual has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability or dysfunction in social, occupational, or other important activities. b. A reasonable probability of significant deterioration in an important area of life functioning. <u>AND</u> 2) The individual's condition is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems. b. A suspected mental disorder that has not yet been diagnosed.

SMHS, DMC, and DMC/ODS Access Criteria by Program and Age Group	
SMHS Children	Medi-Cal members under age 21 qualify for SMHS if they meet <u>both</u> of the following requirements: a) The individual has at least one of the following: i. A significant impairment ii. A reasonable probability of significant deterioration in an important area of life functioning iii. A reasonable probability of not progressing developmentally as appropriate. iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. b) The individual's conditions as described in (a) above is due to one of the following: i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the International Statistical Classification of Disease and Related Health Problems. ii. A suspected mental health disorder that has not yet been diagnosed. iii. Health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, or neglect.

(C) Social Risk Factor Requirement

To meet the social risk factor requirement, a member must be experiencing or at risk of homelessness as defined in the table below.

Social Risk Factor	
Homeless or At Risk of Homelessness	Individual must meet the US Department of Housing and Urban Development's (HUD's) current definition of homeless or at risk of homelessness as codified at 24 CFR part 91.5, with three modifications: 1) If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and 2) 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; and 3) For the at risk of homelessness definition at 24 CFR § 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply.

3. Process for Identifying Eligible Members

- a. **Member Identification:** MCPs will be required to use a variety of methods to identify members who may be eligible for from Transitional Rent.
 - i. **Referrals:** DHCS expects MCPs to source the majority of referrals for Transitional Rent from the community; specifically, from the MCP's network of providers and other community-based referral sources already serving members. MCPs will be required to consider requests for Transitional Rent from members and on behalf of members from their families, guardians and caregivers, Enhanced Care Management (ECM) Providers, Community Health Workers, Community Supports and Transitional Rent Providers, other Providers, counties and county agencies such as county behavioral health departments and county housing departments, homeless services organizations and other CBOs, Public Housing Authorities (PHAs), Continuums of Care (CoCs), local public health departments, and local child welfare departments. MCPs will be required to inform members and their networks of providers about Transitional Rent and what the process is to request it. MCPs will also be

required to train their call centers about how to manage referrals for Transitional Rent.

- ii. **Review of Internal Data:** DHCS expects MCPs to identify members who may be eligible for Transitional Rent through a review of internal MCP data (e.g., Street Medicine place of service (POS) code 27, Z codes for homelessness, information on members receiving Housing Transition Navigation Services, and to the extent possible, Homeless Management Information System (HMIS) matching).
- iii. **HRSN Screening Tool:** DHCS will not require MCPs or their contracted networks of providers to use a standardized screening tool for Transitional Rent but will require that any screening be culturally appropriate and trauma-informed. DHCS may offer guidance and technical assistance to MCPs to support their development or use of culturally appropriate and trauma-informed screening techniques.

b. **Eligibility Determination:**

- i. DHCS will release statewide guidance which standardizes referral and authorization practices for Transitional Rent so that practices are as aligned as possible among MCPs, housing providers, counties, other referral sources, and stakeholders at launch. The referral standards will define the information MCPs are expected to collect from referring entities for individuals being referred to an MCP for Transitional Rent.
- ii. Upon receipt of the information from a referring entity, the MCP will determine whether the member is eligible for Transitional Rent and authorize the service.
- iii. Eligibility determination will consist of verification that:
 - 1. The member is enrolled in the MCP;
 - 2. The member is included in one of the transitioning populations;
 - 3. The member has at least one qualifying social risk factor;
 - 4. The member has at least one qualifying clinical risk factor;
 - 5. The member is included in a population that the MCP has elected or been required to cover from within the universe of eligible individuals provided in Section 2 above; and
 - 6. The member has not exceeded the maximum service limits.
- iv. Authorization practices will be standardized as much as possible to minimize administrative burden among Transitional Rent providers and housing partners.

4. Application of Clinical Criteria and Medical Appropriateness Determination

- a. In addition to inclusion in a transitioning population, Transitional Rent must be identified as medically appropriate based on clinical and social risk factors.
- b. Medical appropriateness must be determined by a provider at the plan or network level using their professional judgment.
- c. Where a provider at the plan or network level, using their professional judgment, determines that the member has at least one qualifying social risk factor and one qualifying clinical risk factor, Transitional Rent may be found to be medically appropriate.

5. Care Plan Development Based on Assessment of Need

- a. **Individualized Housing Support Plan:** In alignment with ECM and Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, and Housing Deposits (“the Housing Trio” of Community Supports which are approved under managed care In Lieu of Services authority, not under the BH-CONNECT demonstration), members receiving Transitional Rent will be required to have an individualized housing support plan. The purpose of the individualized housing support plan is to ensure that Transitional Rent is being provided as part of a larger strategy for achieving long-term housing stability for the member. The individualized housing support plan will be required to have the following components:
 - i. The plan must identify the permanent housing strategy for the member (e.g., connections to permanent supportive housing, connections to longer-term vouchers, etc.).
 - ii. The plan must identify the full range of permanent supports that could be available to the member and how, when, and with what assistance, the member will apply for these supports.
 - iii. The plan must be informed by member preferences and needs and reviewed and revised as needed based on changes in member circumstances.
 - iv. The plan must be based on a housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member’s approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
 - v. The plan must be developed in a way that is culturally appropriate and trauma-informed.
- b. **Closed Loop Referrals:** Closed-Loop Referrals (CLR) are a key component of DHCS’s Population Health Management Program under CalAIM. DHCS intends to require that MCPs implement its CLR requirements beginning on July 1, 2025,

which aligns with the Optional go-live for MCPs. The CLR requirements will apply to Transitional Rent, as well as ECM and Community Supports.

6. No Duplication or Displacement of Other Housing Resources

- a. Transitional Rent will supplement and not supplant services provided through other state, local, or federally funded programs.
- b. Transitional Rent will not duplicate state, local, or federally funded rental assistance or housing.
- c. As part of the development and execution of the Housing Support Plan, members must be supported in applying for other available state, local, and federal housing subsidies.

ATTACHMENT H
HRSN Services Matrix

Target Populations	Housing Services
Transition Populations who meet the clinical and social risk factors. Transitions defined as:	Rent/temporary housing for up to 6 months
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 facility, an inpatient or residential mental health treatment facility, or nursing facility.	X
Are transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities	X
Are transitioning out of foster care	X
Are transitioning out of short-term recuperative care or short-term post-transition housing	X
Are transitioning out of transitional housing or rapid re-housing	X
Are transitioning out of a homeless shelter/interim housing, including domestic violence shelters or domestic violence housing	X
Meet the criteria of unsheltered homelessness as described at 24 CFR part 91.5	X
Meet eligibility criteria for a Full Service Partnership (FSP) program	X

Social Risk Factor
Beneficiaries must 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: 1) If exiting an institution individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and 2) 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 The state only seeks to use 91.5 (1)(ii) and (1)(iii), (2), and (3) of the at-risk of homeless definition and will omit 91.5 (1)(i) from their definition.

BH-CONNECT HRSN Matrix: Clinical Criteria

Clinical Condition	Clinical Criteria Detail
Clinical Condition 1	Pregnant individuals
Clinical Condition 2	Up through 12 months postpartum
Clinical Condition 4	One or more serious chronic physical health condition
Clinical Condition 5	Physical, intellectual, or developmental disabilities
Clinical Condition 6	Meets the access criteria for Drug Medi-Cal (DMC)
Clinical Condition 7	Meets the access criteria for Drug Medi-Cal Organized Delivery System (DMC-ODS)
Clinical Condition 8	Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS) stipulated in this matrix

Access Criteria	State Criteria
Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Adults	Medi-Cal members age 21 or older meet access criteria for DMC-ODS or DMC services if they meet at least one of the following criteria: (1) Have at least one diagnosis from the most current version of the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders OR (2) Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Children	Members under 21 are eligible for DMC-ODS or DMC if they meet the medical necessity standard for one or more SUD services provided through these delivery systems, as recommended by a licensed behavioral health practitioners.
Medi-Cal Specialty Mental Health Services Children	Medi-Cal members under age 21 qualify for SMHS if they meet both of the following requirements: a. The beneficiary has at least one of the following: i. a significant impairment ii. A reasonable probability of significant deterioration in an important area of life functioning iii. A reasonable probability of not progressing developmentally as appropriate. iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. b. The beneficiary's conditions as described in (2) above is due to one of the following: i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the International Statistical Classification of Disease and Related Health Problems. ii. A suspected mental health disorder that has not yet been diagnosed. iii. Individuals with health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect.
Medi-Cal Specialty Mental Health Services Adults	Medi-Cal members age 21 or older qualify for SMHS if they meet both of the following criteria: (1) the beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability or dysfunction in social, occupational, or other important activities. b. A reasonable probability of significant deterioration in an important area of life functioning. AND (2) the beneficiary's condition is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems. b. A suspected mental disorder that has not yet been diagnosed.

ATTACHMENT I
HRSN Implementation Plan

Attachment I

Transitional Rent Implementation Plan

In accordance with the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration and Special Terms and Conditions (STCs), the Transitional Rent Implementation Plan provides additional detail on the strategic approach to implementing Transitional Rent.

I. Implementation Timeline & Approach. DHCS will phase in the implementation of Transitional Rent over the course of the demonstration.

a. Implementation Approach.

- i. DHCS will implement Transitional Rent in the Medi-Cal Managed Care (MCMC) Delivery System.
- ii. Building on the DHCS' ongoing transformation of Medi-Cal, Managed Care Plans (MCPs) will offer Transitional Rent as part of a set of services known as Community Supports that promote the objectives of the Medicaid program by addressing Medi-Cal members' Health Related Social Needs (HRSNs), thereby helping to improve health outcomes and the quality and experience of care and avoid higher, costlier levels of care. Since 2022, MCPs have been encouraged to offer as many of the existing 14 Community Supports as possible.¹ This list of 14 pre-approved Community Supports was developed in part from foundational work done in the prior successful demonstration including the Whole Person Care (WPC) Pilots² and the Health Homes Program (HHP)³. Community Supports build on successful WPC and HHP effort and learnings.
- iii. Transitional Rent will be a required service for MCPs to offer. The other Community Supports will remain optional.
- iv. Key required activities for the MCPs are consistent with those of the other Community Supports and include:
 1. Building a network of Transitional Rent providers.
 2. Developing policies and procedures and conducting training for Transitional Rent providers to support administration of the service.

¹ The Community Supports Policy Guide contains the comprehensive list of Community Supports MCPs can offer: <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf>

² See the Final Evaluation of the WPC Pilots program for more information: <https://www.dhcs.ca.gov/CalAIM/Documents/Final-Evaluation-of-California-Whole-Person-Care-WPC-Program-05042023.pdf>

³ See the HHP Second Interim Evaluation for more information: <https://healthpolicy.ucla.edu/sites/default/files/2023-04/second-interim-report-hhp-mar2022-ada.pdf>

3. Conducting eligibility and service authorization determinations, including by:
 - a. Identifying members who may be eligible for Transitional Rent through review of internal MCP data, e.g., Z Codes, Street Medicine place of service (POS) code 27, member-level data, specifically individuals who qualify for the “individuals experiencing homelessness Enhanced Care Management (ECM) Population of Focus”, and Homeless Management Information System (HMIS) matching;
 - b. Coordinating with ECM, Community Supports, and Community Health Worker service providers to facilitate outreach;
 - c. Establishing a referral pathway with County Behavioral Health Delivery Systems.
4. Accepting referrals from the MCP’s Provider Network and other community-based referral sources already serving members
5. Connecting members receiving Transitional Rent to ECM and the existing housing-related Community Supports, as well as other Community Supports and other appropriate covered Medi-Cal services and social services for which they may qualify.
6. Ensuring that members receiving Transitional Rent have an individualized housing support plan, to ensure that Transitional Rent is being provided as part of a larger strategy for achieving long-term housing stability for the member.
7. Coordinating closely with county behavioral health delivery systems, Public Housing Authorities (PHAs), and other Transitional Rent providers, including on the development of the housing support plan and the handoff to rental subsidies and related supports funded under the Behavioral Health Services Act (BHSA)⁴, or other non-Medicaid funding sources.
8. Sharing data to facilitate integrated whole-person care for the member in accordance with the CalAIM Data Sharing Authorization Guidance and any relevant Memoranda of Understanding (MOUs).
9. Establishing payment mechanisms with Transitional Rent providers, including processes for Transitional Rent providers to submit claims or invoices with requisite information, verifying invoices are payable or providing claims remittances, and providing timely payments.
10. Receiving payment from DHCS.
11. Ensuring compliance with provider contracting, credentialing, and oversight.

⁴ A separate state-level reform, known as the Behavioral Health Services Act (BHSA), which goes into effect on 7/1/2026, will open new housing options for individuals with significant behavioral health needs.

12. Ensuring the provision of Transitional Rent is culturally appropriate and trauma-informed.

b. Phased Implementation of Transitional Rent

- i. All members must meet the eligibility criteria set forth in Section 2 of the Protocol for Assessment of Member Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services (“Eligibility”). DHCS intends to phase in populations on the following timeline:
 1. No sooner than July 2025:
 - a. Optional launch for Medi-Cal managed care plans (MCPs) to cover Transitional Rent.
 - b. MCPs electing to launch Transitional Rent at this time may select one or more Transitional Rent-eligible populations to cover with DHCS approval.⁵
 - c. MCPs electing to launch at this time will be required to continue to cover Transitional Rent for all Transitional Rent-eligible populations they elected to cover.
 2. No sooner than January 2026:
 - a. Mandatory launch for all MCPs to cover Transitional Rent. From this point in time, MCPs will be required to cover Transitional Rent for members meeting the Behavioral Health Population of Focus criteria.
 - b. The Behavioral Health Population of Focus will be comprised of MCP members who are eligible for Transitional Rent and who have one of the qualifying behavioral health clinical risk factors for Transitional Rent provided in Section 2b of the Protocol for Assessment of Member Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services (“Eligibility”).
 - c. In addition, MCPs may elect to cover Transitional Rent for other Transitional Rent-eligible populations, with DHCS approval.
 - d. MCPs electing to launch earlier than this mandatory launch phase will be required to continue covering Transitional Rent for all Transitional Rent-eligible populations they previously elected to cover.
 3. No sooner than January 2027:
 - a. MCPs must cover Transitional Rent for all populations who meet the eligibility criteria for Transitional Rent.

⁵ As established in Section 2 of the Protocol for Assessment of Member Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services, DHCS will develop a list of optional populations that MCPs may voluntarily cover; optional coverage will be limited to the identified populations. All of the optional populations will fall within the universe of members eligible for Transitional Rent.

- c. The timeline and approach will ensure that DHCS collaborates with MCPs, the housing sector, the county behavioral health delivery system, and other key implementation partners. DHCS' ongoing support of launch and early implementation will include:
 - i. Throughout 2025:
 1. Assembling regular stakeholder engagement meetings with MCPs, counties, housing agencies and service providers, housing subject matter experts, members, and advocates to inform finalized state policies and implementation guidance.
 2. Amending the MCP Contract to include applicable requirements for Transitional Rent.
 3. Developing and releasing comprehensive MCP policy guidance, which will include more detailed requirements for MCPs' implementation of the Transitional Rent service.
 4. Updating reporting and data exchange guidance defining required reporting to DHCS, including updating the Healthcare Common Procedure Coding Systems Codes (HCPCS) codes that will be used for Transitional Rent.
 5. Finalizing and releasing a payment model and corresponding maximum reimbursement ceilings for Transitional Rent.
 6. Providing technical assistance to MCPs and Transitional Rent providers, including about payment and reporting/data exchange for Transitional Rent.
 7. Developing a monitoring plan for Transitional Rent.
 - ii. Throughout 2026:
 1. Continuing to regularly engage with MCPs, providers engaged as or interested in becoming Transitional Rent providers, and other stakeholders to discuss implementation progress, challenges, and to inform necessary updates to the MCP policy guidance.
 2. Updating MCP policy guidance, including to reflect population-specific guidance as part of the phased implementation.
 3. Updating MCP contract requirements as needed for CY 2027.
 4. Evaluating MCP-reported data to better understand Transitional Rent service delivery and make continuous improvements.
 5. Continuing to provide technical assistance to MCPs and other implementation partners.
 6. Monitoring the implementation of Transitional Rent.

II. Data Sharing and Key Partnerships

a. Data Sharing

- i. Referrals & Authorizations
 1. Overview: Building on previous implementation experience for the existing Community Supports services, DHCS will release statewide guidance which standardizes referral and authorization practices for Transitional Rent so that practices are as aligned as possible among MCPs, housing providers, counties, other referral

sources and other stakeholders at launch. The referral standards will define the information MCPs are required to collect from referring entities for individuals being referred to an MCP for Transitional Rent. DHCS will work with stakeholders to define and standardize the data elements that MCPs must collect and consider to determine eligibility for Transitional Rent pursuant to the eligibility criteria set forth in Section 2 of the Protocol for Assessment of Member Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services. These elements may include (but are not limited to) housing status; information about receipt of related services, including the provider(s) of those services (e.g., ECM, housing Community Supports); information verifying that the member has not already received the maximum available Transitional Rent; and any housing options already identified and information about appropriateness of those options for the member. The referral and authorization standards will incorporate verification by a provider that Transitional Rent is medically appropriate for the Member.

ii. Closed-Loop Referrals

1. Overview: Closed-Loop Referrals (CLR) are a key component of DHCS's Population Health Management Program under CalAIM. DHCS intends to require that MCPs implement its CLR requirements beginning on July 1, 2025, which aligns with the Optional go-live for MCPs. The CLR requirements will apply to Transitional Rent, as well as ECM and Community Supports.

iii. Reporting

1. Overview: DHCS will work with MCPs to monitor their implementation of Transitional Rent by leveraging the existing reporting framework that was devised to support the ECM and Community Supports initiatives. MCPs are already familiar with the quarterly reporting process, and, as noted previously, DHCS will update the data elements the MCPs will be required to submit for Transitional Rent early in 2025. At a minimum, DHCS intends to collect the following key data elements from the MCPs:
 - a. Number of members who have received Transitional Rent, along with key demographic data
 - b. The number of members who have been referred to receive Transitional Rent
 - c. The number of members who have been authorized to receive Transitional Rent
 - d. The number of members who have been denied for Transitional Rent
 - e. Provider network data, including the total number of contracted providers MCPs have to deliver Transitional Rent

- f. The number of members who are connected to federal and state housing assistance programs through its MCP quarterly reporting requirements.
 - iv. Public Reporting: State law requires DHCS to publish an annual report regarding utilization of ECM and Community Supports, which must include the characteristics and demographics of those served⁶. When Transitional Rent launches, it will be subject to the annual reporting requirement. DHCS will continue to leverage its existing reporting infrastructure to meet this requirement.
- b. **Key Partnerships and Approach to Soliciting Community Partner Feedback:**
To support the delivery of Transitional Rent, MCPs must develop partnerships with the entities listed below:
 - i. **Transitional Rent Providers:** organizations serving people experiencing homelessness and who may themselves be housing providers or contract with housing providers. Key activities for Transitional Rent providers include:
 - 1. Contracting as an MCP network provider to provide Transitional Rent.
 - 2. Paying landlords/housing providers for furnishing housing to eligible members or contract with organizations that perform this function.
 - 3. Receiving payment from their contracted MCP for delivering the service.
 - 4. Helping members access ECM, other housing-related Community Supports, and other needed services.
 - 5. Sharing data to facilitate integrated whole-person care for the member in accordance with DHCS' data sharing requirements.
 - 6. Sharing data and coordinating with county behavioral health delivery systems to support the transition of members from Transitional Rent to rental subsidies and related supports funded under the BHSA or other non-Medicaid funding sources.
 - ii. **County Behavioral Health Delivery Systems:** members living with significant behavioral health needs receive specialty behavioral health services through separate delivery systems, known as the Specialty Mental Health System (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS). Individuals served by these delivery systems often have a strong connection to the providers and plans that administer these services. As mentioned, the separate state-level reform, known as BHSA, will open new housing options for individuals with significant behavioral health needs. DHCS' vision is that Transitional Rent will also create a glide path into these housing options for members who qualify for both. Accordingly, County

⁶ DHCS implements this requirement by publishing a comprehensive set of data in the public domain, which is refreshed quarterly:

<https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117>

Behavioral Health Delivery Systems will refer their members to MCPs for the coverage of Transitional Rent, along with other housing-related Community Supports services. Key activities for the County Behavioral Healthy Delivery Systems include:

1. Outreaching to and engaging individuals who are experiencing or at risk of homelessness and may be eligible for coverage of Transitional Rent.
2. Contracting as an MCP network provider to provide Transitional Rent, consistent with the provisions set forth in Section II(b)(i)(1)-(5).
3. Receiving data from and coordinating with MCPs to support the transition of members from Transitional Rent to rental subsidies and related supports funded under the BHSA or other non-Medicaid funding sources.
4. Working in close coordination and alignment with MCPs on the development of individualized housing support plans for helping members with significant behavioral health needs transition from Transitional Rent to permanent housing or permanent rental subsidies, including those funded under the BHSA.

- iii. **ECM Providers, Community Supports Providers, and other Health Care and Social Services Providers:** DHCS' vision is that ECM and the existing "Housing Trio" of housing-related HRSN services covered as Community Supports (Housing Transition Navigation, Housing Tenancy Sustaining Services and Housing Deposits), will be companion services to Transitional Rent, and that MCPs and ECM and Housing Trio Providers will work to achieve strong connectivity between the services. DHCS expects that engagement in ECM and the Housing Trio will be a referral point into Transitional Rent for many members. For those not already engaged in ECM and Housing Trio services when they are referred for Transitional Rent, DHCS seeks to facilitate member access to and engagement in these services. Members will not be required to be enrolled in ECM or receive one of the Housing Trio services as a condition of eligibility for Transitional Rent, consistent with Housing First best practices. Key activities for ECM providers, Housing Trio providers, and other health care and social service providers include:
1. Referring members to their MCP for Transitional Rent.
 2. Receiving referrals for those entering into Transitional Rent who may not already be engaged in ECM or the Housing Trio.
 3. Seeking to engage referred members in ECM, the Housing Trio, and other needed services. Note that in many cases, the Housing Trio provider may also be functioning as the member's Transitional Rent provider. ECM providers will play a lead role in helping address members' needs, including providing connections to and coordinating all Medi-Cal covered services (including Transitional Rent and other Community Supports), as well as providing referrals to social services.

4. Sharing data with the MCP to facilitate integrated whole-person care for the member in accordance with the CalAIM Data Sharing Authorization Guidance.
 5. Sharing data and coordinating with county behavioral health delivery systems to support the transition of members from Transitional Rent to permanent housing funded under the BHSA or other non-Medicaid funding sources.
- c. **Approach to Soliciting Community Partner Feedback:** Gathering feedback from MCPs, counties, housing agencies and service providers, members, advocates, and other community stakeholders has been essential to informing the policy design for Transitional Rent, and will continue to be critical throughout the phased implementation. DHCS will continue to engage with the following groups to vet policies for Transitional Rent, and to inform the development of additional operational guidance.
- i. Regular meetings with housing experts at MCPs
 - ii. Regular workgroup meetings with MCP financial staff focused on the payment model
 - iii. Regular meetings with behavioral health delivery systems
 - iv. Regular meetings (as needed) with an interdisciplinary forum known as the Implementation Advisory Group (IAG) comprising MCPs, county behavioral health delivery systems, and providers
 - v. Weekly meetings with MCP and County Behavioral Health Directors' Associations (as needed)

III. Partnerships with State and Local Entities: At a minimum, MCPs will be expected to undertake the following efforts to develop partnerships with the key entities listed below in the delivery of Transitional Rent. Coordination with these entities will be essential in realizing DHCS' goal of Transitional Rent serving as a bridge to permanent housing. DHCS also intends to continue engaging with these entities through stakeholder engagement forums.

- a. **Continuums of Care (CoCs):** The state has active CoCs that develop locally appropriate approaches to end homelessness. MCPs will be required to work closely with their local CoCs in implementing Transitional Rent. CoCs and MCPs will need to work together to ensure coordination and information sharing, as well as non-duplication of services, through processes such as the Coordinated Entry System and data sharing agreements. Many MCPs and CoCs have developed relationships, including data sharing agreements related to HMIS, in response to the Housing and Homelessness Incentive Program (HHIP).
- b. **Public Housing Authorities (PHAs):** PHAs administer HUD-funded public housing and permanent housing vouchers, including but not limited to Housing Choice Vouchers (HCVs). Notwithstanding significant waiting lists, HCVs remain a critical source of permanent rental subsidies and subsidized housing throughout the State. MCPs will be required to build relationships with their local PHAs. MCPs, county behavioral health delivery systems, and PHAs can work together to maximize the uptake of these federally funded permanent housing supports by

Medi-Cal members receiving Transitional Rent. For example, MCPs may offer Housing Transition and Navigation Services to members who have vouchers but need assistance locating and applying for an apartment unit.

c. Key activities for CoCs and PHAs include:

- i. Work in partnership with MCPs to identify potentially eligible members for Transitional Rent.
- ii. Assist members in transitioning from Transitional Rent to permanent housing where possible, including through coordinated entry processes and connections to PHAs and BHSA-funded housing interventions.
- iii. Share data with MCPs, county behavioral health delivery systems, and other providers to support care coordination, transition to permanent housing for members eligible for or receiving Transitional Rent as well as to ensure non-duplication of services.
- iv. May serve as Transitional Rent providers if they have the requisite capabilities to administer the Medi-Cal service.

IV. Information Technology Infrastructure

- a. DHCS requires MCPs to have an IT infrastructure and data analytic capabilities to support Transitional Rent, including the capabilities to:
 - i. Consume and use claims and encounter data, as well as other data types specified in DHCS guidance;
 - ii. Assign members to Transitional Rent providers;
 - iii. Keep records of members receiving Transitional Rent and their consent;
 - iv. Securely share data with Transitional Rent providers;
 - v. Receive, process, and send encounters and invoices from Transitional Rent Providers to DHCS in accordance with DHCS standards;
 - vi. Receive and process supplemental data from Transitional Rent Providers;
 - vii. Send Transitional Rent supplemental data to DHCS; and
 - viii. Open, track, and manage referrals to Transitional Rent providers.
- b. **Closed Loop Referrals for Transitional Rent:** DHCS requires MCPs to build systems for collecting updates on CLR status on at least a monthly basis with Transitional Rent providers and other service providers. MCPs may choose their own systems to store data and process referrals to implement the CLR requirements. DHCS will not require nor provide a universal system to implement CLRs. Some MCPs may choose to procure a CLR platform through an outside vendor while others may continue to directly receive and process referrals through existing health records and systems.
- c. **Billing, Invoicing, and Encounter Data Reporting:** DHCS will require MCPs to submit encounter data for Transitional Rent through existing encounter data reporting mechanisms for all covered, contracted and rendered services. DHCS has also stipulated that MCPs must require their contracted Transitional Rent providers to submit compliant claims for the provision of Transitional Rent services. Providers that are unable to submit compliant claims may instead submit invoices to MCPs with the minimum necessary data elements defined by DHCS. In these instances, MCPs are responsible for translating invoice data into compliant encounters for submission to DHCS.

- d. **DHCS Objectives to Improve Encounter Data Quality:** DHCS is coordinating several department-wide activities to improve encounter data quality, utility, and reporting. Specific objectives of these activities include:
 - i. Efficiently identifying major encounter data reporting issues and deficiencies
 - ii. Ensuring stakeholders are equipped with appropriate reporting tools and processes to identify and understand their encounter data reporting deficiencies, and implementing clear expectations for remediation that are aligned across stakeholders
 - iii. Adhering to CMS T-MSIS encounter data reporting requirements and being responsive to CMS priority Outcomes Based Assessments; and
 - iv. Receiving high-quality Medi-Cal encounter data to support development of managed care capitation rates and inform other business priorities, including the introduction and ongoing monitoring of Community Supports, including Transitional Rent
- e. **DHCS Encounter Data Quality Improvement Activities:** DHCS seeks to advance these objectives by:
 - i. Having a centralized data quality team to refine internal encounter data monitoring and reporting and address high priority T-MSIS data issues
 - ii. Updating encounter data monitoring reports to reflect new CMS and DHCS program requirements, which could be expanded to include Community Supports and Transitional Rent reporting measures
 - iii. Having an encounter data outreach and education team tasked with improving coordination and communication with MCPs and other program areas within the department
 - iv. Implementing a targeted provider encounter data improvement effort to connect providers with technical resources to address persistent encounter data reporting issues
 - v. Developing MCP-facing dashboards to improve MCP oversight and accountability for encounter data reporting deficiencies
 - vi. Developing All Plan Letters and refining MCP contract language to memorialize updated expectations and processes for encounter data reporting.
- f. **Monitoring & Oversight:** DHCS is responsible for monitoring MCPs' implementation of Transitional Rent, and for following up through technical assistance and/or escalation where deficiencies are identified. DHCS vision is to be strongly data-centered in the way that monitoring processes are carried out, as well as to be as consistent as possible in the approach across the MCPs and across DHCS teams performing the oversight. Establishing a strong data foundation for this work is a journey rather than a destination, and DHCS intends to utilize various methods of monitoring activities in phases, according to the type and quality of quantitative data available. DHCS will assess MCPs' implementation of Transitional Rent in the same manner it is currently following for Community Supports across the following domains:
 - i. Provider Networks

- ii. Member Access to Services (including Provider and Member Awareness, Utilization, and Equitable Access)
- iii. Delivery of the Services (including Grievances and Appeals)

V. Tracking and Improving Housing Assistance Program Enrollment:

- a. Overview: Transitional Rent is designed to provide a time-limited opportunity to improve health outcomes by helping a member exit homelessness, establish a bridge to permanent housing, and thereby realize the improvements in physical and behavioral health and functioning that have been shown to result from long-term housing stability. DHCS is working to align the design of Transitional Rent with federal (HUD) housing assistance programs to increase the likelihood that a recipient of Transitional Rent will qualify for HUD-funded housing assistance. This includes making Transitional Rent payment standards as similar as possible to Housing Choice Voucher and Continuum of Care Program rent payment standards and requiring that permanent housing supported by Transitional Rent will meet similar housing quality/inspection standards as a Housing Choice Voucher or Continuum of Care Program rental assistance. In addition, DHCS is encouraging Managed Care Plans to partner with local public housing authorities and Continuums of Care to adopt policies that will prioritize Transitional Rent recipients for Housing Choice Vouchers and Continuum of Care rental housing assistance whenever possible. Given the objectives of the Transitional Rent program, over time, DHCS would expect to see an increase in the number of members who are connected to federal and state housing assistance programs. As indicated above, DHCS intends to track the number of members who are connected to federal and state housing assistance programs through its MCP quarterly reporting requirements.

VI. Maintenance of Effort (MOE)

- a. DHCS will determine baseline spending for ongoing social services related to housing supports, not including one-time or non-recurring funding, by surveying the Fiscal Forecasting Branch of the California Department of Social Services (CDSS) for a list of programs, and associated appropriations, that meet the definition of ongoing social services related to housing transition supports. To ensure completeness and consistency of reporting, DHCS will utilize the same method for collecting data for the annual MOE reporting required by STC 10.18 of the BH-CONNECT 1115 waiver STCs as for the annual MOE reporting required by STC 8.15 of the CalAIM 1115 waiver STCs.
- b. DHCS has provided the programs that should be considered in determining baseline spending and the relevant appropriation amounts further below in Appendix A. The appendix also contains detail regarding other social services programs that were evaluated but did not meet the definition due to not being ongoing social services or not specifically providing housing transition supports.

VII. Payment Methodology & Rates

- a.** On November 27, 2024, DHCS submitted the payment methodology template requested by CMS, describing its approach to payment for Transitional Rent.

Appendix A

The table below provides funding breakouts tied to the 2023-24 Appropriation (as of the May 2023 Revision), and a link to the premise write-up with specific details of the program.

2023-24 Appropriation

Budget Item	Total	Federal	State/Other
Transitional Housing Supplement	\$5,284,000	\$1,329,000	\$3,955,000
Family Stabilization	\$54,960,000	\$47,974,000	\$6,986,000
Housing Support Program	\$95,000,000	\$56,105,000	\$38,895,000

The State assesses the following programs meets the definition of ongoing social services related to housing transition supports:

- [Transitional Housing Supplement - Administration](#): Provides a housing supplement for youth participating in eligible Transitional Housing Placement programs based on the Fair Market Rate for each county published by the United States Department of Housing and Urban Development.
- [Family Stabilization](#): In addition to an increased level of case management, Family Stabilization may include *transitional housing*, emergency shelter, rehabilitative services, counseling, and other services. Note, providing transitional housing is not a requirement of the program.
- [Housing Support Program](#): Interventions are provided to CalWORKs families to help obtain and keep permanent housing by providing rent and move-in assistance, focused case management and individualized services (legal services, credit repair, etc.).

The following programs were evaluated but deemed not to meet the criteria:

- [Domestic Abuse Homeless Assistance Program](#): Provides CalWORKs applicants two periods of 16 cumulative calendar days of temporary shelter assistance. Note, funding is not explicitly for transitional housing.
- [Documents for Dependent Children](#): Social workers are provided 15 minutes per case to document information on the results of referrals to *transitional housing* or other housing assistance efforts provided to a dependent child in the court report to be submitted at the last regularly scheduled review hearing before a dependent child attains 18 years of age. Note, funding is for administrative time for social workers.
- [Housing for Non-Minor Dependents](#): Social workers will require one hour per case to evaluate placement and emergency housing resources. Note, funding is for administrative time for social workers.
- [Housing and Disability Advocacy Program](#): Housing supports (outreach, case management) and disability benefit application assistance to people likely eligible for disability benefits and experiencing homelessness or at risk of homelessness.

ATTACHMENT J

DSHP List

Attachment J
Approved List of Designated State Health Programs (DSHPs)

The DSHP-eligible expenditures in this list exclude prohibited costs, in accordance with STC 11.2.

Program	Description	DSHP-Eligible Expenditures
Department of Developmental Services (DDS or Lanterman)	The Lanterman Act provides for the coordination and provision of services and supports to enable people with intellectual and developmental disability to lead more independent, productive, and integrated lives.	\$2,438,721,971
Total Allowable DSHP-Eligible Expenditures		\$2,438,721,971
Total Allowable DSHP-Eligible Expenditures with Adjustment		\$2,316,785,872
Total DSHP Cap. The state must not claim more than the capped amount of DSHP.		\$1,615,000,000

ATTACHMENT K

Reserved for **Provider Rate Increase**

Attestation Table