Behavioral Health Integration Incentive Program Application

Application due January 21, 2020

Background

According to California Department of Health Care Services (DHCS) mental health prevalence estimates, 15.9% of Californian adults suffer from a mental health disorder (MHD). This translates to 4.4 million Californians who are in need of mental health treatment. Nearly two million Californians are suffering from a serious mental illness (SMI), 4.3% of whom are adults and 7.6% children. A common co-occurring condition with MHD is substance use disorder (SUD), which affects 8.8% of Californians. A fragmented health care system is ill equipped to treat people with chronic medical and behavioral health issues.

The prevalence of MHDs varies greatly by economic status. Adult members of households below 200% of the federal poverty level are 150% more likely to have a MHD. Among the SMI population, the disparity is even greater. Adult members of households below 200% of the federal poverty level are almost two times more likely to have a MHD. The prevalence of MHDs also varies greatly by race/ethnicity. Native Americans and Latinos are the most likely to have MHDs (20%), followed by African Americans (19%), Whites (14%), and Asians (10%), who are the least likely to report having MHDs.[1] Within distinct cultures and communities of color, stigma and cultural attitudes about behavioral health have a significant impact on whether individuals seek care and adhere to care plans, and will need to be a factor in designing care teams and treatment plans.

Additionally, drug overdose deaths, including those involving opioids, continue to increase in the United States. Deaths from drug overdose are up among all genders, races, and adults of nearly all ages.[2] Two out of three drug overdose deaths involve an opioid.[3] The current opioid crisis is arguably the most deadly public health epidemic in the U.S. since the 1918 influenza pandemic. However, stimulant use is on the rise in the West and Midwest (and in more rural areas), and methamphetamine is used at an increasing rate among this patient population. In 2018, the overdose rate from methamphetamines in California exceeded that of opioids[4]. While there is no medication to treat stimulant use, there are evidenced-based practices that can be employed to treat this SUD.

MHDs and SUDs reduce a person's life expectancy by 10 to 25 years, which is equivalent to reduced life expectancy from heavy smoking.[5] People with a MHD and/or SUD die from the same causes as the general population, such as heart disease, diabetes, and cancer. However, these diseases are more prevalent among people who

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[1] California Mental Health Prevalence Estimates, Task Team: HSRI, TAC and Expert Consultation From Charles Holzer. http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

[2] Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2017. NCHS Data Brief, no 329. Hyattsville, MD: National Center for Health Statistics. 2018.

[3] Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2018. Available at http://wonder.cdc.gov.

[4] California Opioid Dashboard: https://discovery.cdph.ca.gov/CDIC/ODdash/

[5] University of Oxford, "Many mental illnesses reduce life expectancy more than heavy smoking." ScienceDaily. ScienceDaily, 23 May 2014. www.sciencedaily.com/releases/2014/05/140523082934.htm.

suffer from a MHD or SUD and lead to earlier death.[6] For the entire population, the greatest risk factors for such diseases are smoking, obesity, hypertension, poor diet, and low levels of physical activity. Such health risks have an increased prevalence among those with a MHD and/or SUD, and have an earlier onset. In addition, untreated MHD or SUD often prevents people from adhering to effective medical therapy for these and other diseases, turning what would be a treatable disease into a lethal disease.

Furthermore, MHDs and SUDs in pregnancy and postpartum women affect both the mother and child. Up to one in five women face pregnancy-related or postpartum depression, anxiety, or other maternal MHDs,[7] which affect a child's growth and development as well a mother's ability to function and form healthy bonds. [8] Prenatal substance use continues to be a significant problem, which, if untreated, poses maternal and fetal health risks and can have lasting effects on an exposed child's growth, behavior, cognition, executive functioning, language, achievement, and future drug use.[9]

Only one in three people with a MHD and one in ten people with a SUD access treatment,[10] and individuals who do not access treatment experience serious health burdens and are at risk of premature death.[11] The Substance Abuse and Mental Health Services Administration and Health Resources Services Administration's jointly fund the Center for Integrated Health Solutions (SAMHSA-HRSA CIHS), which advocates for providing better care to those with co-occurring conditions, whether medical or behavioral, by integrating care. Care for individuals with complex medical and social needs is too often fragmented. These individuals seek care from multiple service systems that can each be confusing and difficult to navigate. As a result, persons with co-morbid physical and behavioral health conditions are typically high utilizers of hospital services. When behavioral health (BH) conditions are detected early and treated appropriately, those individuals experience a greater quality of life, better self-care, improved adherence to medical and behavioral health treatments, and better overall health outcomes.[12]

The implementation of validated screening tools along with brief intervention techniques serve as strategies for early detection of MHDs and SUDs, resulting in reduced alcohol and other drug misuse and earlier intervention and treatment opportunities. When preventive efforts are combined with coordinated care efforts (e.g., psych-consultation, team-care approach, peer providers, enhanced linkages to community, and BH settings), the result is a significant improvement in health outcomes. One example of

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[6] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011;49(6):599–604.

[7] https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Communications/Maternal-Mental-Health.aspx

[8] https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

[9] https://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf

[10] Behavioral Health Barometer: California, Volume 4, Substance Abuse and Mental Health Services Administration, 2017, www.samhsa.gov

[11] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011; 49(6):599–604.

[12] SAMHSA-HRSA Center for Integrated health Solutions. http://www.integration.samhsa.gov/

such success is the IMPACT model, also called collaborative care, which led to clinical outcomes that were twice as good as compared to general care.[13] Programs such as collaborative care not only improve care at the individual and population levels, but lead to lower overall health care costs.[14]

Objective

The objective of the DHCS Behavioral Health Integration (BHI) Incentive Program is to incentivize plans to improve 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, using culturally and linguistically appropriate teams with expertise in primary care, substance use disorder conditions, and mental health conditions who deliver coordinated comprehensive care for the whole patient.

The goal of the BHI Incentive Program is to increase MCP network integration for providers at all levels of integration (those just starting behavioral health integration in their practices as well as those that want to take their integration to the next level), focus on new target populations or health disparities, and improve their level of integration or impact.

General Instructions

Thank you for your interest in the DHCS BHI Incentive Program. DHCS collaborated with MCPs to roll out a standard, statewide BHI Incentive Program application. DHCS will work directly with MCPs across the state to achieve the goals and objectives of the BHI Incentive Program.

In order to apply, providers must complete and sign this application and submit it directly to the local MCP. Prior to completing this application, applicants should carefully review the entire application and other supporting documents that are available on the DHCS website https://www.dhcs.ca.gov/provgovpart/Pages/VBP_BHI_IncProApp.aspx, and consult with the local MCP.

If the provider is contracted with more than one MCP, the provider shall choose one MCP to receive their application. If the provider is awarded BHI funding by the MCP, the selected MCP will be responsible for oversight and payment to the provider for meeting the BHI Incentive Program milestones, based on their approved application.

Please complete the BHI Incentive Program application and return it to the applicable MCP no later than **5 p.m. PST on January 21, 2020**. The MCP may require the application to be submitted to the MCP's online grants management system portal. Incomplete applications will not be considered. In order for this application to be considered complete for the purposes of submission, all components of the application

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[13] IMPACT. Evidence-based depression care. http://impact-uw.org/

[14] Jurgen Unützer, Jeffrey Lieberman. Collaborative Care: An Integral Part of Psychiatry's Future. Psychiatry Online, Psychiatric News Article, November 12, 2013.

must be completed, the application must be signed, and the four attachments below must be included:

1. Detailed budget for the applicant's defined milestones and associated proposed incentive funding.
2. Letter of support from their county mental health managed care plan, if the selected BHI project addresses SMI or requires coordination with county mental health.
3. Letter of support from their county substance use disorder managed care plan or substance use disorder fee-for-service program. This attachment is only required if the selected BHI project addresses SUD.
4. An executed *DHCS Behavioral Health Integration Incentive Program Memorandum of Understanding (MOU) (Appendix B).* (If the applicant is selected for the BHI Incentive Program, the applicable MCP will sign the MOU and return a fully executed copy to the awardee.)

The application review process and timing is as follows:

Deliverable/Activity	Date
1. DHCS releases BHI Incentive Program RFA	November 12, 2019
2. DHCS conducts webinar for potential applicants/interested entities	November 22, 2019 at 1:00p.m.
3. BHI Incentive Program Applications due to the MCP(s)	January 21, 2020
4. MCPs review applications based on the standardized scoring tool	February 18, 2020
5. Participation decisions go out from MCPs to applicants	March 18, 2020
6. BHI Incentive Program start date for approved applicants	April 1, 2020
7. BHI Incentive Program operations duration	April 1, 2020 to December 31, 2022

DHCS BHI Incentive Program Application Overview

Through this BHI Incentive Program application, each applicant will select one or more behavioral health integration projects to implement over a 33-month period (April 2020 through December 31, 2022). The applicant will demonstrate how they will meet various behavioral health integration goals, objectives, and milestones. Each BHI project contains a target population, practice redesign components, and corresponding performance measures. Each application will:

*   Identify which BHI project(s) they have selected.

- Identify the specific target population for each selected BHI project (pediatric, adolescent, and/or adult) based on the population(s) served by the entity.
  - Optional: Identify if the project will focus on reducing disparities by race, ethnicity, or primary language. If the entity chooses to target disparities, the entity must identify the specific disparity target population (e.g., non-English speaking, Native American, Black, Hispanic) and report selected measures stratified by the relevant target disparity population.
- Describe the practice redesign component/tasks they will implement to achieve the goals and objectives of the selected BHI project(s).
- Identify which performance measures the applicant will report, in addition to the required measures for each BHI project (if applicable). Each BHI project will indicate how many performance measures are required.

In Incentive Program Year 1 (April through December 2020), MCPs will receive a flat incentive payment to reward selected BHI applicants that report baseline data, build infrastructure, hire staff, modify IT systems, and begin implementing practice redesign components as outlined in their application. For Incentive Program Years 2 (calendar year 2021) and 3 (calendar year 2022), MCPs will receive incentive payments from DHCS based on achieving outlined milestones and performance metrics to reward selected BHI applicants for completing Incentive Program redesign component milestones and reporting all performance metrics. The Incentive Program milestones, and the funding amounts for each, will be listed in the application. The total funding amounts that DHCS will award, per selected BHI applicant, will be the same for Incentive Program Years 2 and 3. The funding amount for Incentive Program Year 1 will be two-thirds of the amount that is available for each of the subsequent program years, which the application should reflect.

Section 1: BHI Incentive Program Applicant Information

The purpose of this section is to provide information about the BHI Incentive Program lead applicant. Primary care, specialty care, perinatal care, hospital based and behavioral health providers, federally qualified health centers (FQHCs)/rural health clinics (RHCs)[15], Indian health services (IHS) and public providers who provide services to Medi-Cal beneficiaries are eligible to submit BHI Incentive Program applications. County-based providers are eligible to apply.

All applicants must have a signed MCP network provider agreement.

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[15] FQHC/RHC providers are eligible to apply if they provide behavioral health services, and/or intend to add such services, and indicate the intention to apply for a scope of service change in the future.

1.1 BHI Incentive Program Applicant and Contact Person

Organization Name	
Type of Entity (from lead entity description above)	
Service Location Physical Address(es)	
Geographic Service Area(s)	
Number of all Medi-Cal Members Served Per Year	
Percentage of all clients served per year who are Medi-Cal Members at Sites Implementing BHI	
Contact Person	
Contact Person Title	
Telephone Number	
Email Address	
Mailing Address	

Section 2: BHI Incentive Program Project Options

The purpose of this section is to identify the applicant's selected BHI project(s). The first part of this section describes the project options. The applicant will indicate their project selection(s) and additional information in the second part of this section. Applicants can select up to six BHI projects.

BHI Project Options

Below is a list of allowable BHI projects that can be applied in either a pediatric, adolescent, and/or an adult practice:

1. Basic Behavioral Health Integration

2. Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment
3. Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses
4. Diabetes Screening and Treatment for People with Serious Mental Illness
5. Improving Follow-Up after Hospitalization for Mental Illness
6. Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

Below are the target population goals, practice redesign considerations, and performance measures for each BHI project. Please note that the practice redesign considerations are just overall guidance on practice redesign components to consider when putting together the BHI project plan.

See *Appendix A: Core Components and Tasks of Effective Integrated Behavioral Health Care Programs* for examples of integration components/tasks that could be incorporated into the applicant's BHI project across the following categories:

- Patient Identification and Diagnosis
- Engagement in Integrated Care Programs
- Evidence-Based Treatment
- Systematic Follow-up, Treatment Adjustment, and Relapse Prevention
- Communication and Care Coordination
- Systematic Psychiatric Case Review and Consultation
- Program Oversight and Quality Improvement
- Strategies and Practice Redesign Components to Increase Level of Integration

Basic Behavioral Health Integration

Target Population Goal:
Improve evidence-based medical and behavioral health integration practices with a primary care, specialty care, or behavioral health provider's office or clinic. This package is best suited for practices that are new to behavioral health integration.

Practice Redesign:
Ensure culturally appropriate interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and substance use disorder services. Preventive care screenings,[16] including behavioral health screenings (e.g., PHQ-2, PHQ-9, GAD-7, and SBIRT), should be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) to ensure access for

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[16] https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

further evaluation and evidence-based treatment, when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Required Measures for the Behavioral Health Integration Package		
NCQA	Screening for Unhealthy Alcohol Use	Pediatric and Adult
CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Pediatric
CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Adult
NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Pediatric and Adult
NCQA	Antidepressant Medication Management (AMM-AD)	Adult
Applicant to select two or more additional measures to report from list below		
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Pediatric
NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Pediatric
NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Pediatric
NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Adult
PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Adult
NCQA	Pharmacotherapy for Opioid Use Disorder [17]	Adult
NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Adult
NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Adult
NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (MSC-AD)	Adult
NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Pediatric
NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Adult
NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Adult
NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Adult
NCQA	Comprehensive Diabetes Care (CDC)[18]	Adult
NCQA	Controlling High Blood Pressure	Adult

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[17] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf
[18] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment

Target Population Goal:
Increase prenatal and postpartum access to mental health and substance use disorder screening and treatment.

Practice Redesign:
Ensure culturally appropriate interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and substance use disorder services. Preventive care screenings,[19] including behavioral health screenings (e.g., PHQ-2, PHQ-9, GAD-7, and SBIRT), would be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and evidence-based treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Required Measures for Maternal Mental Health and Substance Use Package [20]	
CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)
CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)
NCQA	Screening for Unhealthy Alcohol Use
NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)
Applicant to select one or more additional measures to report from list below	
NCQA	Antidepressant Medication Management (AMM-AD)
NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)
NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)
NCQA	Pharmacotherapy for Opioid Use Disorder [21]

Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses

Target Population Goal:
Improve evidence-based behavioral health prescribing and management of psychotropic, opioid use disorder (OUD), and alcohol use disorder medications.

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[19] https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

[20] This measure denominator technical specifications will be altered to allow for data collection that captures pregnant or postpartum women.

[21] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf

Practice Redesign:

Ensure culturally appropriate interventions and systems are in place to support improvement in medication adherence, follow-up care, psychosocial care, and metabolic monitoring. Implement appropriate systems to improve patient safety and medication adherence through monitoring per the current evidence-based clinical guidelines. Deploy sustainable interventions to target improvements in medication management and adherence, link to community treatment, and enhance self-management strategies.

Please note that for this BHI project, the entity would identify the specific target population (adults, children, or both) based on the population served by the entity. The entity would report the required measures and additional measures as applicable to the specified target population.

Required Children and Adolescent Measures for Medication Management Package	
NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
NCQA	Metabolic Monitoring for Children and Adolescents on Anti-Psychotic Medication
NCQA	Pharmacotherapy for Opioid Use Disorder [22]

Required Adult Measures for Medication Management Package	
NCQA	Antidepressant Medication Management (AMM-AD)
PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)
NCQA	Pharmacotherapy for Opioid Use Disorder [23]

Diabetes Screening and Treatment for People with Serious Mental Illness

Target Population Goal:

Improve health indicators for patients with both diabetes and serious mental illness.

Practice Redesign:

Ensure culturally appropriate interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and substance use disorder services. Preventive care screenings,[24] including medical

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[22] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf
[23] https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf
[24] https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

and behavioral health screenings (e.g., United States Preventive Services Task Force (USPSTF) diabetes screenings, PHQ-2, PHQ-9, GAD-7, and SBIRT), would be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and evidence-based treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Required Measures for Diabetes Screening and Treatment for People with Serious Mental Illness	
NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
NCQA	Comprehensive Diabetes Care (CDC)[25]

Follow Up after Hospitalization for Mental Illness

Target Population Goal:
Improve timely follow up after hospitalization for mental illness.

Practice Redesign:
Culturally appropriate interventions are needed that link individuals in inpatient settings to outpatient mental health treatment following acute treatment.[26] Enhanced access to primary care and/or to mental health specialists could be integrated into discharge planning for these patients. Improved communication mechanisms and data sharing between inpatient and outpatient facilities to support linkages to primary care physicians, mental health specialists, and other community services through the discharge process are critical to successful follow up and ongoing treatment needs. Implementation of outpatient patient navigators, peer navigators, peer support, and/or case management, and developing protocols regarding follow up after hospitalization and/or missed visits.

Please note that for this BHI project, the entity would identify the specific target population (adults, children, or both) based on the population served by the entity. The entity would report the required measures as applicable to the specified target population.

Required Measures for Follow-Up after Hospitalization for Mental Illness Package		
Child Core	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
Adult Core	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)

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[25] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182296/

Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

Target Population Goal: Improve timely follow-up after emergency department visit for mental illness and substance use disorder.

Practice Redesign: Integrate appropriate screening tools, staff training, and culturally appropriate decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and/or substance use disorders. Enhanced access to primary care and/or to behavioral health specialists could be integrated into discharge planning for these patients. When appropriate, patients should be started on behavioral health medications in the ED. Use of ED care navigators (e.g., community physician liaison program, substance user navigators) may be used to support linkages to primary care physicians and mental health and substance use disorder specialists and other community services through the discharge process.

Required Measures for Follow-Up after Emergency Department Visit Package		
Adult Core	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)
Adult Core	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)

Section 3: BHI Project Selection

The six BHI projects options are listed below, with a specific form for each project. Complete items a-g for each BHI project selected.

3.1 ☐ <u>Basic Behavioral Health Integration</u> **Check the box if this project is selected.**
a. Check the box for the Specific Target Population(s) for this project (based on the populations served by the entity): ☐ **Pediatric** ☐ **Adolescent** ☐ **Adult** **In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.**
a:
b. <u>**Optional**</u>**:** ☐ **Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.** **If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.**
b:
c. This BHI project requires the applicant to select two, or more, performance measures beyond the required measures. Check the boxes for the selected additional measures in the white section below. (See Project measure requirements on pages 6-11 for each Project.)

Applicant to select two, or more, measures to report from list below:		
☐ NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Pediatric
☐ NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Pediatric
☐ NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Pediatric
☐ NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Adult
☐ PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Adult

☐ NCQA	Pharmacotherapy for Opioid Use Disorder	Adult
☐ NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Adult
☐ NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Adult
☐ NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (MSC-AD)	Adult
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Pediatric
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Adult
☐ NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Adult
☐ NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Adult
☐ NCQA	Comprehensive Diabetes Care (CDC)	Adult
☐ NCQA	Controlling High Blood Pressure	Adult

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:
1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**
3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:
1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the applicant has reported all metric data that is past due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application, through December 2022. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).

f: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the

component/task will be completed and the funding requested for the component/task.

g: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

3.2 ☐ Maternal Mental Health and Substance Use

Check the box if this project is selected.

a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity):

☐ **Pediatric**

☐ **Adolescent**

☐ **Perinatal**

☐ **Adult**

In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.

a:

b. Optional: ☐ **Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.**

If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.

b:

c. This BHI project requires the applicant to select one, or more, performance measures beyond the required measures. Check the boxes for the selected additional measure(s) in the white section below. (See Project measure requirements on pages 6-11 for each Project.)

Applicant to select one, or more, measures to report from list below		
☐ NCQA	Antidepressant Medication Management (AMM-AD)	
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	
☐ NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	
☐ NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	
☐ NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	
☐ NCQA	Pharmacotherapy for Opioid Use Disorder	

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed

information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:
1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**
3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:
1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that

will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application, through December 2022. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).

f: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

g: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

3.3 ☐ Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnosis

Check the box if this project is selected.

a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity):

☐ **Pediatric**

☐ **Adolescent**

☐ **Adult**

In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.

a:

b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.

If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.

b:

c. This BHI project this project only requires the standard performance measures. (See Project measure requirements on pages 6-11 for each Project.)

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:
1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:
1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application, through December 2022. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).

f: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

g: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

3.4 ☐ Diabetes Screening and Treatment for People with Serious Mental Illness

Check the box if this project is selected.

a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity):

☐ **Pediatric**

☐ **Adolescent**

☐ **Adult**

In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.

a:

b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.

If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.

b:

c. This BHI project only requires the standard performance measures (See Project measure requirements on pages 6-11 for each Project.)

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:
1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:
1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).

f: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

g: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

3.5 ☐ Improving Follow-up after Hospitalization for Mental Illness

Check the box if this project is selected.

a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity):

☐ **Pediatric**

☐ **Adolescent**

☐ **Adult**

In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.

a:

b. Optional: ☐ **Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.**

If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.

b:

c. This BHI project only requires the standard performance measures. (See Project measure requirements on pages 6-11 for each Project.)

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:
1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:
1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

e: (500 Words or less.)

Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

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f: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

g: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

3.6 ☐ Improving Follow-up after emergency Department Visit

Check the box if this project is selected.

a. Identify the Specific Target Population(s) for this project (based on the populations served by the entity):

☐ **Pediatric**

☐ **Adolescent**

☐ **Adult**

In the white section below, provide an estimate of the number of the Medi-Cal members who are likely to be impacted by this BHI Project through your entity.

a:

b. Optional: ☐ Check this box if the project will focus on reducing disparities by race, ethnicity, and/or primary language and report stratified metrics for the target population.

If the project will focus to reduce disparities, identify the specific disparity target population(s) in the white section below.

b:

c. This BHI project only requires the standard performance measures. (See Project measure requirements on pages 6-11 for each Project.)

d. Provide an overview of the practice redesign components and tasks that the project will implement over the entire duration of the project. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." (More detailed information for activities for each Project Year, milestones, and funding will be provided in e-g below.)

d: (500 Words or less.)

Why is this Project important for your entity and the Medi-Cal clients that you serve? Include information that supports your belief that:
1. **You serve a population that is an appropriate target group for this Project and that can benefit significantly from the Project components:**
2. **Your entity is best suited to operate this Project for your clients:**

3. **Include problem statement information that is as specific as possible for your entity and a target population of your clients:**

What will be your entity's approach for implementing this Project? Include information regarding your plan of action that indicates your ability to achieve significant outcome improvements, including:
1. **The project design, including the practice redesign components and tasks that the project will implement over the entire duration of the project:**
2. **Implementation steps over the duration of the Project:**
3. **Operational capacity and leadership commitment to meet the operational milestones:**
4. **How the project redesign strategies will be sustained after the BHI project and funding end:**

e. For Project Year 1 (2020), in the white section below describe the activities and accomplishments that will occur to achieve the goal and objective of the BHI Project. List the single flat payment amount requested for Project Year 1.

For Project Year 1, awardees will receive one flat, up-front payment to report baseline data, build infrastructure, hire staff, modify IT systems and begin implementing practice redesign components. See the Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Baseline data collection is an applicable activity for Project Year 1 only. Applicants may request funding to support BHI Project-related metric reporting activities.

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Narrative:

Flat Funding Amount Requested:

Milestone List (include the accomplishment and date, and a description of how achievement of the milestones will support implementation and collection of the selected measures):

f. For Project Year 2 (2021), include discrete details in the white section below regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

Project Year 2 and 3 payment is dependent on completing approved practice redesign components/tasks (as listed in the application) and reporting of all performance metrics. See Project Goals and Practice Redesign requirements on pages 6-11. See also the Appendix A "Core Components and Tasks of Effective Integrated Behavioral health Care Programs." Applicants may request funding to support BHI Project-related metric reporting activities. The MCP will not provide payment for any completed milestones until the

applicant has reported all metric data that is due. At the MCP's discretion, milestones and funding may roll over if the milestone is not completed according to the timing that is listed in the application. The applicant shall include completion of metric reporting as a milestone(s) in the milestone list, with a specific funding amount(s).

f: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

g. For Project Year 3 (2022), include discrete details regarding all practice redesign components and tasks that will be implemented to achieve the Project goal and objective. Provide a narrative overview of the work that will be done. Also provide a milestone list of redesign components/tasks that includes the date the component/task will be completed and the funding requested for the component/task.

g: (500 words or less.)

Narrative:

Milestone List (for each milestone, include the accomplishment, completion date, and funding amount):

Section 4: Attestations and Certification

4.1   Attestation

I certify that as the representative of the BHI Incentive Program applicant, I agree to the following conditions:

- The BHI Incentive Program applicant will comply with the terms of the Memorandum of Understanding (Appendix B) executed with its partner MCP.

- The purpose of the BHI Incentive Program funding is to better integrate physical and behavioral health care for Medi-Cal members. The applicant will use the BHI Incentive Program funding to better integrate physical and behavioral health care for all target population members within the applicant's practice panel.

- BHI Incentive Program funding will not duplicate or supplant other previously identified funding that is specifically dedicated to the deliverables listed in this application. BHI Incentive Program funding may be combined with other funding sources to accomplish the milestones listed in this application, to the extent permissible under federal law.

- BHI Incentive Program funding will not be used to reimburse for services currently reimbursable under Medi-Cal, but must be used to improve the delivery system for Medi-Cal managed care enrollees.

- If the BHI Incentive Program applicant is a FQHC, either behavioral health is currently included in the scope of practice, or the FQHC will apply for a future scope of practice change to include behavioral health services.

- The BHI Incentive Program applicant will report and submit timely and complete data to the partner MCP in a format specified by the MCP.

- The BHI Incentive Program applicant shall submit reports in a manner specified by the partner MCP.

- Implementation of the BHI Incentive Program is contingent upon DHCS obtaining all necessary approvals from the Centers for Medicare & Medicaid Services, and the terms for participation are subject to change based on the availability of federal approvals. In addition, continuation of the BHI Incentive Program is contingent upon state legislative appropriations in future fiscal years.

- Payments for BHI projects will be contingent upon completion of the application milestone deliverables.

☐ **I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of BHI Incentive Program participation requirements.**

_____

Signature of BHI Incentive Program Applicant Representative   Date

Appendix A: Core Components and Tasks of Effective Integrated Behavioral Health Care Programs[27]

Patient Identification and Diagnosis
- Screen for behavioral health problems using valid instruments
- Diagnose behavioral health problems and related conditions
- Use valid measurement tools to assess and document baseline symptom severity

Engagement in Integrated Care Program
- Introduce collaborative care team and engage patient in integrated care program
- Initiate patient tracking in population-based registry

Evidence-Based Treatment
- Develop and regularly update a biopsychosocial treatment plan
- Provide patient and family education about symptoms, treatments, and self-management skills
- Provide evidence-based counseling (e.g., motivational interviewing and behavioral activation)
- Provide evidence-based psychotherapy (e.g., problem solving treatment, cognitive behavior therapy, and interpersonal therapy)
- Prescribe and manage psychotropic medications as clinically indicated
- Change or adjust treatments if patients do not meet treatment targets
- Train staff and providers in trauma-informed care

Systematic Follow-up, Treatment Adjustment, and Relapse Prevention
- Use population-based registry to systematically follow all patients
- Proactively reach out to patients who do not follow up
- Monitor treatment response at each contact with valid outcome measures
- Monitor treatment side effects and complications
- Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment
- Create and support relapse prevention plan when patients are substantially improved

Communication and Care Coordination
- Coordinate and facilitate effective communication among providers
- Engage and support family and significant others as clinically appropriate
- Facilitate and track referrals to specialty care, social services, and community-based resources

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[27] *e.g.,* AIMS Center Behavioral Integration Checklist, McHAF Site Self-Assessment
https://www.integration.samhsa.gov/AIMS_BHI_Checklist.pdf

Systematic Psychiatric Case Review and Consultation

- Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving
- Provide specific recommendations for additional diagnostic work up, treatment changes, or referrals
- Provide psychiatric assessments for challenging patients in person or via telemedicine

Program Oversight and Quality Improvement

- Provide administrative support and supervision for the program
- Provide clinical support and supervision for the program
- Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, and patient satisfaction), and use this information for quality improvement

Strategies and practice redesign components that can increase your level of integration[28]

- The behavioral health specialist (BHS) is integrated into the workflow of the clinic
- The BHS shares access to the electronic medical record (EMR)/patient chart with primary care providers (PCPs)
- Clinic treatment plans reflect an integrated approach to patient behavioral and physical health needs
- The clinic scheduling system allows patients to be scheduled for same day appointments with the BHS
- The clinic systematically triages the behavioral health needs of its patients
- The clinic systematically tracks the progress of behavioral health treatment
- The PCP and BHS do warm hand offs according to patient needs
- The PCP and BHS regularly consult about patient care
- The PCP and BHS collaborate in making decisions about mutual patients
- The clinic has at least one integrated care "champion"

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[28] Level of Integration Measure (LIM): Purpose: To rate the degree to which behavioral health providers or behavioral health care is integrated into primary care settings from the perspective of staff and/or providers. Developer: Antioch University
https://integrationacademy.ahrq.gov/sites/default/files/measures/5_Level_of_Integration_Measure.pdf

MEMORANDUM OF UNDERSTANDING
BETWEEN
[PROVIDER]
AND
[PLAN]
FOR PROPOSITION 56 VALUE-BASED PAYMENT BEHAVIORAL HEALTH INTEGRATION INCENTIVE PROGRAM

This Memorandum of Understanding ("MOU") is made and entered into as of this ____ day of _____, 2020, by and between [NAME] ("Provider") and [NAME] ("Plan") in order to facilitate successful implementation of the provider's behavioral health integration project(s) ("BHI Project(s)") set forth in the approved BHI Incentive Program application.

Whereas, Section 14188.1 of the Welfare and Institutions Code authorized the Department of Health Care Services ("DHCS") to develop the Proposition 56 Value-Based Payment ("VBP") Program, including the Behavioral Health Integration ("BHI") program in Medi-Cal managed care, with the goals of improving physical and behavioral health outcomes, efficiency in care delivery, and improved patient experience by integrating and coordinating primary care, mental health, and substance use disorder treatment for Medi-Cal beneficiaries; and,

Whereas, DHCS established an application process in partnership with managed care plans whereby eligible providers submitted BHI Incentive Program applications establishing BHI project(s) to be considered for BHI Incentive Program payments, and incentivized plans to oversee and administer payment for approved BHI project(s); and,

Whereas, the provider's BHI project(s) has been selected by the plan for the BHI Incentive Program according to the terms of the provider's BHI Incentive Program application; and,

Whereas, the plan is responsible for oversight and administration of payments to the provider consistent with the terms of the BHI Incentive Program, any terms imposed as a condition of federal approval of the BHI Incentive Program, and any DHCS guidance related to the BHI Incentive Program.

Therefore, the provider and plan agree as follows:

1. **Term**. The Term of this MOU shall begin on [GRANT AWARD DATE] and shall terminate on [END DATE OF GRANT].

2. **Termination**. The terms of this MOU are contingent upon BHI Incentive Program application approval, the availability of sufficient state and federal Medicaid funding, and all necessary federal approvals to be obtained by DHCS. Should sufficient funds not be allocated, or federal financial participation be unavailable, services may be modified accordingly, or this MOU can be terminated by any party after giving 30 days advance written notice. The plan may terminate this MOU with 30 days advance written notice to the provider and DHCS due to the provider's failure to meet terms of a corrective action plan as set forth in Section 5 (Corrective Action).

3. **Scope.** The provider is responsible for the implementation of and compliance with the project(s), as set forth in their BHI Incentive Program application, which is attached as Exhibit 1 and incorporated here by reference, including reporting to the plan on the achievement of milestones and objectives consistent with the terms of the BHI Incentive Program application. The provider shall promptly notify the plan of any material change in information submitted in support of the project(s) or the BHI Incentive Program application, including changes in organizational leadership, business operations, and financial standing. The plan is responsible for overseeing the project(s), including monitoring and verifying milestone achievement and administering payments consistent with the terms of the project(s) or the BHI Incentive Program application, any terms imposed as a condition of federal approval of the BHI Incentive Program, and any subsequent DHCS guidance related to the BHI Incentive Program.

4. **Confidentiality.** The plan and provider collaboration in support of project(s) may require the exchange of confidential or proprietary information ("Confidential Information") as may be identified by either party. The plan and provider agree to abide by processes and requirements applicable to the exchange of either party's respective confidential information, in accordance with applicable state or federal law.

5. **Corrective Action**. In recognition of the need for project flexibility, the plan may utilize a corrective action plan, or other mutually agreed upon or DHCS-required mechanism, for modifying the project terms to facilitate the provider's compliance with project terms or to adjust project goals and objectives and related payments, as necessary. Such modifications are subject to DHCS review and approval. Provider noncompliance with modified project terms may result in termination of this MOU consistent with Section 2 (Termination). In the event of project termination, the

provider shall return funds as directed by the plan.

6. **Provider Responsibilities**:

A. **Use of Funding**

   i. The provider shall expend project award funds for the purposes of carrying out activities and achieving milestones as set forth in the approved project(s).

   ii. The provider shall document to the plan, in a form and manner determined by the plan, that project activities have been carried out and milestones have been achieved.

   iii. To the extent the provider does not or is unable to carry out project activities and achieve milestones, the provider shall notify the plan and return any funds that the provider may have received related to those project activities or milestones.

B. **Practice Redesign and Infrastructure Development Reporting**

   i. The provider will implement the practice redesign and infrastructure development components set forth in the BHI Incentive Program application.

   ii. The provider will shall report to the plan on the progress of the project's practice redesign and infrastructure development on a schedule in a format and process specified in the BHI Incentive Program application, or as otherwise mutually agreed upon by the plan and provider.

C. **Milestone Achievement**

   i. The provider will perform tasks necessary to meet milestones required by the BHI Incentive Program application. The provider shall provide the plan with information necessary to demonstrate progress in achieving milestones as set forth in the BHI Incentive Program application.

D. **Measure Reporting**

   i. The provider will report to the plan on target population measures on a schedule in a format and process required by the BHI Incentive Program application, or as otherwise mutually agreed upon by the plan and provider.

ii.   The provider will report measures to the plan consistent with the specifications required by the respective measure author (e.g., National Committee for Quality Assurance).

7.   **Plan Responsibilities**

A.   **Monitoring Project Milestones and Measures**. The plan will collect and evaluate all information related to implementation of the provider's project(s) for the purposes of ensuring progress toward the provider's goals and objectives, reporting to DHCS and other objectives as set forth in the BHI Incentive Program application.

B.   **Reporting to DHCS.** The plan will report to DHCS on the project status as specified in the terms of the BHI Incentive Program application, the terms of federal approval for the BHI Incentive Program, and any applicable DHCS-issued guidance.

C.   **Information Exchange**. The plan will provide the provider with the following information to support the provider on reporting project target population(s):

i.   [LIST MEASURES OR DATA ELEMENTS, E.G., "EMERGENCY DEPARTMENT UTILIZATION"]

D.   **Administration of Project Funds**

a.   **Initial Payment**. Within 30 days of the managed care plan's selection of a BHI Incentive Program applicant, or as otherwise mutually agreed upon by the plan and provider, the plan will provide initial payment to the provider as set forth in the terms of the project and BHI Incentive Program application.

b.   **Milestone Payments.** Subsequent to the initial payment, all ongoing payments to the provider will be tied to achieving practice redesign components, milestones, or defined progress toward goals required by terms of the project and BHI Incentive Program application. The plan will remit milestone payments to the provider within [NUMBER OF DAYS] days of the provider's successful demonstration to the plan of each milestone achievement per the terms of the project. The plan may adjust milestone measurement and related payments consistent with the terms of a corrective action plan. The plan will not make any milestone payment until all past due reporting is completed.

8. **Liaison.** The plan and provider will each designate a liaison(s) to serve as a point of contact for activities performed related to this MOU.

9. **MOU Monitoring. The** plan and provider will meet on a mutually agreed upon frequency, or upon request to monitor the performance of parties' responsibilities related to this MOU.

10. **Dispute Resolution.** If there is a dispute that cannot be resolved by the parties through Section 9 "MOU Monitoring," either party can submit a request for resolution to the Department of Health Care Services. A party shall give the other five business days of notice of its intent to submit a request for resolution.

Witness whereof, the parties hereto have executed this MOU as of [DATE].

Attest:

[PROVIDER]

By:

[PLAN]

By:

ATTACHMENTS:

Included in MOU	Exhibit/Attachment
X	Exhibit 1 – Approved Provider VBP BHI Project ("Project")