VENTURA COUNTY

BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

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September 2024

CALIFORNIA'S BEHAVIORAL HEALTH TRANSFORMATION (BHT): PROPOSITION 1 AND BH-CONNECT

Ventura County Implementation Update

Dr. Loretta Denering, Director & Courtney Lubell, Special Projects/BHSA Manager

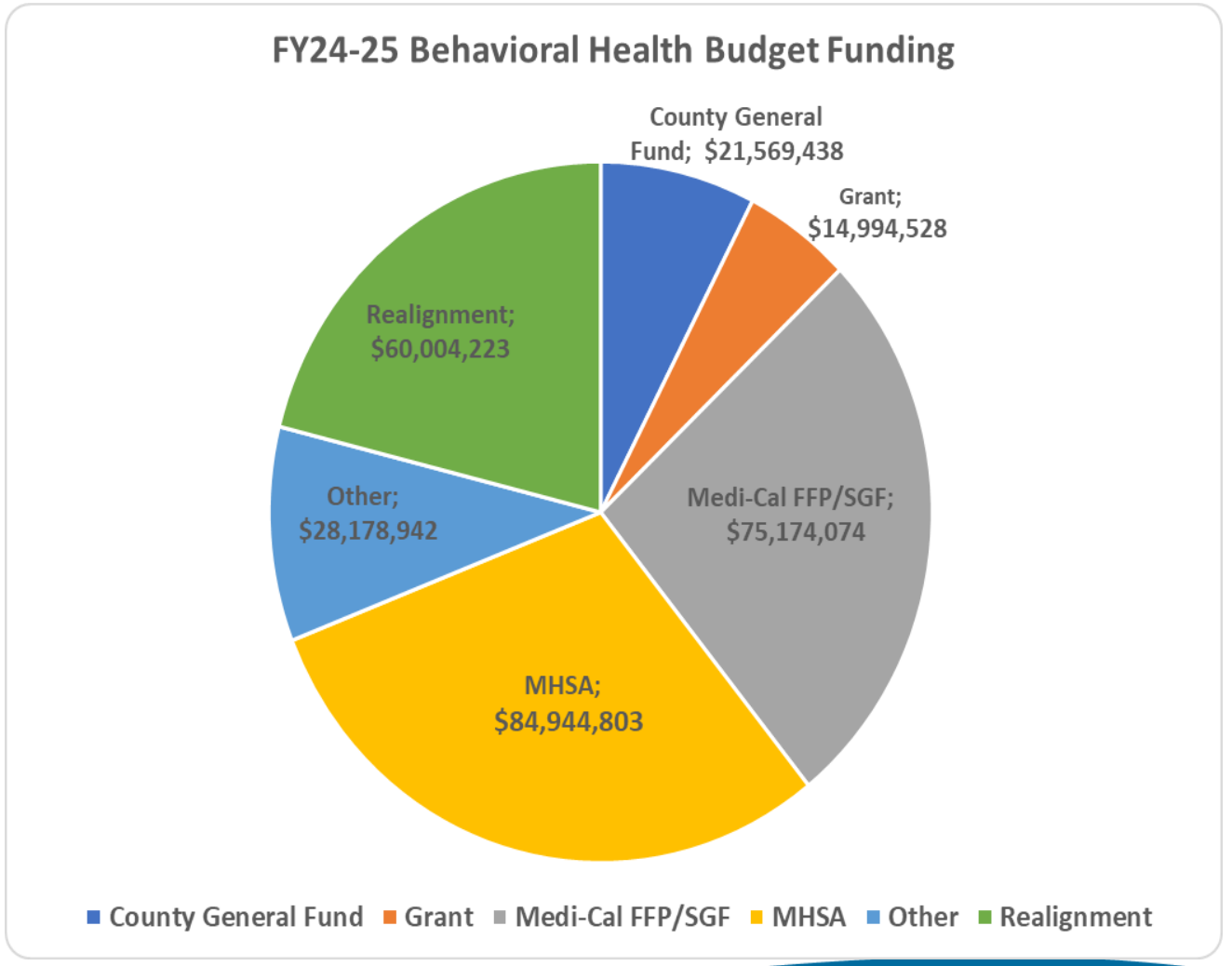
Proposition 1 (SB 326) Changes Overview

VENTURA COUNTY BEHAVIORAL HEALTH

Behavioral Health Department Funding
FY 24/25 Preliminary Budget

- Ventura County Behavioral Health's budget is comprised of the following elements:
  - General Fund
  - Grants
  - MHSA*
  - Medi-Cal
  - Realignment
  - Other
- CalAIM and Payment Reform impacts are still under review.
- New state initiatives on the horizon including Care Court, and BH Connect will also have budgetary impact.

*MHSA increase due to large one-time payment, generally MHSA funds around 25% of VCBH department's budget.



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Transitioning from MHSA to BHSA Requirements

- Senate Bill (SB) 326 and Assembly Bill (AB) 531 combined to became Proposition (Prop) 1
- Prop 1 passed in March of 2024
- Adds a $6.3B Housing bond to fund treatment facilities and housing for homeless (AB531)
- Requires significant shifts in MHSA allocations, impacting funding from core mental health services (Outpatient, Crisis, Linkage) to create a new housing category (SB 326)

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Overview of BHSA Changes

Funding: Changes from 5 components to 3 categories

Reporting: Expanded community planning, data, and funding for all revenue sources not just BHSA money

Services: Adding Substance Use Disorder (SUD) services for SUD-only populations (no additional funding will be added)

Limits: Cap for prudent reserve is reduced 33% to 20%

Limits: No specific allocation for - Workforce Education and Training, Innovation, and Capital Facilities and Technological Needs **however are still required**

Adds: Requires counties to engage commercial plans and MCPs for contracting

Cuts: Doubles the States allocation from 5% to 10% to fund and administer the following

- Prevention funds and services
- Workforce Education and Training

Target Timeline

2026

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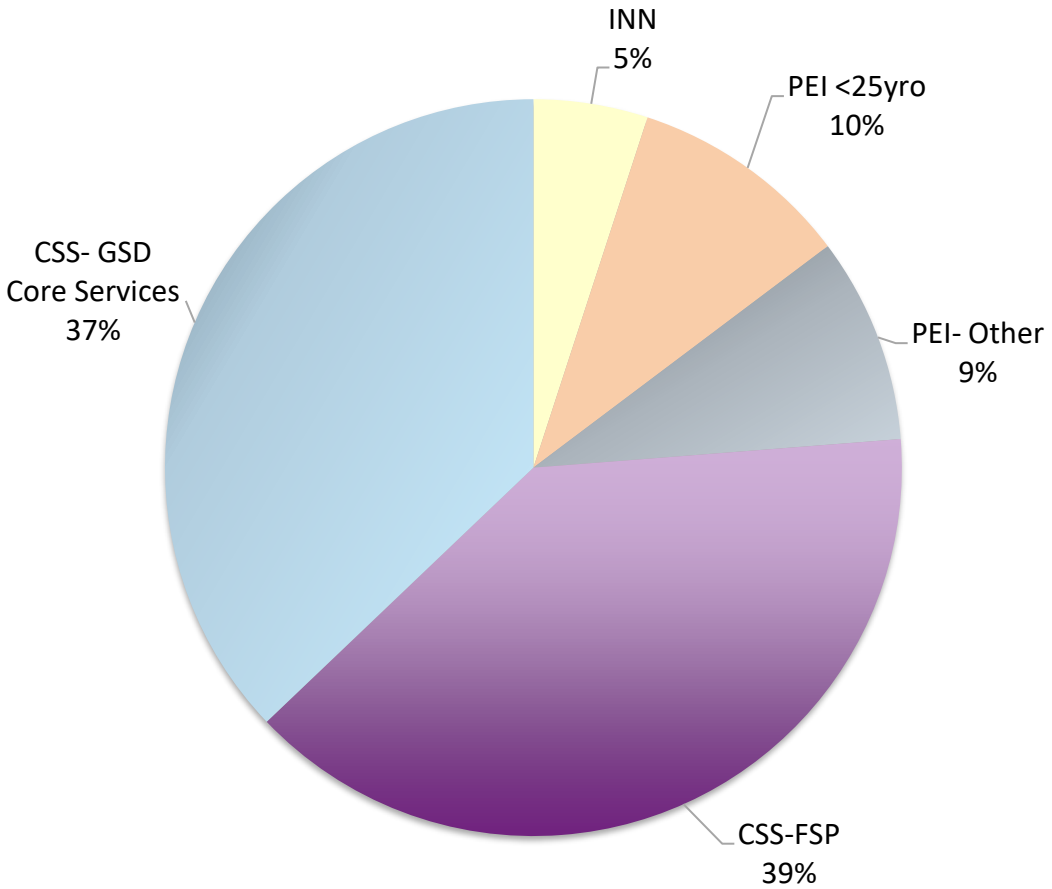
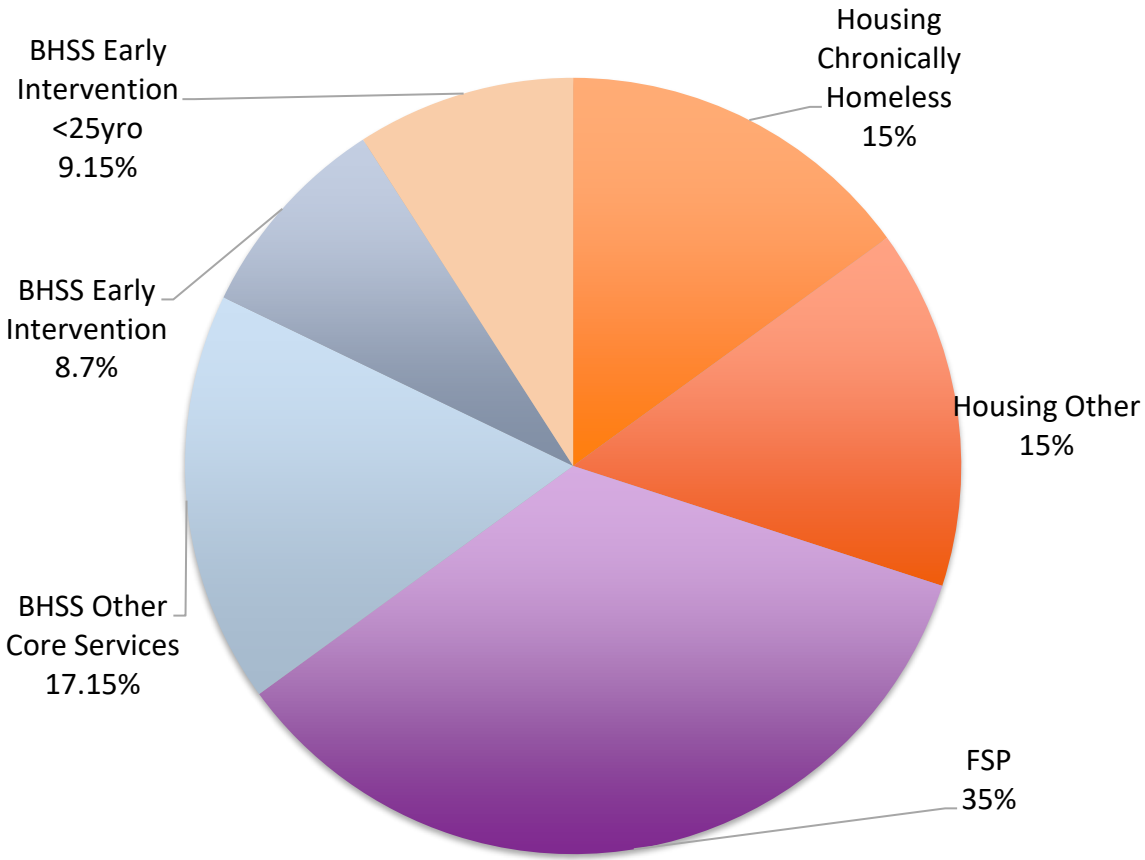
MHSA Components vs. BHSA Categories

MHSA State Funding Components



BHSA Proposed Funding Categories



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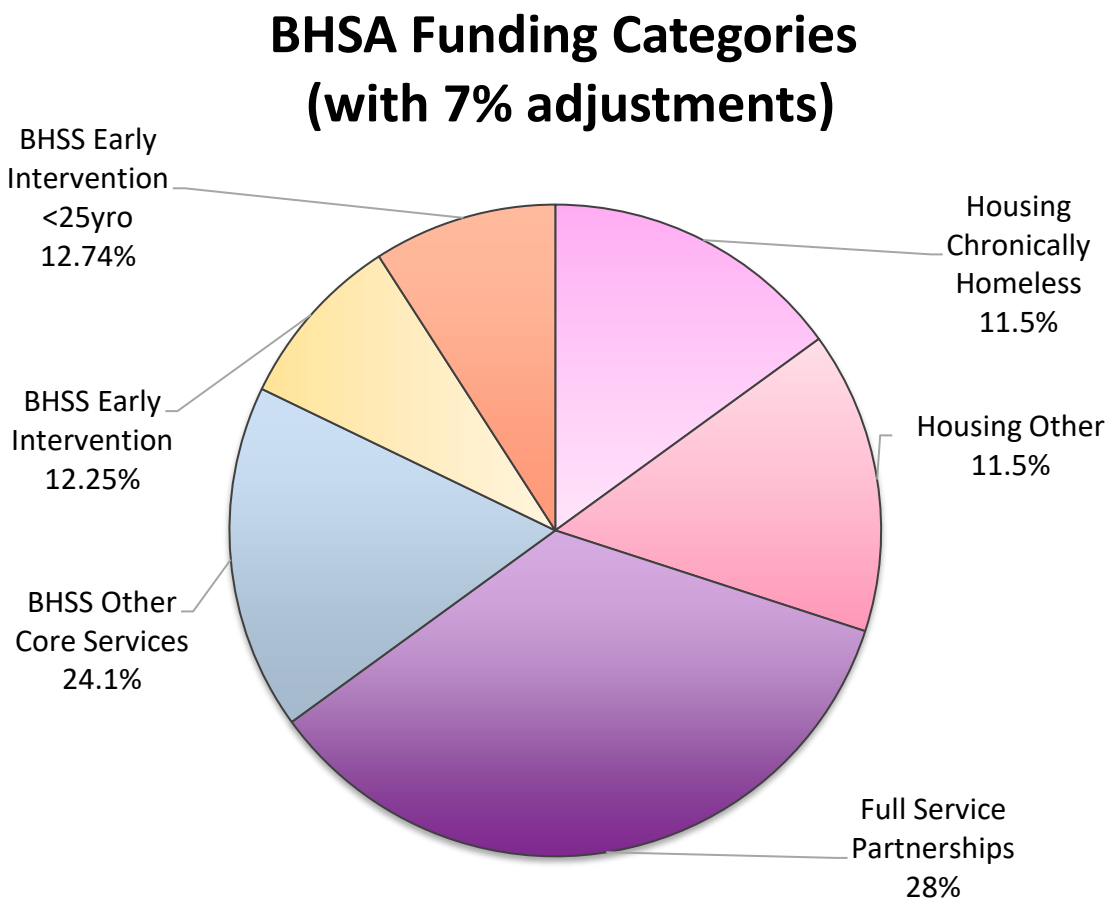
Allowable BHSA Adjustments



- **Up to** 14% can be Adjusted between categories
  - Up to 7% from FSP and Up to 7% Housing
  - Requires an approval process though DHCS
- All data from here forward is a snapshot of what is known currently and is subject to change as DHCS and other administrative bodies provide more clarity to the legislation.
- Categories that need additional spending or cuts in funding may even out more once that clarification is provided.
- **Key areas needing DHCS clarification:** Housing, FSP levels of care, and Early Intervention

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Changes in Amounts per BHSA Category based 3-Year Average Budget

NEW CATEGORIES							
FSP	**N/A**	**BH Services & Supports 35%**			**Housing 30%**		**Total**
FSP 35%	**Prevention**	Minimum 51% of BHSS to Early Intervention	Minimum 51% of EI to age <25	Remaining BHSS % for Other Svcs	Minimum 50% to Chronically Homeless	Remaining %	
17,553,900	0	7,676,800	7,990,100	15,052,500	7,209,600	7,209,700	**62,692,600**
28.0%	**0**	**12.2%**	**12.7%**	**24.0%**	**11.5%**	**11.5%**	**100%**
Increase	**Decrease**	**Increase**	**Increase**	**Decrease**	**Increase**	**Increase**	

- Numbers are based on three-year budget average FY22-23, FY23-24, FY24-25
- Does not reflect changes to Prudent reserve or SUD only expenses yet

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Estimated Funding Shift based on 3-Year Average Budget

Category	% of Avg Budget	BHSA Future Allocation	Change
Core Services (CSS)	61.97%	24.01%	-37.96%
Housing	2.52%	23.00%	**20.48%**
FSP	8.50%	28.00%	**19.50%**
PEI-Prevention/Outreach/Access & Linkage	16.01%	0.00%	-16.01%
PEI-Early Intervention	5.74%	24.99%	**19.25%**
WET	0.23%	0.00%	-0.23%
CFTN	0.00%	0.00%	**0.00%**
INN	5.03%	0.00%	-5.03%

- Core Services are all non-FSP services previously funded with the CSS component.

****Based on three-year budget average FY22-23, FY23-24, FY24-25. Does not reflect transfers to CFTN and Prudent Reserve or impact of new State share.***

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Estimated Funding Shift Using Average of 3-Year Budget

Category	Avg Budget	BHSA Future Allocation	Change
Core Services (CSS)	$ 41,772,900	$ 15,052,500	$ (26,720,400)
Housing	$ 1,700,700	$ 14,419,300	**$ 12,718,600**
FSP	$ 5,730,100	$ 17,553,900	**$ 11,823,800**
PEI-Prevention/Outreach/Access & Linkage	$ 10,793,500	$ -	$ (10,793,500)
PEI-Early Intervention	$ 3,868,200	$ 15,666,900	**$ 11,798,700**
WET	$ 156,900	$ -	$ (156,900)
CFTN	$ -	$ -	**$ -**
INN	$ 3,389,000	$ -	$ (3,389,000)
Total	$ 67,411,300	$ 62,692,600	$ (4,718,700)

- Amount currently being utilized for Core Services will shift to Housing and FSP services.

Based on three-year budget average FY22-23, FY23-24, FY24-25. BHSA Future Allocation includes deductions for new amounts that will be retained by the State and 2% to be allocated to administration for new reporting requirements.

****This is budget - not actual spend. Actual spend may be different.***

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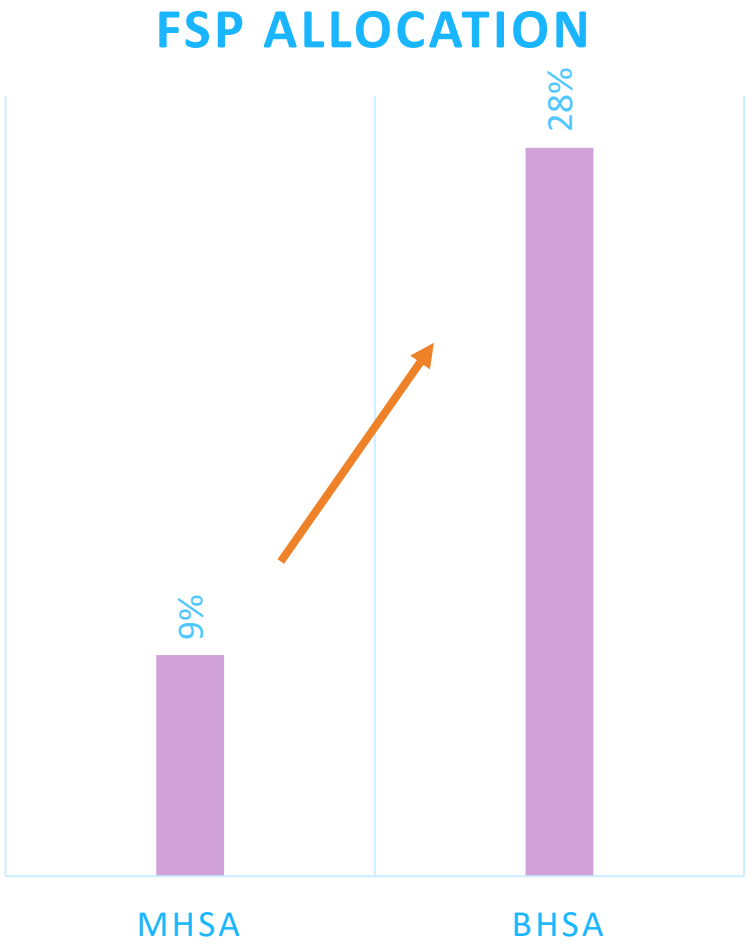
Full-Service Partnerships



Increase programs in category by $11,823,800*

Additional Requirements

- Fidelity Requirements:
  - Individualized Placement Services Supportive Employment
  - Wraparound and other EBPs as identified by DHCS
  - Assertive Community Treatment Model (higher cost/better outcomes)
- Create a Substance Use Service including MAT
- Step down care criteria to be developed by DHCS

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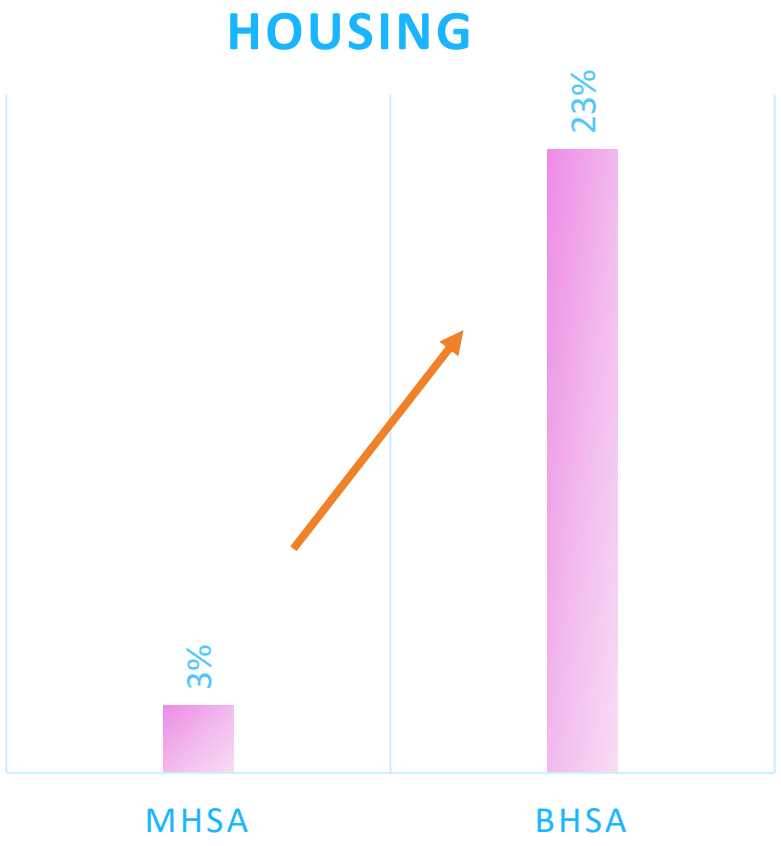
*Based on current analysis and subject to change based on further clarification from the Department of Health Care Services

Housing



Increase programs in category by $12,718,600 *

New Standalone Category

- Housing First model
- Includes, but not limited to, rental subsidies, operating subsidies, shared housing, family housing
- 50% to be used for Chronically homeless (678 in Ventura County in 2024)
- Not restricted to individuals enrolled in Medi-Cal
- May include recovery housing as defined by HUD
- Housing was previously limited and primarily for FSP clients

Not allowed

- Support services to keep SMI individuals housed
- Treatment services

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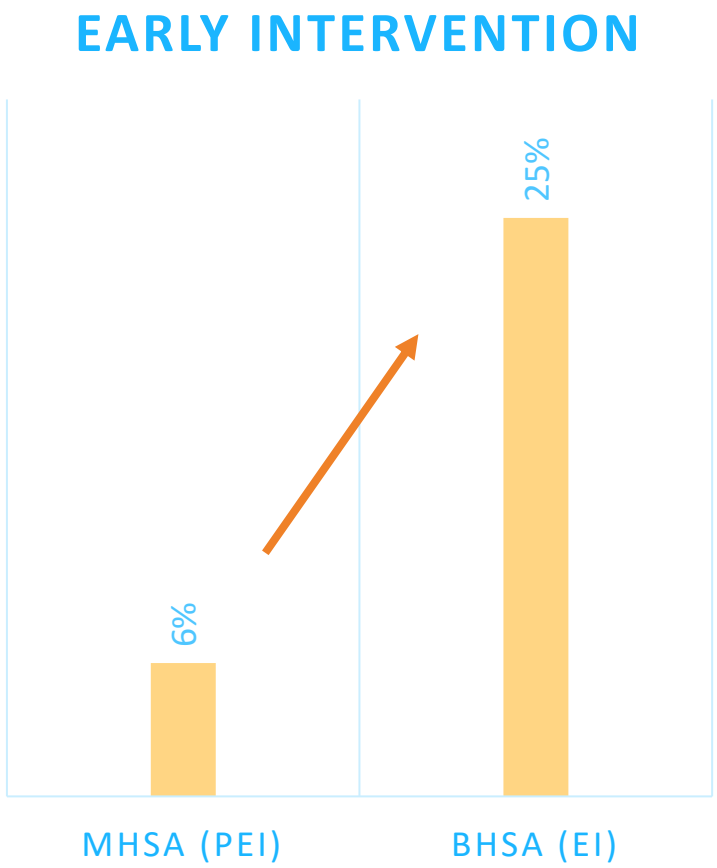
*Based on current analysis and subject to change based on further clarification from the Department of Health Care Services

Behavioral Health Services and Supports – Early Intervention



Increase programs in category by $11,798,700*

Changes

- Minimum 51% to serve youth under the age of 25
- May include response services for MH Crisis
- One on One services
- Focused on Medi-Cal reimbursable
- Must include SUD only population
- List of Community Defined Evidence-Based Practices (CDEP) maintained and may be required by DHCS

No longer Allowed

- Eliminates local funding for Prevention Services ($11 million)
- Eliminates stigma reduction as allowable
- No specific allocation for Suicide Prevention

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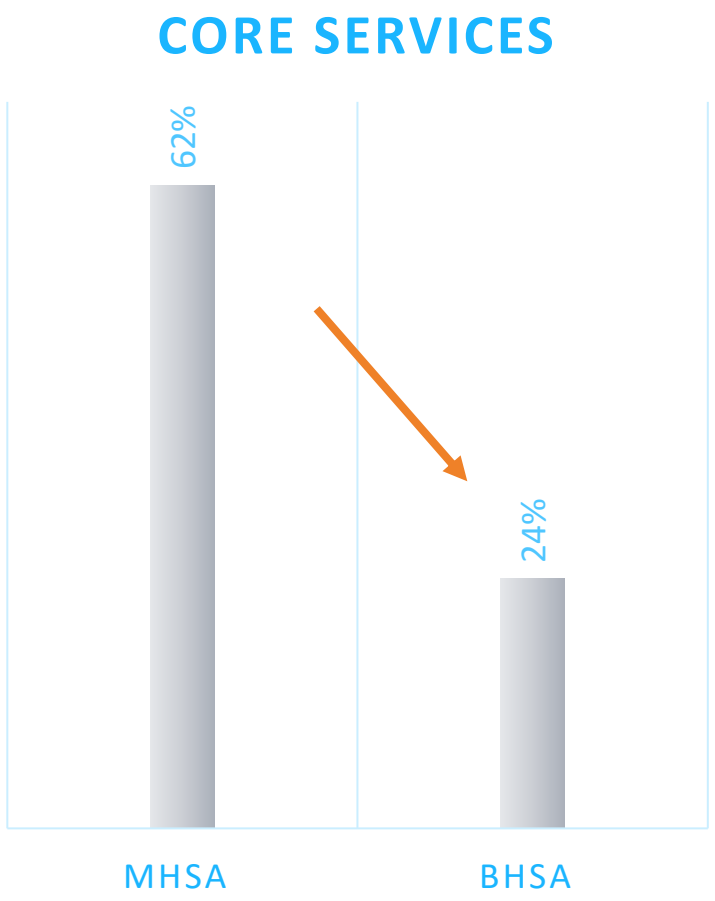
*Based on current analysis and subject to change based on further clarification from the Department of Health Care Services.

Behavioral Health Services and Supports – Other



Decrease programs in this category by up to $26,720,400*

Changes

- Largest overall cut to allowable dollars spent
- Existing services covered in this category:
  - **Crisis Services**
  - **Regular Outpatient Treatment**
  - **Peer Services**
  - **Access**
  - **Engagement**

Additional Requirements – No Allocation

- Innovation Programs
- Workforce Enhancement and Training
- Capital Facilities and Technology

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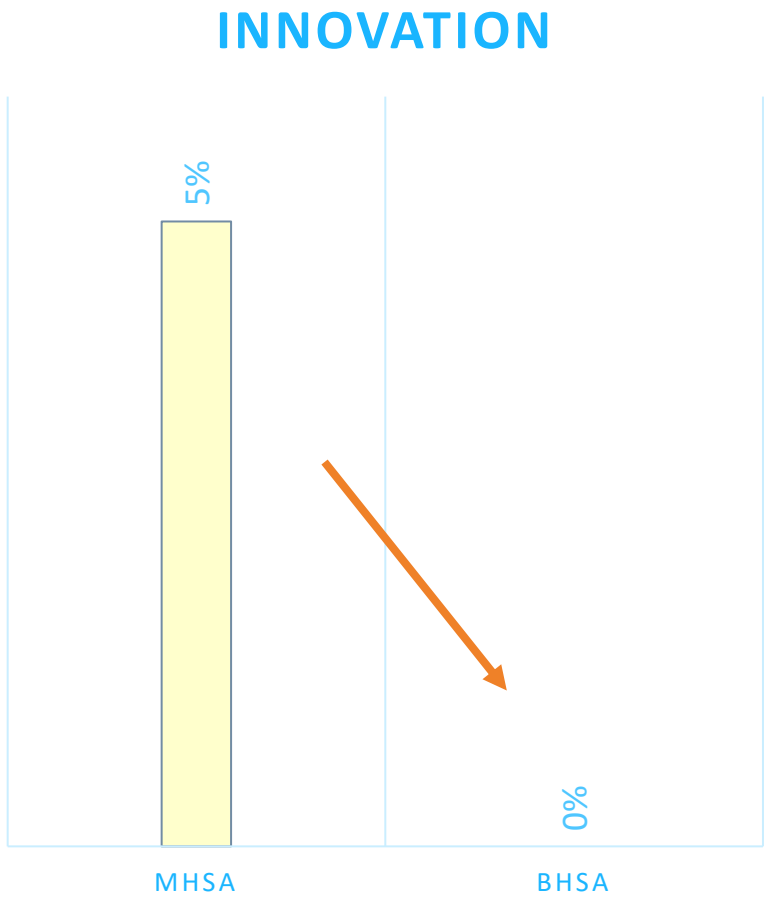
*Based on current analysis and subject to change based on further clarification from the Department of Health Care Services.

Innovation



Decrease in new Programs by $3,000,000 dollars*

Changes

- Remains a requirement
- Eliminates the required percentage of the overall budget

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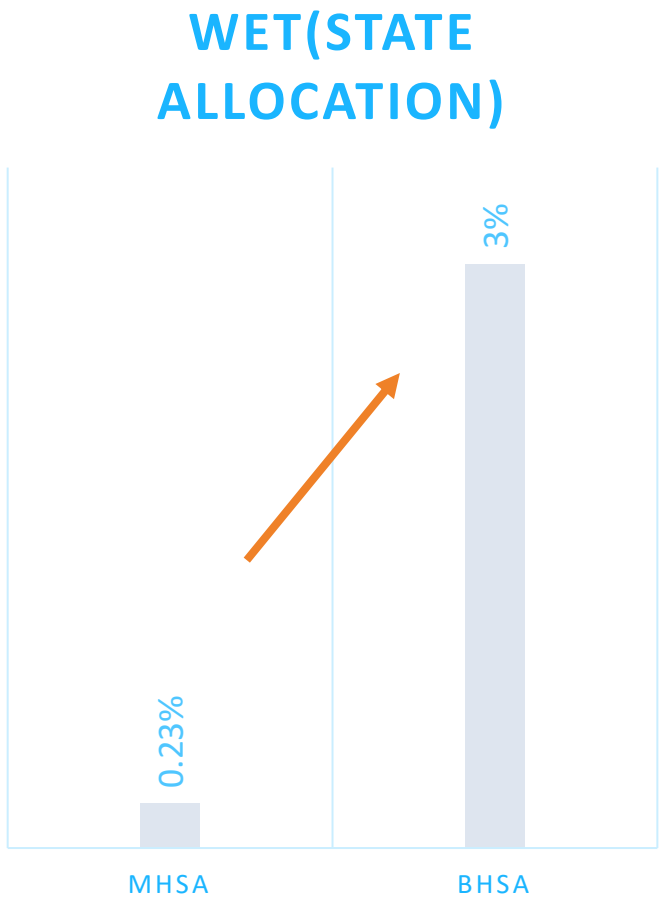
*Based on current analysis and subject to change based on further clarification from the Department of Health Care Services.

Workforce Enhancement and Training



Decrease in local control of programing by $156,500*

Changes

- The 3% of funding comes off the top and goes to the state for allocation and identification of new initiatives
- Currently includes
  - Specialty trainings
  - Loan forgiveness
  - Internships

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*Based on current analysis and subject to change based on further clarification from the Department of Health Care Services.

Priority Populations for BHSA

- **Eligible adults and older adults who are:**
  - Chronically homeless or experiencing homelessness or are at risk of homelessness.
  - In, or are at risk of being in, the justice system.
  - Reentering the community from prison or jail.
  - At risk of conservatorship.
  - At risk of institutionalization.

- **Eligible children and youth who are:**
  - Chronically homeless or experiencing homelessness or are at risk of homelessness.
  - In, or at risk of being in, the juvenile justice system.
  - Reentering the community from a youth correctional facility.
  - In the child welfare system.
  - At risk of institutionalization.

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Summary of overall Impacts

- Increased access to housing resources
- Increased field-based services
- Increased access to substance use services
- Decrease in available BHSA funds for outpatient services
- Elimination of local decision making and dissemination of Prevention funds which will be handled by the State
- Early Intervention may provide outreach services
- No population-based services at the local level, all mental health promotional work will be done at the State level

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Additional Considerations for Decision Making

Federal and state funding is often not whole. Adult outpatient care is reimbursed at around 50-60% of total cost. MHSA money is used as a match for some of these programmatic costs.

A match dollar is required for reimbursable services and often grants. MHSA is flexible enough to cover this regularly. On average the MHSA dollars used for this **match for Core Services** is estimated to be **$39,800,000/year.**

With these new allowable terms for the BHSA **it is unknown what the limitation will be on the overall services due to the reduction in allowable matched services.**

Additional funding streams (not BHSA) will need to be explored and leveraged in order to minimize loss and maintain the level of care that exists currently.

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Additional Considerations for Decision Making - Cont.

Example of the type of potential additional funding streams Ventura County Behavioral Health may pursue to partially offset the impact of Prop 1:

AB531

- Authorizes $6.38 billion in general obligation bonds to **finance the conversion, rehabilitation, and construction of supportive housing and behavioral health housing and treatment settings**. Of the total, $1.5 billion is to be awarded through grants exclusively to counties, cities, and tribal entities; and local jurisdictions are not precluded from applying for additional funds.
- The bond will be distributed in a similar approach as BHCIP and Project Home Key processes with a combination of competitive and noncompetitive applications.
- Meaning, counties will need to be able to put together competitive applications that are already identified by **December (2024).**
- **This would be one of the only ways to fund new treatment facilities**

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BHSA Timeline Overview

Development Period
Analysis of new funding categories

Implementation Period

February 2, 2024
- Counties' submission of administrative cost estimates to CBHDA to inform proposed State's Budget May Revision by CBHDA and CSAC

March 5, 2024
- Presidential Primary Election and voters' passage of Prop 1

March 15, 2024
- DHCS engagement of CBHDA and CSAC to evaluate statewide estimate related to BHSA admin cost for inclusion in the Governor's FY 2024–25 May Revision

July 1, 2025
- Counties can start using BHSA funds to pay for the new admin costs up to 2% of their annual BHSA revenue received

June 30, 2026
- The county BOS must approve the first BHSA Three-Year Integrated Plan for

July 1, 2026
- The county BOS must approve the first BHSA Three-Year Integrated Plan for FYs 2026/27-2028/29
- Counties must submit approved document to both DHCS and the BHSOAC

June 30, 2027
- Counties must submit the first Annual Update under BHSA
- **Note:** *Future Annual Updates and Three-Year Plans will need to be submitted on June 30th*

2028
- Counties to begin submitting County Behavioral Health Outcomes, Accountability, and Transparency Report which replaces the ARER

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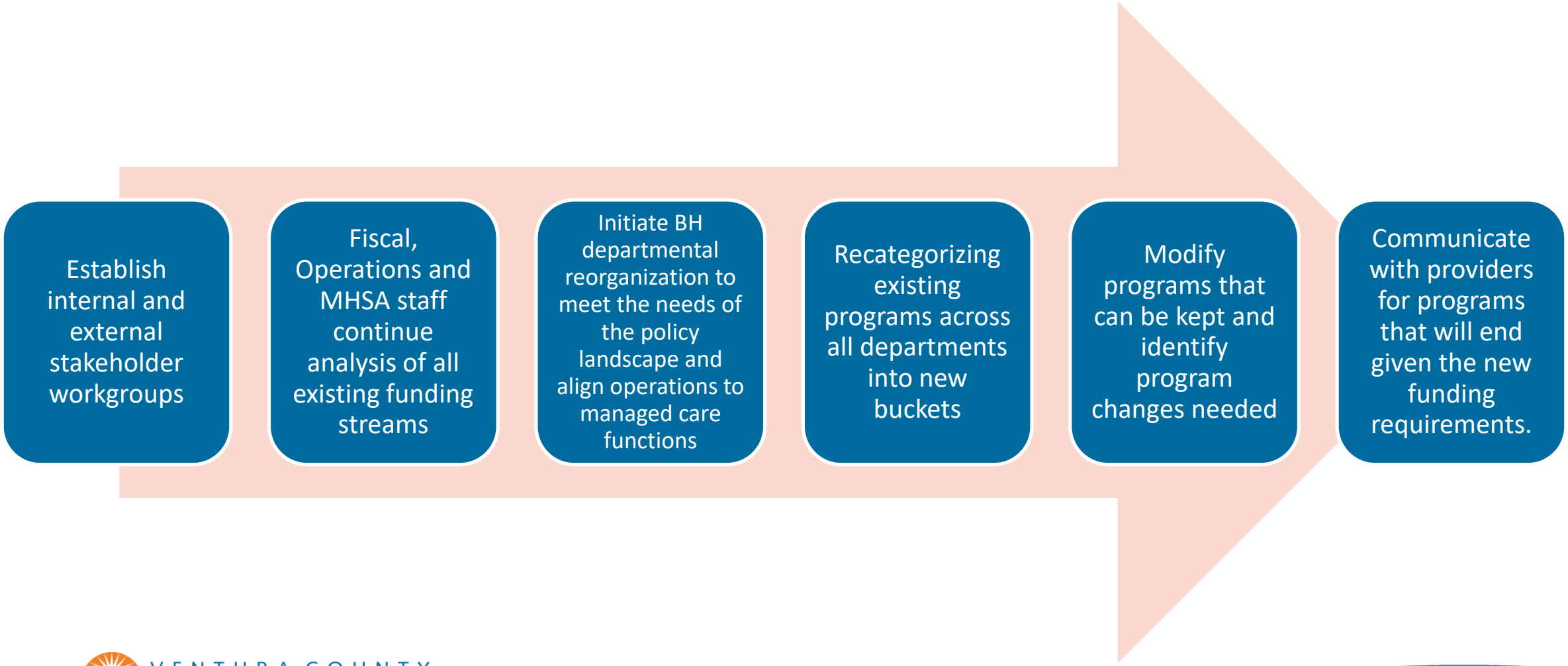
Concurrent Next Steps



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BHSA Three Year Integrated Plan

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Integrated Plan Development – Prop 1 Driven

All Behavioral Health Counties will be required to complete a completely new BH integrated plan which addresses the Department as a whole, not just those programs that are MHSA Funded.

Integrated Plan for Behavioral Health Services and Outcomes

	Three-Year County Integrated Plans (IP)
Purpose	Prospective plan and budget for all county BH services.
Goal	Standardize data collection and reporting to increase transparency, promote stakeholder engagement, and improve local outcomes.
Frequency	Developed every three years.
Timing	First due June 30, 2026.

Expanded Focus of Integrated Plan

Per DHCS, the expanded scope for the Integrated Plan (formerly the MHSA 3 Year plan) will support the state to achieve the following goals:

1. Collect local and aggregate information on all Behavioral Health services delivered statewide.
2. Increase transparency and accountability in county reporting and ensure counties are efficiently using federal dollars.
3. Conduct robust data analysis across counties, services, and funding streams and identify gaps in service delivery.

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Behavioral Health Integrated Plan to Guide Visioning

The integrated plan must **(right column)** now include the bolded sections in the Community Planning Process and the final report submitted to DHCS.

Key MHSA and BHSA Plan Requirements

Topic	MHSA	BHSA
Stakeholder Engagement	Stakeholder involvement on: • Mental health policy • Program planning and implementation • Monitoring • Quality improvement • Evaluation • Budget allocations Requires participation from unserved/underserved populations, individuals with SMI or SED and their families; providers of mental health, physical health, and/or social services; educators or their reps; law enforcement.	Stakeholder involvement on: • Mental health **and substance use disorder** policy • Program planning and implementation • Monitoring • **Workforce** • Quality improvement • **Health equity** • Evaluation • Budget allocation Also requires sufficient participation from diverse groups
Public Comment and Hearing	30-day comment, public hearing, and annual report on recommendations not included in plan	30-day comment, public hearing, and annual report on recommendations not included in plan

Key MHSA and BHSA Plan Requirements

Topic	MHSA	BHSA
County Demographics and BH Needs	County demographics, FSP demographics, narrative analysis of the MH needs of unserved, underserved/inappropriately served, and fully served, CSS priorities and disparities based on race/ethnicity and gender, Capacity Assessment	County demographics, unmet BH needs and disparities, **collaboration with MCPs and local health jurisdiction**, plans to improve BH outcomes for specified populations
Plan Goals and Performance Reporting	Report on achievement of performance outcomes for MHSA-funded services established by DHCS and MHSOAC	**County goals and objectives and description of alignment with statewide and local goals**, outcome measures, and performance outcomes measures
Service and Expenditure Plan	Plan and budget for MHSA-funded services and programs only	Description of all planned **local, state, and federally funded** BH services, **including Continuum of Care capacity** and budget

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Topic	MHSA	BHSA
Workforce/ Personnel	Identification of personnel shortages to provide MHSA-funded services	**Strategy** to ensure BH workforce is robust, well-supported, and culturally and linguistically concordant with populations served
Prudent Reserve	Prudent reserve for MHSA-funded services	Prudent reserve for BHSA-funded services
Local Certification	Compliance with MHSA requirements and state fiscal requirements	Compliance with all pertinent policies and fiscal accountability requirements

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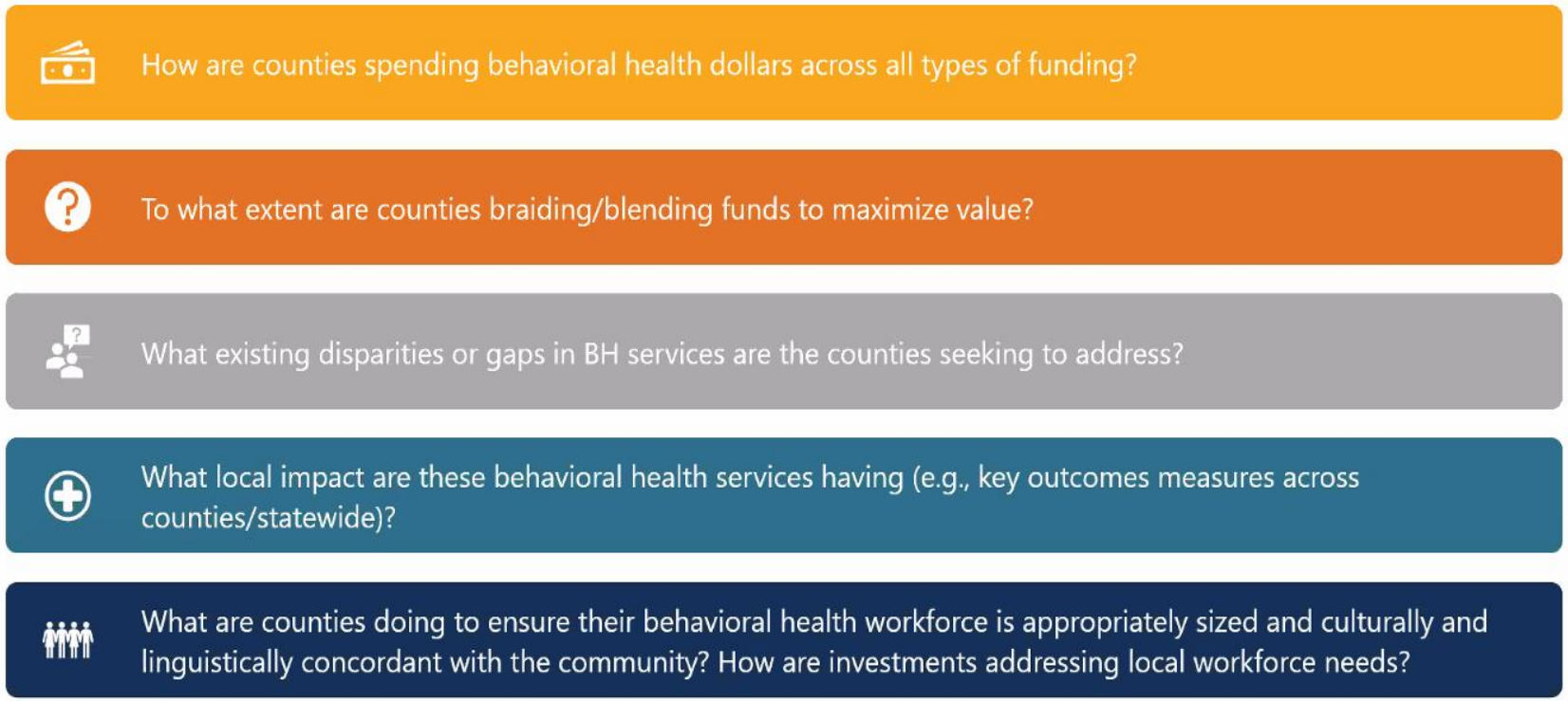
Behavioral Health Integrated Plan to Guide Visioning

Macro Questions Addressed Through the Integrated Plan



Fiscal Focus to inform CPPP

Need focus for 3-year plan

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CPPP Additions and Considerations – Integrate into 3-year plan for community relevancy

Integrated 3-Year Plan for ALL BH funding sources must include and align with the planning process:

- **Demonstration** of how plan addresses needs of those who are or at risk of becoming homeless, incarcerated, institutionalized, conserved, involved with CWS or Adult Protective services, as well as addressing needs of adults/older adults and children/youth defined by the ACT
- **Demonstration** of how other local planning efforts e.g., PNA, CHA and commercial health plans, maximizes and leverages funding and services from other programs including MCPs and commercial plan
- Consider **data sources** including prevalence of MH and SUD treatment in the county, disparities and homeless PIT Count and demonstrate how the plan appropriately allocates funding between MH and SUD treatment services
- Stratified data to identify **BH disparities and approaches to eliminate disparities**

Integrated Plan Development – Prop 1 Driven

Below outlines high-level timeframes for several milestones that will inform requirements and resources. Additional updates on timelines and policy will follow throughout the project.

Beginning Early 2025

Integrated Plan Guidance and Policy

Policy and guidance will be **released in phases** beginning with policy and guidance for Integrated Plans.

Summer 2026

Integrated Plan

New Integrated Plans, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle)

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Summary of Additions CPPP

- **Integrated 3-Year Plan for *ALL* BH funding sources including county general funds:**
  - Report to include expanded data on the planning process, expenditures, progress on disparities, and outcomes per program
- **The local review process is generally the same for the development and approval of the 3-Year plan with exceptions:**
  - Local review process is NOT required for annual updates and intermittent updates to the 3-Year Plan (30 day posting and BOS approval)
- **Significantly expanded the required stakeholder list:**
  - Requirement to partner with MCPs in the development of their Population Needs Assessments (PNA) and local Health Jurisdictions in the development of their Community Health Assessments (CHA)
  - Adds language re stakeholder representation to include marginalized communities to include **racially and ethnically diverse communities**, **LGBTQ** community, **victims of domestic violence** and **sexual abuse** and people with **lived experience of homelessness**.
- **For counties with a population over 200,000 shall collaborate with 5 most populous cities.**
- **Must collaborate with 5 most populous cities, MCPs and continuums of care to outline responsibilities and coordination of housing interventions.**

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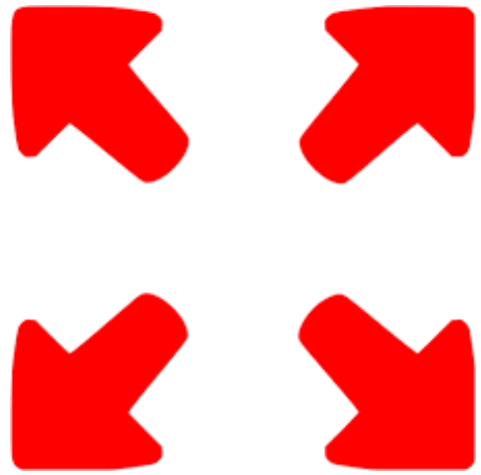
Changes to the 3-year Planning Process Under Prop 1

Roughly the same planning process but the focus of the continuum of care shifts to:

- Adds additional stakeholder representation to include
  - marginalized communities to include racially and ethnically diverse communities,
  - LGBTQ community,
  - victims of domestic violence and sexual abuse and
  - people with lived experience of homelessness.



The shift also includes:

- Prevention program planning and Innovation processes is eliminated
- **All VCBH services (not just MHSA-funded programs)** will be considered in the needs assessment and planning process

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Behavioral Health Advisory Board (BHAB)
Current composition as outlined on current bylaws:

- 1 Board of Supervisor Sitting.
- 50% or more should be consumers or the parents, spouses, siblings, or adult children of consumers who are receiving or have received mental health services.
- At least 20% (i.e., 5 members) shall be consumers.
- At least 20% (i.e., 5 members) shall be family members of consumers of mental health services.
- One member shall be recommended to the BOS by the Ventura County Sheriff to represent law enforcement.
- 1 psychiatrist practicing in Ventura

Changes for BHAB Consideration

NEW

- Ensure that the composition of the mental health board represents and reflects the diversity and demographics of the county
- Ensure adequate representation of SUD population

Additional stakeholder requirements under Prop 1

- marginalized communities to include racially and ethnically diverse communities,
- LGBTQ community,
- victims of domestic violence and sexual abuse and
- people with lived experience of homelessness.

BHAB Approaches for consideration:

1. Create workgroups or subcommittees to align with priority populations
2. Expand requirements of current representatives

CalAIM Behavioral Health Administrative Integration

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CalAIM Background

» California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal. CalAIM includes multiple initiatives designed to reduce complexity across Medi-Cal delivery systems for behavioral health services. CalAIM has three primary goals:

Identify and manage beneficiary risk through whole person care approaches and addressing Social Determinants of Health;

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

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Goals of Behaviorial Health Administration Integration

The **primary goals** of Behavioral Health Administrative Integration are to **improve health care outcomes and the experience of care** for Medi-Cal beneficiaries—particularly those living with co-occurring mental health and SUD issues—**by reducing administrative burden** for beneficiaries, counties, providers, and the state.

Improve health care outcomes and the experience of care for Medi-Cal beneficiaries (particularly those living with co-occurring mental health and SUD issues).

Reduce the administrative burden for beneficiaries, counties, providers, and the state.

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Behavioral Health Administrative Integration Framework

Current Administrative Structure	Administrative Integration
• Medi-Cal SMH and SUD services are administered in each county under two distinct contracts. • SMH and SUD have program-specific requirements for clinical documentation, health plan and provider compliance reviews, billing and claiming, licensing and certification, etc.	• Medi-Cal SMH and SUD services are administered in each county under a single, integrated contract. • SMH and SUD program requirements are aligned and integrated to the greatest extent possible* to increase flexibility and reduce administrative burden for counties, providers, and the state.

*Federal and state law create certain requirements that apply specifically to SMHS and/or SUD services. CalAIM BH Administrative Integration seeks to promote integration primarily within existing financial and legal parameters.

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Phased Implementation

Note: The time periods specified above and on the coming slides refer to calendar years. AB 133 currently provides for the statewide adoption of integrated contracts by January 1, 2027.

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11 Components of Behavioral Health Administrative Integration

Streamlining the Beneficiary Experience	Integrating County Structures & Processes	Integrating DHCS Oversight Functions
1. County-Operated 24/7 Access Line	**4. DHCS-County Contracts**	**8. External Quality Reviews**
2. Screening, Assessment & Treatment Planning	5. Data Sharing & Privacy	**9. DHCS Compliance Reviews**
3. Beneficiary Materials, Appeals & Grievances	**6. Cultural Competence Plans**	**10. Network Adequacy**
	7. Quality Improvement	11. Provider Oversight

*Counties that adopt integrated contracts in Phase 2 must participate in integration of the 8 components show in **bold**.

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Timeline & Next Steps

Date*	Activity
July 31, 2024	• DHCS circulated for review the complete draft integrated contract text.
September 30, 2024	• Deadline for Integrated Contract Early Implementers Workgroup counties to commit to voluntary early integrated DHCS-county contracts.
October to December 2024	• DHCS will reconvene the Early Implementers workgroup for opt-in counties to provide updates and implementation support. • DHCS established a dedicated email inbox for opt-in counties to submit questions/request technical assistance in preparation for Phase 2 and continue to update the FAQ page to provide policy guidance.
January 1, 2025	• Integrated DHCS-county contracts take effect.

**Subject to change.*

VENTURA COUNTY BEHAVIORAL HEALTH

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

VENTURA COUNTY BEHAVIORAL HEALTH

Overview of BH-CONNECT

BH-CONNECT builds upon California's unprecedented investments and policy transformations to establish a robust continuum of community-based behavioral health services and improve access, equity, and quality for Medi-Cal members living with significant behavioral health needs.

In October 2023, DHCS submitted an application to CMS for a new Section 1115 Demonstration to increase access to and improve mental health services for Medi-Cal members living with significant behavioral health needs.

- BH-CONNECT takes advantage of CMS's 2018 guidance that permits states to use 1115 waivers to receive federal matching funds for short-term care*for Medicaid members with a serious mental illness in IMDs, provided states establish a robust continuum of community-based care and enhance oversight of inpatient and residential settings.

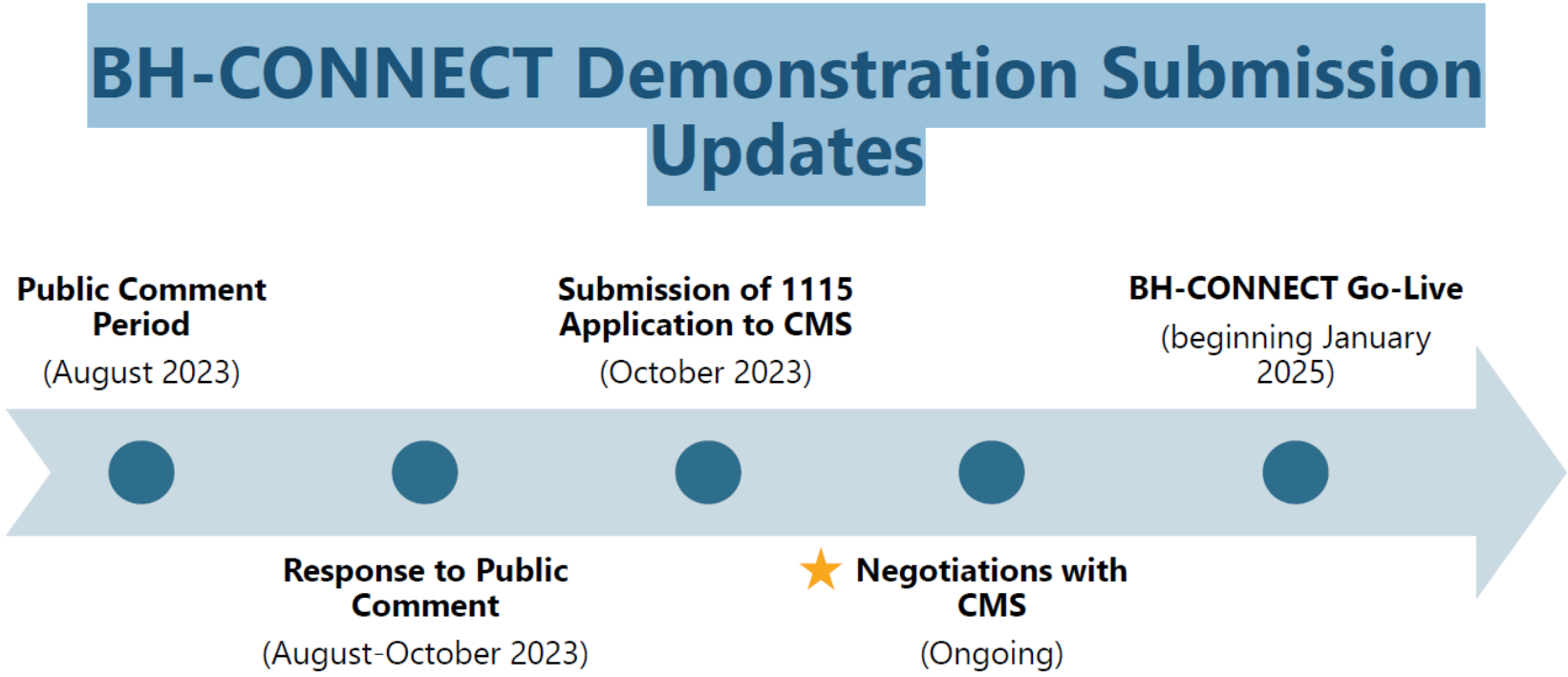
- BH-CONNECT will complement Behavioral Health Transformation and the State's other ongoing behavioral health initiatives to better support Californians living with significant behavioral health needs.

- The main objectives of BH-CONNECT are to:
  - Amplify the State's ongoing investments in behavioral health and further strengthen the continuum of **community-based care**.
  - Meet the specific mental health needs of **children, individuals who are justice-involved, and individuals experiencing or at risk of homelessness**.
  - Ensure residential and inpatient care is **high-quality, time-limited, and used only when clinically appropriate**

**The opportunity is limited to stays that are no longer than 60 days, with a requirement for a statewide average length of stay of 30 days.*

VENTURA COUNTY BEHAVIORAL HEALTH

BH-CONNECT Demonstration Submission Updates



Find the BH-CONNECT Section 1115 demonstration application and public hearing materials posted on https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

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VENTURA COUNTY BEHAVIORAL HEALTH

Key Components of BH-CONNECT

DHCS is requesting Section 1115 demonstration authorities for specific features of BH-CONNECT. Some components will require a State Plan Amendment, and others can be implemented using existing federal Medicaid authorities.

Section 1115 Authorities

Expenditure Authority Requests

- ✓ Workforce Initiative
- ✓ Statewide Incentive Program
- ✓ Cross-Sector Incentive Program
- ✓ Activity Stipends
- ✓ Evidence-Based Practice (EBP) Incentive Program
- ✓ Transitional Rent Services
- ✓ FFP for IMDs
- ✓ Designated State Health Programs (DSHPs)

Waiver Authority Requests

- ✓ Statewideness
- ✓ Amount, Duration, and Scope and Comparability

Forthcoming State Plan Amendment

- ✓ Assertive Community Treatment (ACT)
- ✓ Forensic ACT
- ✓ Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- ✓ Supported Employment
- ✓ Community Health Worker (CHW) Services
- ✓ Clubhouse Services

Existing Federal Medicaid Authorities

- ✓ Centers of Excellence
- ✓ Clarification of Coverage of Evidence-Based Child and Family Therapies
- ✓ Initial Child Welfare/Specialty Mental Health Assessment
- ✓ County Child Welfare Liaison within Managed Care Plans (MCPs)
- ✓ Alignment of the Child and Adolescent Needs and Strengths (CANS) Tool
- ✓ Requirements for Counties that Opt-In to Receive FFP for IMDs
- ✓ Implementation of Other CMS Milestones

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BH-CONNECT

The BH-CONNECT incentive program is a key "carrot" that DHCS is using to drive behavioral health delivery system reform. The incentive program aligns with the overall goals of BH-CONNECT and DHCS' broad behavioral health reforms, and has three specific goals:

1. Strengthen county BHPs' **managed care performance and quality improvement capabilities.**
2. Implement and scale new **evidence-based service models with fidelity.**
3. Improve member outcomes, especially for **high-risk populations experiencing disparities.**

VENTURA COUNTY BEHAVIORAL HEALTH

Managed Behavioral Health Organization

The MBHO self-assessment is a prerequisite for participation in the Statewide and EBP incentive payment programs as part of BH-CONNECT.

What is Managed Behavioral Health Organization (MBHO)?

It is a National Committee for Quality Assurance (NCQA) **accreditation** that demonstrates to health plans, communities, regulators, various stakeholders, and consumers an organization's **commitment** to follow **evidence-based practices** to provide **high-quality care**.

Does VCBH have to receive an accreditation?

No, accreditation is not required at this time.

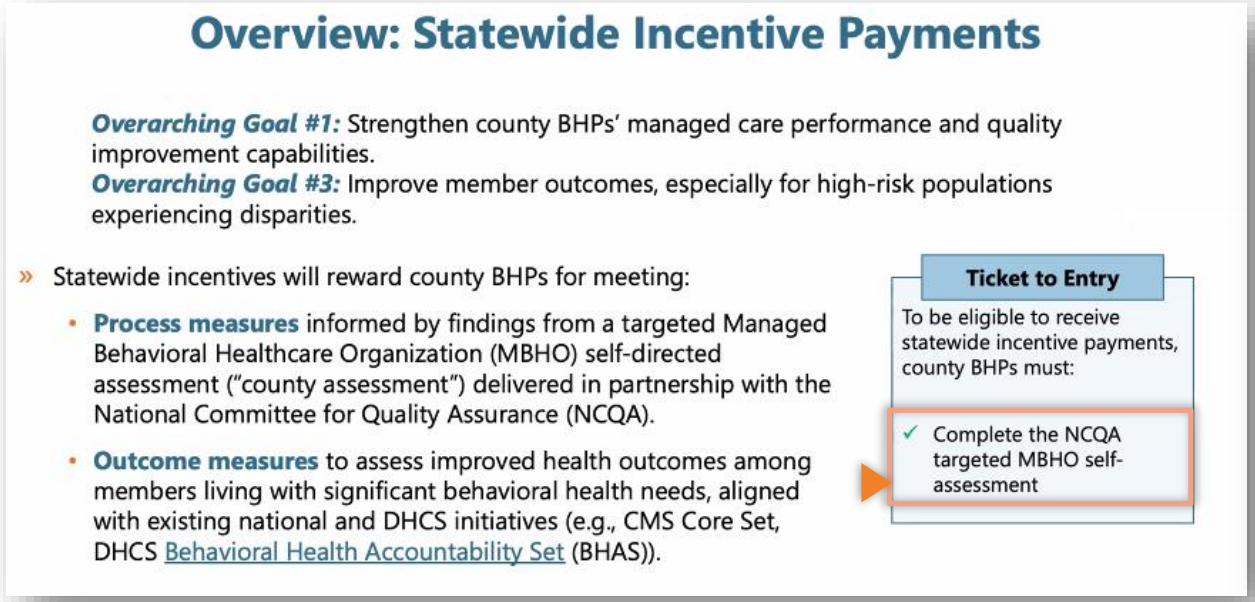
How does MBHO relate to CalAIM?

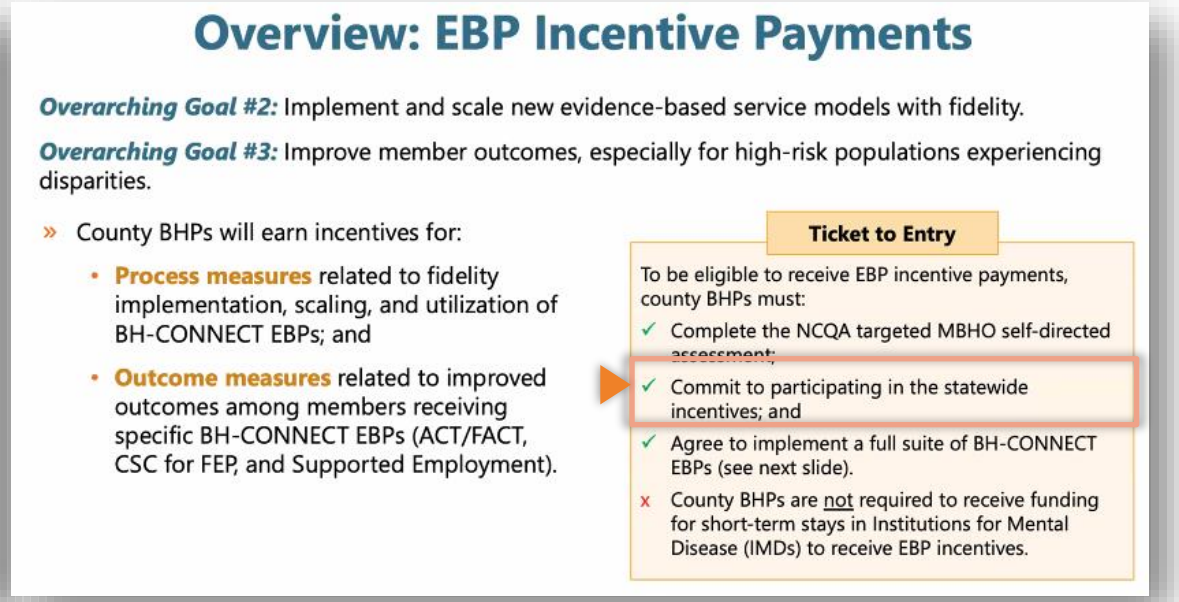
Part of the CalAIM initiative is Medicaid Section 1115 Demonstration Waiver, also known as **BH-CONNECT** (California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment). This waiver aims to increase access to and improve behavioral health services for Medi-Cal members statewide. The first step in BH-CONNECT implementation is a **targeted, self-assessment** by counties that uses a **limited set of MBHO standards** to establish a **baseline** for quality improvement initiatives.

BH-CONNECT Incentive programs will launch on January 1, 2025.

VENTURA COUNTY BEHAVIORAL HEALTH

MBHO Self-Assessment



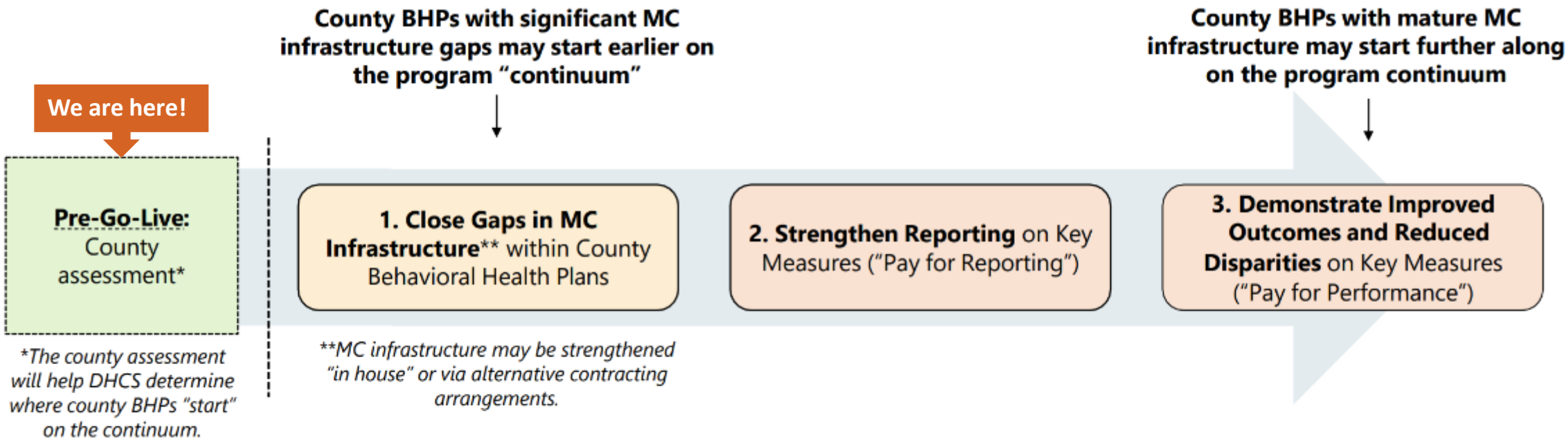


NOTE: The self-assessment is not a pre-requisite for participation in the **Cross-Sector Incentive Program** that targets coordination between MCPs, MHPs, and CWAs specifically.

VENTURA COUNTY BEHAVIORAL HEALTH

BH-CONNECT Timeframe

Statewide Incentive Program

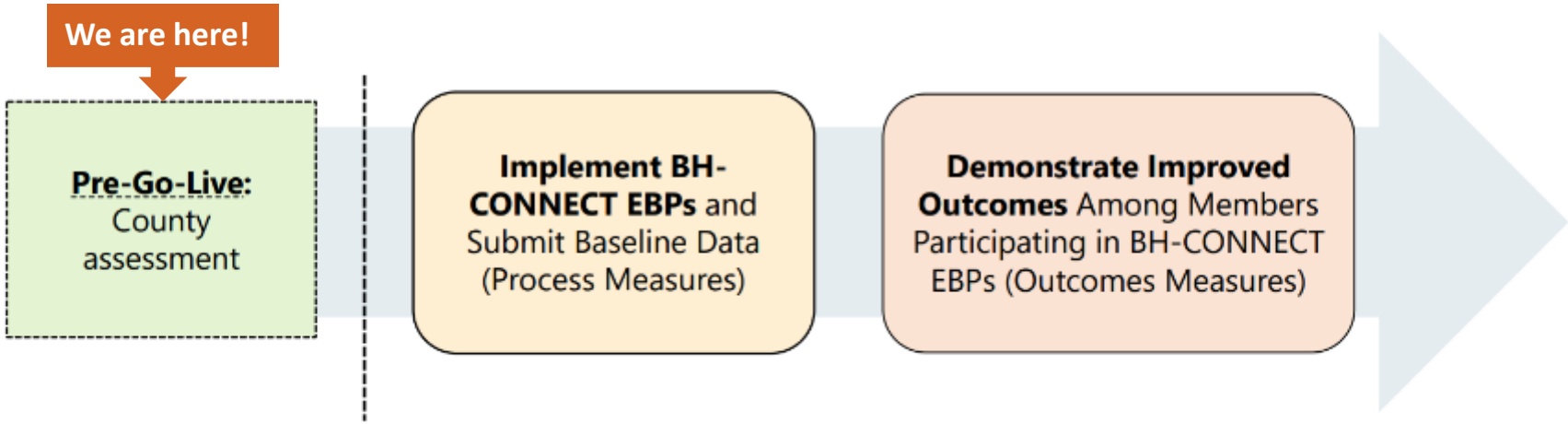


VENTURA COUNTY BEHAVIORAL HEALTH

BH-CONNECT Timeframe

EBP Incentive Program

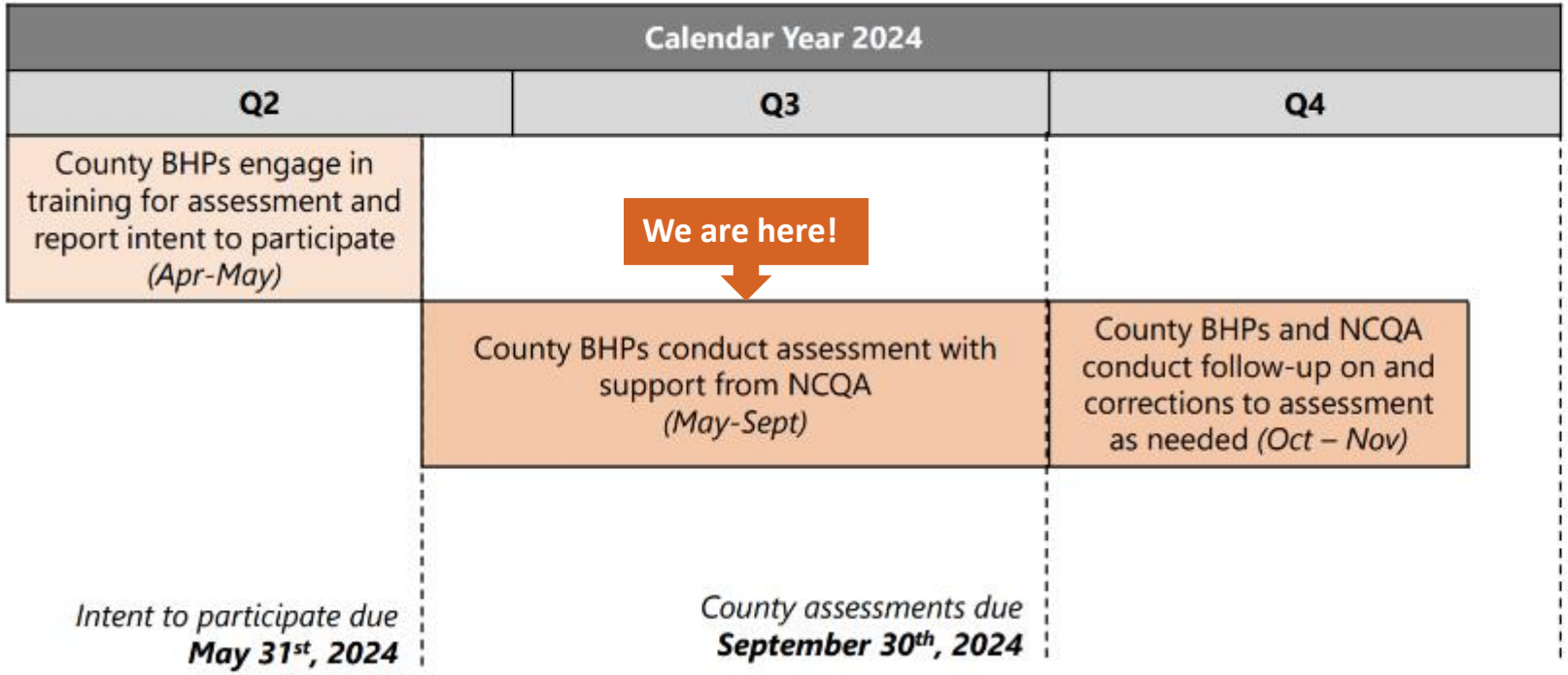
Measures will progress from process measures in early program years to outcomes measures in later program years:



VENTURA COUNTY BEHAVIORAL HEALTH

MBHO Self-Assessment Timeframe

Timing of County Assessment Activities



Estimated Time Commitment

County BHPs should expect to dedicate approximately **1-1.5 hours per week between April – November 2024** for training, TA, and to complete the assessment, or approximately 40 – 60 hours total.

Note: The time commitment may vary by county BHP.

*County BHPs may be eligible to earn **incentive dollars** through the BH-CONNECT statewide incentive program for completing a written plan to address gaps based on their county assessment results*

VENTURA COUNTY BEHAVIORAL HEALTH

MBHO Standards

Targeted Self-Assessment Standards

Care Coordination

- Continuity and Coordination of Behavioral Health Care
- Continuity and Coordination between Behavioral Health and Medical Care
- Continued Access to Care

Credentialing and Recredentialing

- Credentialing policies and systems
- Credentialing Committee
- Credentialing Verification
- Recredentialing Cycle Length
- Ongoing Monitoring
- Practitioner Rights
- Assessment of Providers

Quality Management & Improvement

- Program Structure and Operations
- Services Contracting
- Continuity and Coordination of Medical Care
- Continuity and Coordination between Medical and Behavioral Health Care
- Member Experience
- Behavioral Health Screening
- Self-Management Tools
- Complex Case Management
- Clinical Practice Guidelines
- Clinical Measurement Activities
- Effectiveness of the QI Program

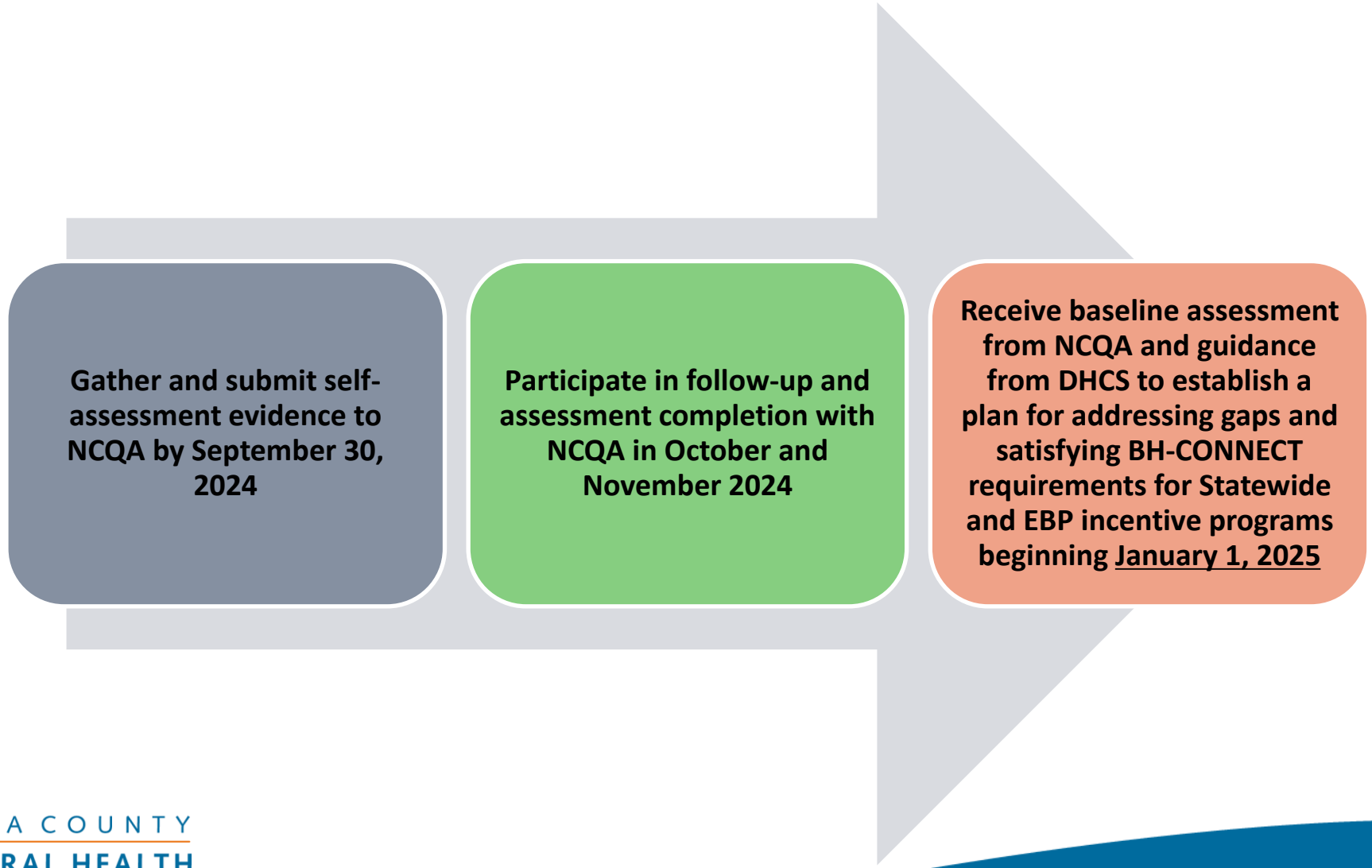
Rights and Responsibilities

- Statement of Members' Rights and Responsibilities
- Policies and Procedures for Complaints and Appeals
- Subscriber (Member) Information Management
- Practitioner and Provider Directories

Utilization Management

- Program Structure
- Clinical Criteria for UM Decisions
- Communication Services
- Use of Appropriate Professionals
- Timeliness of UM Decisions
- Clinical Information Management
- Denial Notices
- Policies for Appeals
- Handling of Appeals
- Claims Processing
- UM System Controls

Next Steps



VENTURA COUNTY BEHAVIORAL HEALTH

Questions?

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