Draft Evidence-Based Practices and Community Defined Evidence Practices Resource Guide

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Chapter 1: Introduction

Youth behavioral healthcare in California is at a pivotal moment. In recent years, the state has experienced an increase in demand for behavioral health services among children and adolescents, driven by rising rates of anxiety, depression, and trauma.[1] In 2023, 18 percent of California children reported having one or more emotional, behavioral, or developmental conditions.[2] More than 1 in 14 children (ages 0-17) in California experiences an emotional disturbance that limits daily functioning,[3] and nationwide roughly 50 percent of all lifetime mental illnesses start by age 14.[4] Contributing factors such as the COVID-19 pandemic and economic instability[5] have intensified behavioral health struggles for many young people. Families, particularly those in underserved communities, often face significant barriers to securing timely and affordable behavioral health support.

To address these challenges, the Department of Health Care Services (DHCS), California Department of Social Services (CDSS), and California's Health and Human Services (CalHHS) more broadly have launched multiple statewide initiatives.[6] Several of these initiatives have focused on expanding access to evidence-based practices (EBPs)[7] and community-defined evidence practices (CDEPs)—two types of interventions that have demonstrated effectiveness in improving behavioral health outcomes—throughout the state.[8]

This document was developed with a focus on California's No Wrong Door[9] approach to behavioral health, which ensures Medi-Cal members (1) receive timely mental health services without delay regardless of where they initially seek care and (2) can maintain treatment relationships with trusted providers without interruption. As such, this guidance includes a wide range of EBPs and CDEPs that reflect the diversity of needs, populations, and delivery settings across the state. The inclusion of these practices is intended to support access and equity, not to prescribe or recommend a specific level of care or treatment modality for any individual or population. DHCS is committed to ensuring that all EBPs and CDEPs are implemented with fidelity to their respective models. Providers are expected to adhere to the core components and training requirements of each practice to ensure quality and effectiveness in service delivery.

The guidance provided does not constitute legal advice and should be verified with independent legal counsel.

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[1] California Ranks in Bottom Third of States in Child Well-Being as Youth Depression and Anxiety Jump By 70%. Children Now
[2] Statistics on children, youth and families in California from the Annie E. Casey Foundation and Children Now
[3] Mental Health in California: Waiting for Care, California Health Care Foundation, p. 2
[4] Mental Health Conditions, National Alliance on Mental Illness
[5] California Ranks in Bottom Third of States in Child Well-Being as Youth Depression and Anxiety Jump By 70%. Children Now
[6] Governor Newsom's Master Plan for Kids' Mental Health, August 2022
[7] SAMHSA Evidence-Based Practices Resource Center
[8] The California Reducing Disparities Project Phase 2 Statewide Evaluation Report
[9] DHCS, "No Wrong Door for Mental Health Services Policy" BHIN 22-011

A. Introduction to EBPs and CDEPs

EBPs and CDEPs are designed to deliver timely access to equitable, culturally responsive, services to meet emerging and ongoing behavioral health needs of Californians.[10]

i. Evidence-based practices (EBPs)

EBPs are practices with documented, empirical evidence (e.g., randomly controlled trials, peer-reviewed studies, and publications) of effectiveness in improving children and youth behavioral health. EBPs are widely regarded as the gold standard in behavioral health care,[11] as they offer structured, research-backed approaches to treatment. These practices have been clinically reviewed and codified, meaning the practices have been manualized to ensure they are implemented consistently across various settings. For example, Child-Parent Psychotherapy (CPP) is an EBP designed to support young children and their primary caregivers by addressing trauma and improving emotional and behavioral outcomes. A study conducted on CPP has shown that it effectively reduces trauma symptoms in young children, improves the quality of the parent-child relationship, and enhances emotional regulation and attachment security in children who have faced adverse experiences.[12]

At both the federal and state level, EBP resources have been catalogued in existing databases by Substance Abuse and Mental Health Services Administration (SAMHSA)[13] and California Evidence-Based Clearinghouse (CEBC)[14], respectively. By incorporating well-documented practices like CPP into health and social services programs, California aims to support early intervention for behavioral health conditions and enhance the social and emotional well-being of children and families. EBPs may eventually become a crucial element in addressing the behavioral health needs of youth across the state.

ii. Community-defined evidence practices (CDEPs)

CDEPs are community-based behavioral health practices that have reached a strong level of support within specific communities. CDEPs complement EBPs by integrating culturally relevant and community-specific approaches to behavioral health care. CDEPs also address social determinants of behavioral health, such as intergenerational trauma and community violence, which are often missed in

[10] Evidence-Based and Culturally Relevant Behavioral Health Interventions in Practice: Strategies and Lessons Learned from NNEDLearn (2011-2020)
[11] Shaping evidence-based practice
[12] Child-Parent Psychotherapy: A Trauma-Informed Treatment for Young Children and Their Caregivers, Lieberman, A. F., & Van Horn, P. (2008)
[13] SAMHSA
[14] California Evidence-Based Clearinghouse for Child Welfare

traditional care models. While EBPs are validated through randomized controlled trials (RCTs), CDEPs draw on the lived experiences and traditions of specific communities, making them especially effective for groups that have been historically marginalized. Examples include Cultura y Bienestar by La Clinica de La Raza and Experience Hope for Teens by Catholic Charities of East Bay, both of which provide trauma-informed, culturally responsive behavioral health support to underserved communities.[15]

Research shows that culturally adapted practices, like those informed by CDEP principles, lead to higher participation and completion of treatment, particularly within communities of color.[16] The California Reducing Disparities Project (CRDP), funded by the California Department of Public Health through its Office of Health Equity (OHE), aims to build the evidence base for 35 pilot CDEP programs. The CRDP is supporting the data collection and evaluation of these CDEPs to promote practices that connect with historically underserved populations. Additionally, it seeks to identify strategies for systemic change to integrate CDEPs into the public behavioral health delivery system.[17]

iii. Benefits of EBPs and CDEPs

Together, EBPs and CDEPs create a more inclusive and effective behavioral health system. Increasing access to and utilization of EBPs and CDEPs for behavioral services that are well supported in scientific literature and by community-based practitioners could improve beneficiary outcomes.[18] Additionally, while the long-term impact of these interventions will depend on various factors, such as implementation quality and scalability, research suggests that addressing behavioral health challenges early and effectively may help reduce reliance on more intensive and costly services and potentially alleviate pressures on public systems like healthcare, education, and social services.[19]

Example in action:[20] Parent–Child Interaction Therapy (PCIT) is an EBP designed to address disruptive behaviors in children and strengthen parent-child relationships. Supported by more than 40 years of research, PCIT has been used widely and adapted to meet the diverse needs of families. Its effectiveness has been shown across situations and child diagnoses, including autism spectrum disorder (ASD), Attention-Deficit Hyperactivity Disorder (ADHD), and other emotional or behavioral

[15] Cultura y Bienestar; Catholic Charities East Bay

[16] Guerrero, et al. Advancing theory development: Exploring the leadership–climate relationship as a mechanism of the implementation of cultural competence, Administration and Policy in Mental Health and Mental Health Services Research

[17] California Reducing Disparities Project

[18] Information about outcomes for individual EBPs available through the SAMHSA Evidence-Based Practices Resource Center and California Evidence-Based Clearinghouse

[19] For example, research by Evernorth based on Cigna claims data (costs decreased by up to $1,377 per person in one year and up to $3,109 per person over two years). See also Highland, et al. (showing that both provider-supported and self-directed behavioral home health approaches achieved significant reductions in total cost relative to comparison cohorts)

[20] Parent-Child Interaction Therapy (PCIT), California Evidence-Based Clearinghouse

challenges. The therapy focuses on improving emotional regulation and fostering positive interactions between parents and children, with interventions tailored to specific families' needs while maintaining the core principles that ensure PCIT's effectiveness.

Research highlights the success of PCIT in reducing behavioral issues in children, improving caregiver confidence, and enhancing family dynamics. Key components driving its effectiveness include positive reinforcement, consistent consequences, and a growing emphasis on emotion regulation for both parents and children.[21] Recent advancements have explored modifications to PCIT to better support families with unique needs, such as those requiring additional emotional support or managing complex diagnoses. These adaptations allow therapists to personalize interventions while preserving the program's foundational elements. By balancing flexibility with fidelity of its core purpose, PCIT remains a powerful and adaptable tool for helping families thrive.

Prioritizing EBPs and CDEPs can also help ensure that behavioral health services are culturally responsive and inclusive. Many EBPs and CDEPs combine similar elements of traditional outpatient behavioral health treatment with other social and cultural supports. Programs that are tailored to the unique needs and experiences of California's diverse populations are more likely to engage individuals and families. Culturally tailored programs, such as CDEPs, are especially important for engaging historically underserved communities. These programs build trust and ensure equitable access to care by addressing the unique needs and experiences of diverse populations.

Example in action:[22] Strong African American Families (SAAF) is an EBP designed to strengthen family relationships, improve parenting, and reduce risky behaviors among African American youth.

A 2022 study conducted on the effectiveness of SAAF highlights the widespread impact of racial discrimination on African American adolescents, affecting their behavioral health, future opportunities, and behaviors. It emphasizes the role of racial socialization and fostering Black pride as crucial protective factors that can help shield adolescents from the harmful effects of discrimination.

The study shows that SAAF was associated with increases in racial socialization, which in turn fostered increases in adolescent Black pride. Black pride was indirectly associated with reduced risk behavior through adolescent psychological functioning. The research also shows that SAAF enhances family communication, reduces substance use, and promotes positive youth development. It confirms that

[21] Evidence-Based Treatment in Practice: PCIT Research on Addressing Individual Differences and Diversity Through the Lens of 20 Years of Service, National Library of Medicine

[22] The California Evidence-Based Clearinghouse, SAAF, see section on About This Program

family-based prevention can support African American adolescent behavioral health in the context of discrimination.[23]

EBPs and CDEPs offer an opportunity to create a behavioral health system that delivers proven clinical results while also addressing the unique needs and experiences of individuals. The state's focus on expanding the use of EBPs and CDEPs has been key to shaping a healthier and more inclusive future for California communities and will remain vital in addressing the evolving behavioral health needs of its residents.

iv. Investing in EBPs and CDEPs in the State of California

EBPs and CDEPs are often uniquely positioned to deliver positive outcomes because they consider a wide range of social and cultural factors and use diverse, sometimes non-traditional types of providers. However, these same factors can present challenges when trying to expand these practices through conventional approaches. For instance, EBP and CDEP providers might find it difficult to translate certain EBP and CDEP service components into clinical terms commonly recognized by MCPs and insurers and used to determine if a service component can be reimbursed (Chapters 5-10 of this resource guide address this challenge by offering possible billing codes that can be used for specific EBPs).
To address these challenges, California has supported the expansion of EBPs and CDEPs through significant investments. Recent state initiatives have included:

- **CYBHI Scaling EBP & CDEP grant program:** As part of the Children and Youth Behavioral Health Initiative (CYBHI),[24] DHCS authorized a total of $381 million in grants[25] to organizations seeking to scale EBPs and CDEPs that improve access to quality behavioral health services for children and youth.
- **Family First Prevention Services Act:** CDSS has developed a prevention plan to enable California to access federal Title IV-E prevention funding for EBPs through the Family First Prevention Services Act (FFPSA).[26] FFPSA outlines a set of EBPs that are eligible for reimbursement under Title IV-E to provide enhanced support to children and families and prevent foster care placements.
- **The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative:** BH-CONNECT is a DHCS initiative to increase access and strengthen community-based behavioral health services (including EBPs) for Medi-Cal members with significant behavioral health needs.[27] BH-CONNECT includes a new five-year Medicaid Section 1115

[23] The Strong African American Families Program: Disrupting the Negative Consequences of Racial Discrimination Through Culturally Tailored, Family-Based Prevention, National Library of Medicine
[24] California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration, DHCS
[25] Evidence-Based and Community-Defined Evidence Practices Grants
[26] Five-Year State Prevention Plan (Approved), CDSS
[27] California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration, DHCS

demonstration, State Plan Amendments (SPAs) to expand EBPs under Medi-Cal, and complementary guidance and policies to improve behavioral health services statewide. Three of the EBPs covered under BH-CONNECT (Parent-Child Interaction Therapy (PCIT), Multisystemic Therapy (MST), and Functional Family Therapy) are focused on children and are described in additional detail below.

v. Key terms that will be used throughout this document

Note: ordered alphabetically

County Mental Health Plans (MHPs): Plans contracted with DHCS to provide or arrange for the provision of specialty mental health services (SMHS) provided to Medi-Cal members that meet access criteria for medically necessary SMHS aligned with their behavioral health treatment needs and goals. These services can be offered directly by county MHPs or through contracts with other entities.[29]

Drug Medi-Cal (DMC): Counties contracted with DHCS to provide or arrange for the provision of treatment for substance use disorders (SUD) for eligible Medi-Cal members in 20 counties. Services must be delivered at a DMC-certified program. SUD services funded by DMC are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22 of CCR govern DMC treatment.[30]

Drug Medi-Cal Organized Delivery System (DMC-ODS): Plans contracted with DHCS to provide or arrange for the provision of a broad array of SUD treatment services for eligible Medi-Cal members in 38 counties that opt-in. DMC-ODS is a voluntary program through which counties provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria.

Local Educational Agency (LEA): A school district, county office of education (COE), charter school, the California Schools for the Deaf, and the California School for the Blind.[28]

Medi-Cal delivery systems: This term broadly refers to payors and providers that are responsible for delivering care to eligible Medi-Cal members. For example, it includes Medi-Cal fee-for-service, managed care plans, county mental health plans, Medi-Cal enrolled providers, county specialty mental health services providers, Drug Medi-Cal treatment providers and others.

Medi-Cal Fee-for-Service (FFS): The traditional Medi-Cal delivery system through which the state contracts with providers directly to offer services to Medi-Cal members. Medi-Cal FFS covers a minority of members, including those with

[28] Cal. Welf. and Inst. Code § 5961.4 (j)(3)

presumptive eligibility, those with a share-of-cost, dual eligibles (i.e., those eligible for both Medi-Cal and Medicare), and a limited number of other members with full-scope coverage that are not required to enroll in managed care. [29]

Medi-Cal Managed Care: The delivery system through which DHCS contracts for health care services through established networks of organized systems of care (i.e., managed care plans), which emphasize primary and preventive care. Nearly 14 million Medi-Cal members in all 58 counties receive care through five main models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), and Single-Plan. Medi-Cal providers who wish to provide services to managed care members must participate in the managed care plan's provider network.[30]

Medi-Cal Managed Care Plans (MCPs): Health plans contracted by the state to provide coverage to members enrolled in the MCP. Plans receive a set monthly payment for each member enrolled, in return for providing all Medi-Cal services as outlined in their contract. MCPs must ensure they have a sufficient network of providers so that Medi-Cal members can access care.[31] Medi-Cal MCPs are typically responsible for covering non-specialty mental health services (NSMHS).[32] Meanwhile, specialty mental health services (SMHS) and substance use disorder (SUD) treatments are available through different delivery systems, as detailed in Chapter 11.

Medi-Cal State Plan: The Medi-Cal State Plan is based on the requirements of Title XIX of the Social Security Act and outlines how California manages its Medicaid (i.e., Medi-Cal) program. It serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services (CMS). It must fulfill certain criteria outlined in Title XIX of the Social Security Act and in Chapter IV of the Code of Federal Regulations. The State Plan provides all necessary details for CMS to assess California's eligibility for Federal Financial Participation (FFP) in its Medicaid program.[33] When policymakers in California wish to introduce a new Medi-Cal benefit using federal funds, they must follow a process called the State Plan Amendment (SPA). Federal laws limit the state's options under the state plan; if a proposed benefit includes services not currently covered, the state may need to seek special permission through a waiver to utilize federal funds.[34] Certain programs mentioned above like DMC-ODS already operate under such waivers.

[29] The Medi-Cal Program: An Overview, CHCF, p. 10.
[30] Medi-Cal Managed Care
[31] The Medi-Cal Program: An Overview, CHCF, p. 4
[32] Non-Specialty Mental Health Services, DHCS, p. 1
[33] California's Medicaid State Plan (Title XIX)
[34] The Medi-Cal Program: An Overview, CHCF, p. 7

Non-specialty mental health services (NSMHS): Services provided to Medi-Cal members with mild to moderate mental health conditions. NSMHS are available through both managed care and fee-for-service delivery systems.[35] See Chapter 3 for additional details.

Practitioner: Individual who provides eligible services. Practitioners may work independently or as part of a provider group.

Provider: Groups who provide eligible services (e.g., independent physical association, community-based organization, local educational agency).

Specialty mental health services (SMHS): Services provided to Medi-Cal members with serious mental illness (SMI). SMHS are carved out from Medi-Cal FFS and Medi-Cal Managed Care and are delivered via county MHPs under a Section 1915(b) waiver. [36] See Chapter 3 for additional details.

Conclusion

California is committed to expanding behavioral health systems that incorporate evidence-based and culturally relevant approaches to produce measurable outcomes that align with individuals' lived experiences. As it does so, it hopes to achieve a brighter, healthier future for all Californians.

This document highlights specific EBPs and CDEPs that California has prioritized through programs like CYBHI, FFPSA, and BH-CONNECT. These practices serve as a foundation for expanding access to EBPs and CDEPs. For more information on additional EBPs and CDEPs, please explore resources such as the SAMHSA,[37] CEBC,[38] and the Title IV-E Prevention Services Clearinghouses.[39]

[35] Non-Specialty Mental Health Services, DHCS, p. 1
[36] Medi-Cal Specialty Mental Health Services; 9 Cal. Code Regs. § 1810
[37] SAMHSA Evidence-Based Practices Resource Center
[38] The California Evidence-Based Clearinghouse
[39] Title IV-E Prevention Services Clearinghouse

Chapter 2: Considerations for Medi-Cal reimbursement of EBPs and CDEPs

As California expands access to EBPs and CDEPs through several one-time investments like the CYBHI Scaling EBP & CDEP Grant Program, there is also a focus on identifying new recurring funding sources for these practices through initiatives like BH-CONNECT and FFPSA. While these initiatives proceed, many EBP and CDEP providers can access funding today through the existing Medi-Cal delivery system. For example, the family psychotherapy (without patient present) service component of Child-Parent Psychotherapy can be reimbursed through Medi-Cal using CPT code 90846, provided all necessary criteria like patient and service provider eligibility are met.

Providers, MCPs, and insurers should work together on contracting and billing to ensure that eligible Medi-Cal members can access EBPs and CDEPs.

A. Contracting

Providers, MCPs, MHPs, DMC-ODS plans, and DMC counties, and insurers must establish contractual agreements before any reimbursement for EBPs and CDEPs can be provided through Medi-Cal. These contracts will outline terms such as member eligibility for treatment, reimbursement rates, service delivery expectations, and specific quality metrics. Typically, each provider intending to bill an MCP or insurer for services must have a contract with that MCP or insurer.[40] Several common considerations for the contracting process are outlined below.

i. Geographic coverage

Due to California's size, providers and MCPs or insurers often cover overlapping yet distinct regions. Consequently, a provider aiming to maximize reimbursements for services to Medi-Cal members might need to contract with multiple MCPs or insurers active in their counties of operation. Similarly, an MCP or insurer attempting to extend access to as many members as possible may need to contract with at least one provider in each county of operation.

ii. Medi-Cal member eligibility

EBPs and CDEPs are designed to serve specific populations. Factors that could inform the eligibility of Medi-Cal members for different EBPs and CDEPs include

[40] One notable exception to this rule is if the provider is a local educational agency (LEA) or public institution of higher education (IHE) that is participating in the CYBHI Fee Schedule program.[40] In some instances, these LEAs and IHEs may be able to bill multiple MCPs and insurers for components of EBP and CDEP services that are included on the CYBHI Fee Schedule without entering into separate contracts with each MCP and insurer.

demographic factors such as age, gender, cultural background, and specific behavioral health needs. Providers,MCPs, and insurers can consider these factors in the contracting process to ensure appropriate and equitable access to care.

iii. Practitioner eligibility

In addition to traditional licensed practitioner (e.g., medical doctors (MDs), nurse practitioners (NPs), and registered nurses (RNs)), EBPs and CDEPs are often delivered by other credentialed practitioners like peer support specialists (PSS), community health workers (CHW), and certified wellness coaches. Services can also be delivered by community volunteers.

Example in action:[41] Resourceful Adolescent Program-Adolescent (RAP-A) is a school-based resiliency building program designed to build resilience in students from 7th to 10th grade. It integrates cognitive-behavioral and interpersonal strategies to improve coping skills and foster positive growth. Various professionals, including psychologists, social workers, occupational therapists, psychiatrists, nurses specialized in behavioral health, school counselors, guidance officers, chaplains, teachers, and community health workers, can serve as group leaders that facilitate the program's activities.

Some EBPs and CDEPs may need to be administered by practitioners with specific qualifications to ensure quality and effectiveness. To comply and guarantee that services adhere to the standards set by Medi-Cal and MCPs or insurers, providers and MCPs and insurers could collaborate during the contracting process to establish the following regarding practitioner eligibility:

- **Qualifications to deliver EBPs and CDEPs:** Contracts can specify required qualifications for individuals to deliver services following the best practices associated with each EBP or CDEP. This can include verifying that staff have the appropriate certifications, degrees, and training. For instance, some EBPs may require therapists to be licensed clinical social workers (LCSWs) or licensed marriage and family therapists (LMFTs).

- **Qualifications to bill for EBPs and CDEPs:** Contracts could specify criteria for providers and individual practitioners who wish to bill Medi-Cal for services. These requirements must align with state and federal requirements.[42]Practitioners, for instance, might need to register as Medi-Cal providers via the Provider Application and Validation for Enrollment (PAVE) portal to bill for services. A list of provider types eligible to enroll as Medi-Cal

[41] The California Evidence-Based Clearinghouse, RAP-A, see section on About This Program
[42] Medi-Cal provider guidelines; Medicaid Provider Enrollment Requirements

providers is available on the DHCS website under Medi-Cal Managed Care Health Care Options.

iv. Mapping of individual EBP and CDEP service components to reimbursable billing codes

Contracts can clarify which service components of each EBP or CDEP qualify for reimbursement through Medi-Cal and the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code(s) and rates that correspond to each. This is important, as EBPs and CDEPs often include social and cultural supports that may not align directly with traditional behavioral health services.[43]

The descriptions in Chapters 5-10 for each EBP include an initial list of possible Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that could be used to bill Medi-Cal. Providers and MCPs or insurers are encouraged to collaborate to assess which EBP and CDEP service components are billable and determine the applicable CPT and HCPCS codes during the contracting process.

Contracts could also account for other factors that could influence whether a service component is reimbursable, such as Medi-Cal State Plan requirements that certain services only be delivered by a specific type of practitioner to qualify for reimbursement. MCPs and insurers should ensure any mapping of service components to billing codes complies with any state and/or federal requirements. See Chapter 11 for additional details on the potential policies under which service components of EBPs and CDEPs could be reimbursed.

Examples in action:[44] Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a treatment for children exposed to trauma who show significant symptoms of posttraumatic stress disorder (PTSD). Practitioners eligible to provide this care can be reimbursed through various CPT/HCPCS codes for psychotherapy services. This includes specific codes for weekly individual sessions with the child or caregiver, as well as family or group sessions. However, services beyond these limits, such as coaching visits at home, are not eligible for reimbursement through CPT/HCPCS billing codes.

Transition to Independence (TIP) Model[45] is a specialized coaching program designed for youth experiencing emotional and behavioral challenges. It integrates services that could be reimbursable under Medi-Cal with those that are not. For example,

[43] In some cases, such as with EBPs that are included as part of BH-CONNECT, the state is actively examining the possibility of reimbursing EBPs and CDEPs as a single integrated service (rather than by mapping service components to existing CPT and HCPCS codes).

[44] The California Evidence-Based Clearinghouse, TF-CBT, see section on About This Program

[45] The California Evidence-Based Clearinghouse, TIP, see section on About This Program

the program offers coaching sessions with Peer Support Specialists that can be billed as Peer Support Services and other valuable services like group social activities (e.g., monthly dinner gatherings and support for education and employment) that do not currently correspond to a billable CPT or HCPCS code.

While billing each service component individually (also known as fee-for-service billing) may be the most common reimbursement pathway currently available, some EBPs or CDEPs may also be reimbursable in their entirety, for example with the EBPs included in BH-CONNECT.[46]

B. Billing

Once a contract is established between a provider and an MCPs or insurer, it is important for providers to verify that the claims they submit are eligible for reimbursement. Reimbursement generally requires that the service (a) is listed in the contract between the provider and an MCP or insurer, (b) is delivered following the contract terms (e.g., delivered by a practitioner with a valid license or credential), and (c) provides sufficient information in the claim for an MCP or insurer to process it.

C. Alternative sources of funding for service components not covered by MCPs or other insurers

While Medi-Cal is one pathway for reimbursement and should be billed wherever possible, it is unlikely to cover the full costs of delivering services on its own. When not all service components are covered under Medi-Cal policy or other types of insurance, braided funding can help address these funding gaps. Braided funding involves coordinating multiple funding sources to support a single program or individual. Each funding source has its own spending requirements and must be kept separate for reporting purposes.[47]

Example in action:[48] Second Story, a peer respite program located in Santa Cruz, CA launched through a 2010 Federal Transformation award. Since then, Second Story has been funded through multiple sources including other federal funds; philanthropic support from foundations, corporations, and service clubs; third party insurers, and individual clients.[49]

[46] It may be possible for practices to be reimbursed on an encounter or episode of care basis. This could simplify the billing process for providers and sustainably fund these practices by setting an appropriate rate that accounts for the full range of support provided. For example, Clubhouse Services, an EBP included in BH-CONNECT, can be billed as a bundled service under Medi-Cal with a unique billing code using HCPCS code H2031 and bundled rate, per BH-CONNECT Evidence Practice Policy Guide (December 2024).

[47] Examining the Use of Braided Funding for Substance Use Disorder Services, SAMHSA

[48] Psychiatric Services - Impact of the 2nd story peer respite program on use of inpatient and emergency services

[49] Directory of Peer Respites, National Empowerment Center; Financial Information, Encompass

Chapter 3: Overview of EBPs covered in this document

There is a large and growing list of EBPs and CDEPs that have the potential to improve behavioral health outcomes in California. Providers, MCPs, and insurers may reference SAMHSA, CEBC, and CRDP for more additional practices they may wish to incorporate. These resources are vital tools for identifying and scaling practices to improve outcomes for California's diverse populations.[50]

This document focuses on providing guidance for a subset of EBPs and CDEPs that have been prioritized through prior state investments in youth behavioral health. This includes those funded by the CYBHI Scaling EBP & CDEP grant program and/or included in the FFPSA and BH-CONNECT efforts described above.

EBPs described in this document are organized around six themes that were prioritized through the CYBHI Scaling EBP & CDEP grant program. The themes and the chosen EBPs and CDEPs were selected by a DHCS-established public working group of leading experts from academia, government and industry, as well as youth, parents, and relevant community members.[51] These decisions were guided by the Department's core principles for achieving equity in behavioral health, the bold goals included in its Comprehensive Quality Strategy, and Medi-Cal's Strategy to Support Health and Opportunity for Children and Families.[52]

The six themes are as follows:

- **Parent / caregiver support programs and practices:** Programs and practices to increase support for and improve parental and caregiver involvement
- **Trauma-informed programs and practices:** Programs and practices to increase access to services that address behavioral health needs of trauma-exposed children and youth and the impact of Adverse Childhood Experiences (ACE)
- **Early childhood wraparound services:** Services for pregnant individuals and parents/caregivers to build family strength and overall well-being and address behavioral health needs of young children
- **Youth-driven programs:** Programs to provide California children and youth the opportunities to shape their behavioral health services
- **Early intervention programs and practices:** Programs and practices to address child and youth behavioral health needs more effectively earlier, and reduce reliance on more intensive services

[50] SAMHSA Evidence-Based Practices Resource Center; The California Reducing Disparities Project Phase 2 Statewide Evaluation Report

[51] Examples of stakeholders include multi-disciplinary experts and leaders representing a wide variety of programs, organization types, communities, and geographies, as well as youth, parents/caregivers, and community members; Evidence Based Practices (EBP) and Community Defined Practices (CDP) Workgroup Member List

[52] Medi-Cal's Strategy to Support Health and Opportunity for Children and Families, DHCS

Collectively, practices chosen within these themes were selected based on the following principles:

- Maximize impact and reduced disparities for all children and youth with an emphasis on programs/practices that focus on marginalized communities
- Incorporate youth and family voices to ensure that the selected programs/practices resonate with a diverse audience
- Focus on the upstream continuum of care to reduce the risk of significant behavioral health concerns in the future
- Affirm the right to access timely help and provide accessible, high-quality, appropriate care for all children and youth
- Destigmatize community support to enable every community to recognize the signs of behavioral health concerns and be willing to support those with behavioral health concerns without prejudice and discrimination
- Have a data driven-approach to expand the use of evidence-based and community-defined behavioral health services

Table: EBPs included in this document, organized by thematic area

EBPs		Included in…		
Thematic area	**EBPs**	**CYBHI EBP grant program**	**FFPSA Five-Year State Prevention Plan**	**BH-CONNECT**
Chapter 5: Parent / caregiver support programs and practices	HealthySteps (HS)	x		
	Positive Parenting Program (PPP)	x		
	Parents Anonymous (PA)	x		
	Incredible Years (IY)	x		
	Parent-Child Interaction Therapy (PCIT)	x	x	x
	Strong African American Families (SAAF)	x		
	Positive Indian Parenting (PIP)	x		
	Effective Black Parenting Program (EBPP)	x		
	Homebuilders		x	
	Brief Strategic Family Therapy (BSFT)		x	
	Family Check-up (FCU)		x	
	Family Acceptance Project (FAP)	x		

Chapter 6: Trauma-informed programs and practices	Multisystemic therapy (MST)	x	x	x
	Crossover Youth Practice Model (CYPM)	x		
	Attachment & Biobehavioral Catch-Up (ABC)	x		
	Child Parent Psychotherapy (CPP)	x		
	Cognitive Behavioral Interventions for Trauma in Schools (CBITS)	x		
	Family Centered Treatment (FCT)	x		
	Dialectical Behavior Therapy (DBT)	x		
	Functional Family Therapy (FFT)	x	x	x
	Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (M-ADTC)	x		
	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	x		
Chapter 7: Early childhood wraparound services	Healthy Families America (HFA)	x	x	
	Nurse Family Partnership (NFP)	x	x	
	Family Spirit (FS)	x		
	Parents as Teachers (PT)	x	x	
	Infant and Early Childhood Mental Health Consultation (IECMHC)	x		
	allcove centers (AL)	x		

Chapter 8: Youth-driven programs	Drop-in centers for homeless youth (DIC-H)	x		
	Drop-in centers for LGBTQIA+ youth (DIC-L)	x		
	Across Ages (AA)	x		
	Fostering Healthy Futures – Preteen (FHF-P)	x		
	Transition to Independence Model (TIP)	x		
	Peer Respite (PR)	x		
	Club House Model (CH)	x		
	Motivational Interviewing (MI)		x	
Chapter 9: Early intervention programs and practices	Familias Unidas (FU)	x		
	Resourceful Adolescent Program – Adolescent (RAP-A)	x		
	Residential Student Assistance Program (RSAP)	x		
	Blues Program (BP)	x		
	Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA)	x		
	Coordinated Specialty Care (CSC)[53]	x		
	Youth Mobile Crisis Response (YMCR)	x		

[53] Coordinated Specialty Care (CSC) is a multicomponent, evidence-based, early intervention service for individuals experiencing a first episode of psychosis (SAMHSA)

Chapter 4: Introduction to practice level detail

The following chapters (5-10) provide an overview of each EBP included within CYBHI, BH-CONNECT, and/or FFPSA with the following information:

- **California Evidence-Based Clearinghouse (CEBC) designation:**[54] Each EBP is assigned a score ranging from 1-5 according to the CEBC Scientific Rating Scale. These ratings are determined by the CEBC based on available research. A lower score indicates a greater level of research support. Descriptions of each rating are provided below. More information can be found on the CEBC Scientific Rating website:

  1) Well-Supported by Research Evidence
  2) Supported by Research Evidence
  3) Promising Research Evidence
  4) Evidence Fails to Demonstrate Effect

5) Concerning Practice, NR. Not able to be Rated on the CEBC Scientific Rating Scale)

- **Population(s) of focus:** Populations for which the EBP has demonstrated results to date (e.g., age range, racially diverse groups, marginalized communities)
- **Program description:** Overview of services provided through the EBP (e.g., individual treatment sessions, family coaching, assigned homework, group support sessions)
- **Care delivery setting and provider qualifications:** Examples of where treatment is typically conducted (e.g., outpatient clinics, community-based organizations, schools) and minimum qualifications that a provider must have to deliver care (e.g., lived experience, equivalent of a master's degree)
- **Summary of evidence from literature on program efficacy/impact:** Overview of research to date that supports the practice's evidentiary designation
- **Potential Medi-Cal covered benefits/services:** Details on potentially reimbursable services by Medi-Cal delivery system if all necessary conditions are met (e.g., eligible beneficiary, eligible provider type). Information provided includes category of service, relevant CPT/HCPCS codes, and illustrative services provided as part of the EBP that could qualify for each code
- **Potential Medi-Cal non-reimbursable services:** Details on service subcomponents that are unlikely to be reimbursable under any Medi-Cal policy

[54] California Evidence-Based Clearinghouse (CEBC) scientific rating

and/or delivery system. Information provided includes category of service, illustrative activities, and additional notes (e.g., explanation of why service component may not be reimbursable)

While these practice overviews provide general information on reimbursable service components, eligible provider types and potential billing codes, DHCS encourages readers to also refer to the **Appendix** for additional detail on whether/how a service is reimbursable in a specific context. The relevant portion of Appendix A can be accessed via hyperlink by clicking on each CPT/HCPCS code.

Chapter 5: Parent/caregiver support programs and practices

These practices center around implementing effective prevention and early intervention programs that build on the strengths of diverse parents and caregivers and could lead to positive impacts on children and youth facing behavioral health challenges. Research echoes the importance of early intervention with roughly 30 percent of California caregivers reporting moderate concerns over their child's emotional and behavioral health and 20-40 percent of those same caregivers reporting engaging in some ineffective type of parenting.[55]

Priority Populations of Focus: Parents and caregivers of children and youth with behavioral health needs and parents and caregivers of children who benefit most from preventative strategies (e.g., young children 0-5 years of age).

Outcomes/Key Metrics: The goal of these EBPs is to strengthen positive parenting practices, improve the response to emotional and behavioral challenges commonly experienced in childhood, promote child social and emotional development, improve caregiver involvement and relationships with children, and increase support for individuals that may be experiencing heightened levels of caregiver-related stress among other outcomes.

Example EBPs: Example EBPs funded in this theme include but are not limited to HealthySteps/Dyadic Care Services; Incredible Years; Parent-Child Interaction Therapy; Positive Parenting Program (Triple P); and, Parents Anonymous®.

A. HealthySteps (HS)[56]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight.

ii. Population of focus

The HS program primarily focuses on families with children aged 0-3 years.[57]

Studies on the HS program have previously demonstrated effectiveness with families from various races/ethnicities. The HS program has been applied to children across populations from low-income families.[58]

[55] Kids Data
[56] All information contained in the HealthySteps sections comes from publicly available sources. Please refer to each section for specific source details.
[57] HealthySteps Advances Health Equity
[58] HealthySteps, The Evidence Base

iii. Program description[59]

The HS program is a team-based pediatric primary care program that integrates child development expertise into routine pediatric visits. This is done through the collaboration of HS Specialists and primary care providers. These specialists assist families by connecting them to additional resources and services as needed, and by providing answers to questions about child development and overall well-being. Through embedding child development services within primary care settings, HS promotes the early identification and intervention of developmental challenges and behavioral health needs. This approach aims to establish a strong foundation for healthy development and school readiness for young children, ensuring that families receive comprehensive support in a setting where they are most likely to access care.

HS Specialists achieve these goals through a multi-faceted approach, including screening and assessment of child development and family needs, child behavior consultations, positive parenting guidance, and care coordination. The HS model is organized into three Tiers of Service and eight Core Components, where families with higher needs receive more comprehensive services through the tiered-model approach:

1) Tier 1 Universal Services: Includes Core Components 1-3, providing foundational support through developmental screenings, assessment of family needs including social determinants of health (SDOH), and access to a family support line. These services ensure that families receive basic support and resources to promote healthy child development.

2) Tier 2 Short Term Supports – includes Core Components 4-7, offering comprehensive services such as mental health consultations, in-house support, referrals to resources and programs in the community, and follow up support. These services are designed for families with mild concerns that require short-term support, with the aim of strengthening relationships and environments that support healthy growth.

3) Tier 3 Comprehensive Services – includes Core Component 8, providing the highest level of support through joint well-child visits completed by HS Specialists and primary care providers. This comprehensive approach ensures that families with higher need receive comprehensive, team-based care and coordination to address their complex needs effectively.

iv. Care delivery setting and provider qualifications

[59] HealthySteps, Tiers and Core Components

The HS program is available to children and caregivers through pediatric primary care or virtual settings.[60]

HS Specialists are typically social workers with mental health training, psychologists, early child educators, and/or nurses with experience in early childhood development. A bachelor's degree is required, though a master's degree is preferred by the HS program. The program requires HS Specialists to complete training and develop essential competencies in several areas (e.g., knowledge of child development and family dynamics, skills in developmental screening and assessment, providing family-centered care). HS Specialists are trained to offer guidance on positive parenting, to coordinate care with other providers, and to support families with a wide range of needs.[61] Additionally, HS Specialists develop competencies in cultural competence, reflective practice, and effective communication, ensuring they can provide high-quality, integrated support to children and families.

v. Summary of evidence from literature on program efficacy / impact

A selection of findings on the impact of HS are supported by randomized controlled studies (RCTs) and peer- reviewed literature with sustained effects 1-year post intervention.[62] Evidence may suggest a reduction in physical discipline and child behavior problems along with improvements in parent-child attachment, parent-child engagement (e.g., reading books), child developmental screening, child vaccinations, and positive parenting practices (e.g., offering choices, scaling expectations).[63]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse HS services as NSMHS if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[64] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[65]

Note: the HS National Office experts provide support for billing and coding.[66] See also HealthySteps CA Billing and Coding Guide *for additional information:*

[60] HealthySteps, Partnering with Pediatrics
[61] HealthySteps Specialist Competencies
[62] HS Outcomes
[63] HS Outcomes
[64] Specialty Mental Health Services Medi-Cal Billing Manual
[65] Non-Specialty Mental Health Services (NSMHS), DHCS
[66] HealthySteps, Our Services

HealthySteps (HS)[67]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[68]**
Screening	96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument	Child screenings for physical, cognitive, language, social-emotional, developmental, and/or behavior concerns Family screenings (e.g., maternal depression)	Yes
	G8510	Screening for depression documented as negative		No
	G8431	Screening for depression documented as positive: follow-up plan is required		No
	96127	Social-emotional-brief emotional/behavioral assessments		Yes
	G9920	ACE screening-lower risk, patient score of 0-3	ACE screening	No
	G9919	ACE screening-higher risk, patient score of 4 or greater		No
Health and behavior assessment and intervention	96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview,	Healthy and behavior assessment or re-assessment (e.g., health focused	No

[67] HealthySteps CA Billing and Coding Guide

[68] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

		behavioral observations, clinical decision making)	clinical interview, behavioral observations, clinical decision making)	
	96158	Health and behavior intervention, individual, face-to-face; initial 30 minutes	Health and behavior interventions	No
	96159	Health and behavior intervention, individual, face-to-face; each additional 15 minutes		No
	96164	Health and behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes		No
	96165	Health and behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes		No
	96167	Health and behavior intervention, family with patient present, face-to-face; initial 30 minutes		No
	96168	Health and behavior intervention, family with patient present, face-to-face; each additional 15 minutes		No
	96170	Health and behavior intervention, family without patient present, face-to-face; initial 30 minutes		No

	96171	Health and behavior intervention, family without patient present, face-to-face; each additional 15 minutes		No
Psychiatric diagnostic evaluation	90791	Psychiatric diagnostic evaluation without medical services	Psychiatric diagnostic evaluation	Yes
	90792	Psychiatric diagnostic evaluation with medical services		Yes
Developmental test administration (Central nervous system assessments/tests)	96112	Developmental test administration including assessment of fine and gross motor, language, cognitive level, social, and memory or executive functions by standardized developmental instruments with interpretation and report, initial hour	Developmental testing with interpretation	Yes
	96113	Developmental test administration; each additional 30 minutes after the first hour of service		Yes
Psychological testing evaluation (Central nervous system assessments/tests)	96130	Psychological testing and evaluation; first hour (31 minutes minimum)	Psychological testing and evaluation	Yes
	96131	Psychological testing and evaluation; each additional hour after the first hour of service		Yes
Neuropsychological testing and evaluation (Central	96132	Neuropsychological testing evaluation services; first hour	Child neuropsychological	Yes

nervous system assessments/tests)	96133	Neuropsychological testing evaluation services; each additional hour after the first hour of service	testing and evaluation measure	No
Psychological or Neuropsychological Test Administration and Scoring (Central nervous system assessments/tests)	96136	Psychological or neuropsychological test administration and scoring, by physician or other qualified health care professional, two or more tests; first 30 minutes	Psychological or neuropsychological testing and scoring	Yes
	96137	Psychological or neuropsychological test administration and scoring, by physician or other qualified health care professional, two or more tests; each additional 30 minutes		Yes
	96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes		Yes
	96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes		Yes
	96146	Psychological or neuropsychological test administration, via electronic platform, with automatic result, only		Yes

Alcohol and Substance Abuse Screening and Intervention	G0442	Annual alcohol misuse screening, 15 minutes	Family screening for alcohol and drug use	No
	H0049	Alcohol and substance abuse screening (screening only); completed screening tool with scoring		No
	H0050	Alcohol and substance abuse brief intervention, per 15 minutes		No
Smoking and Tobacco Use Cessation	99406	Smoking and tobacco use cessation counseling visit; intermediate, more than 3 minutes up to 10 minutes	Smoking and tobacco cessation counseling for family	No
	99407	Smoking and tobacco use cessation counseling visit; intensive, more than 10 minutes		No
Case Management Medical Team Conference	99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician health care professional	Care coordination	Yes
	99368	Medical team conference with interdisciplinary team of health care professionals when patient and/or family is not present, 30 minutes or more;		Yes

		participation by nonphysician health care professional		
Add-on code	90785	Interactive complexity	Add-on code when there are communication difficulties during a visit	Yes

vii. Potential Medi-Cal non-reimbursable services

HealthySteps (HS)[69]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Non-urgent, non-medical support	Family support line	N/A
Wraparound services	Housing support services, nutritional program	N/A

B. Positive Parenting Program (Triple P)[70]

Included within CYBHI EBP grant program.

i. California Evidence-Based Clearinghouse Designation[71]

1 – Well Supported by Research Evidence (rating for Level 4 of Triple P program).

2 – Supported by Research Evidence for parent training programs that address child abuse and neglect, and prevention of child abuse and neglect (primary) programs.

3 – Promising Research Evidence for parent training programs that address behavior problems in children and adolescents.

ii. Population of focus

[69] HealthySteps CA Billing and Coding Guide

[70] All information contained in the Positive Parenting Program sections comes from publicly available sources. Please refer to each section for specific source details.

[71] The California Evidence-Based Clearinghouse, Triple P, see section on Scientific Rating

Triple P is a population-level system of parenting and family support for families with children (aged 0-16 years) with various levels of engagement depending on the family's needs.[72]

Studies on Triple P have demonstrated its effectiveness with families from various racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[73]

Triple P is a flexible program designed to support caregivers in promoting healthy child development and effectively managing behavior. Its multi-level framework that tailors interventions to the specific needs of families, addressing both everyday challenges and more difficult concerns. Caregivers can choose from 35 specific strategies and parenting skills, including building parental resilience, strengthening parent-child relationships, increasing knowledge of parenting and child development, and improving children's social-emotional competence. These strategies can encourage desirable behavior, manage misbehavior, prevent problems in high-risk situations, enhance child self-regulation, improve parental emotion regulation, and strengthen partner communication.

The program is offered through a multi-tiered system with five levels of education and support, offering varying degrees of support in several formats: [74]

1) Level 1 (Universal Triple P) – Disseminates broad parenting information through media campaigns and distribution strategies, aiming to reach a wide audience and promote positive parenting practices.

2) Level 2 (Selected Triple P) – Offers "light touch" interventions through brief, one-time support to parents who have specific behavioral and/or developmental concerns. This level includes the Triple P Selected Seminar Series, which introduces positive parenting strategies through three 90-minute seminars.

3) Level 3 (Primacy Care Triple P/Group discussions) – Includes Primary Care Triple P and Discussion Groups. Primary Care Triple P offers brief consultations with providers, using tip sheets and a Positive Parenting Booklet. The Discussion Groups offer two-hour sessions addressing specific issues (e.g., oppositional behavior, aggression, bedtime routines, shopping, mealtimes) for children under 12, and emotions, family conflict, and cooperation for adolescents.

4) Level 4 (Standard or Group Triple P) – Includes interventions (spanning 8-10 sessions) for caregivers of children with severe behavioral difficulties and for those

[72] The California Evidence-Based Clearinghouse, Triple P, see section on About this Program
[73] The California Evidence-Based Clearinghouse, Triple P, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery
[74] Triple P – The system explained

seeking more practice in positive parenting strategies. This program is available for parents of children from birth to 12 years and adolescents aged 12 to 16.

5) Level 5 (Enhanced Triple P/Pathways Triple P) – Provides comprehensive support for families with complex concerns, typically after completing a Level 4 Standard or Group program. This intervention addresses challenges including partner conflict, stress, and mental health through three modules that focus on partner relationships and communication, personal coping strategies for high-stress situations, and positive parenting practices. Pathways Triple P is designed for parents at risk of child maltreatment, covering anger management and behavioral strategies to improve coping skills in parenting.

iv. Care delivery setting and provider qualifications

Triple P is typically conducted in an adoptive home, birth family home, foster/kinship care, hospital, outpatient clinic, community-based agency/organization/provider, group or residential care, school setting, or virtually.[75]

Providers are generally practitioners with a post-high school degree in health, education, childcare, or social services. Educational requirements may be relaxed if a prospective practitioner is already serving parents, children, and teens and has established knowledge of child/adolescent development.[76] Such circumstances would require additional clinical supervision and support.

According to the Triple P program, training can consist of multiple courses (e.g., Standard Triple P, Group Triple P, Primary Care Triple P) that include a mix of theoretical and practical components (e.g., role-play, video demonstrations, and feedback sessions). [77] In the training, participants learn to assess parenting needs, deliver interventions, and support parents in implementing positive parenting practices.

v. Summary of evidence from literature on program efficacy/impact

Triple P is considered "promising" through RCTs and peer-reviewed literature with sustained effects 6 months post-intervention.[78] The treatment is recognized by the California Evidence-based Clearinghouse for Child Welfare,[79] Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs,[80] and Social Programs that

[75] The California Evidence-Based Clearinghouse, Triple P, see sections on Program Delivery; Manuals and Training; and Implementation Information
[76] The California Evidence-Based Clearinghouse, Triple P, see sections on Program Delivery; Manuals and Training; and Implementation Information
[77] Triple P – Course details; Triple P – Training information
[78] The California Evidence-Based Clearinghouse, Triple P, see section on Scientific Rating
[79] The California Evidence-Based Clearinghouse, Triple P, see section on Relevant, Published Peer-Reviewed Research
[80] OJJDP, Triple P

Work (evidence rating 'near top tier').[81] Blueprints for Healthy Youth Development also rated Triple P as 'Promising'.[82]

Evidence suggests Triple P may result in reduction in rates of child maltreatment, hospital visits for maltreatment injuries, and foster-care placements, as well as improvements in social, emotional, and behavioral outcomes in children, parenting practices, parenting satisfaction and efficacy, and parental adjustment.[83]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse Triple P services if they are one of the following provider types: Physicians or other licensed practitioners of the healing arts within their scope of practice under state law,[84] Clinical Nurse Specialists, Community Health Workers, Medical Doctors/Doctors of Osteopathy,[85] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[86]

Positive Parenting Program (Triple P)[87]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[88]**
Levels 2-4				
Psychoeducation (Community Health Worker services)	98960	Education and training for patient self-management, individual	~30-minute consultation with caregiver in single-session meeting	Yes
	98961	Education and training for patient		Yes

[81] Social Programs that Work, Triple P
[82] Blueprints for Healthy Youth Development, Triple P
[83] The California Evidence-Based Clearinghouse, Triple P, see section on Relevant, Published Peer-Reviewed Research
[84] Medi-Cal Coverage of CHW Services
[85] Specialty Mental Health Services Medi-Cal Billing Manual
[86] Non-Specialty Mental Health Services (NSMHS), DHCS
[87] Analysis by Manatt Health from Jan 2022 to Feb 2023
[88] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

		self-management, group (2-4)	~2-hour discussion group ~2-hour low-intensity seminar	
	98962	Education and training for patient self-management, group (5-8)		Yes
Level 5 and specialist program				
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	~60-90-minute individual session with family ~30-minute consultation with family	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes
Psychoeducation (Community Health Worker services)	98960	Education and training for patient self-management, individual		Yes
	98961	Education and training for patient self-management, group (2-4)	~1.5-2-hour group session	Yes
	98962	Education and training for patient self-management, group (5-8)		Yes

vii. Potential Medi-Cal non-reimbursable services

Positive Parenting Program (Triple P)[89]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

[89] Analysis by Manatt Health from Jan 2022 to Feb 2023

C. Parents Anonymous®[90]

Included within CYBHI EBP grant program.

i. California Evidence-Based Clearinghouse Designation[91]

3 – Promising Research Evidence

ii. Population of focus

Parents Anonymous® is a program serving caregivers and their children aged 0-18 who are at risk of becoming (or already are) involved in the child welfare system, have behavioral health challenges, substance use disorders, or face family stressors.[92]

Studies on Parents Anonymous® have demonstrated its effectiveness with children and caregivers from various racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

Program description[93,]

Parents Anonymous® is a prevention and treatment intervention program that strengthens families through building a supportive community. Its primary goal is to prevent child abuse and neglect by empowering parents with the tools and support they need to create safe, nurturing, and resilient family environments. Within this program, caregivers develop essential skills and share experiences about parenting. The program emphasizes building resilience in parents, children, and youth, while also reducing parental stress to prevent adverse childhood experiences (ACEs).

The program offers weekly support groups, peer parent partner services, advocacy, kinship navigator services, in-home parenting support, connections to community resources, and helpline services. Parents Anonymous® group session structure includes parents, a parent group leader chosen by participants, and a professional group facilitator. This operating model helps maintain focus and direction, while also fostering a sense of ownership and empowerment among parents. Meetings typically last 1-2 hours and include structured activities, guided meditation, and open discussions.

During group sessions, parents learn skills around effective parenting, stress management, positive discipline techniques, and resilience building. The focus is on improving communication, active listening, mindfulness, and positive reinforcement

[90] All information contained in the Parents Anonymous® sections comes from publicly available sources. Please refer to each section for specific source details.
[91] The California Evidence-Based Clearinghouse, Parents Anonymous, see section on Scientific Rating
[92] The California Evidence-Based Clearinghouse, Parents Anonymous, see section on About This Program
[93] The California Evidence-Based Clearinghouse, Parents Anonymous, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery ; Parents Anonymous

to help parents create structured and nurturing home environments. The four main components of Parents Anonymous® are:

1) Building Family Strengths Interviews: Interviews aimed to understand the strengths and needs of each family. This comprehensive assessment ensures that the support provided is tailored to each family, fostering a personalized approach towards resilience and empowerment.

2) Weekly, 2-hour Online Evidence-Based Parents Anonymous® Groups for Caregivers: Online group sessions for caregivers that utilize four therapeutic processes to strengthen their family; mutual support, shared leadership, parent leadership, and strengths-based development. In these sessions, caregivers share experiences, provide and receive peer support, and engage in activities that strengthen their parenting skills. The focus is on building a strong network of support, enhancing coping mechanisms, and fostering positive parent-child interactions.

3) Weekly, 2-hour Online Evidence-Based Parents Anonymous® Groups for Children: Online group sessions for children, rooted in the same four therapeutic processes, that are designed to enhance their social skills, build self-esteem, and promote emotional well-being. In these groups, children receive peer support and learn valuable life skills in a safe and nonjudgmental environment.

4) Support Between Parents Anonymous® Group Meetings: Services designed to provide continuous support and link caregivers and their children to additional resources. Through Peer Parents and Group Facilitators, families receive help navigating various systems and accessing necessary services.

iii. Care delivery setting and provider qualifications

Parents Anonymous® is typically delivered in a community daily living setting, foster/kinship care, hospital, outpatient clinic, community-based agency/organization/provider, group or residential care, justice setting, public child welfare agency, school setting, shelter, virtual setting, or other setting.[94]

Adult and Children & Youth Group Facilitators have a bachelor's and/or master's degree in social work, psychology, early childhood education, or other behavioral science or credentials as a teacher, clergy, or nurse.[95] Facilitators also have experience and expertise in providing primary prevention and family strengthening programs to diverse populations in urban, suburban, and rural communities and settings. Though not required, Parents Anonymous® is approved by the California Mental Health

[94] The California Evidence-Based Clearinghouse, Parents Anonymous, see sections on Program Delivery; Manuals and Training; and Implementation Information
[95] The California Evidence-Based Clearinghouse, Parents Anonymous, see sections on Program Delivery; Manuals and Training

Services Authority (CalMHSA) to offer Medi-Cal Peer Support Specialist Certification training.[96]

To achieve certification, Group Facilitators and Parent Group Leaders must complete a 40-hour in-person training provided by Parents Anonymous®.[97] Additionally, Group Facilitators observe two to four adult groups and at least one children/youth group. Parent Group Leaders create an Individual Action Plan and engage in virtual guided practice sessions for 4 to 6 months following the in-person training.

iv. Summary of evidence from literature on program efficacy/impact

Parents Anonymous® is deemed "promising" peer-reviewed literature.[98] The program is recognized by the California Evidence-based Clearinghouse for Child Welfare.[99] Casey Family Programs also designated Parents Anonymous® as one of the few nationwide programs in the Federal Title IV-E Prevention Clearinghouse shown to be effective with children and families of color.[100]

Evidence suggests a decrease in reported frequency of physical abuse, reduced substance use, reduced domestic violence, and improvements in child maltreatment outcomes, risk factors, and protective factors.[101,] **Potential Medi-Cal covered benefits/services**

Eligible providers may use the below CPT/HCPCS codes to reimburse Parents Anonymous® services if they are one of the following provider types: certified Medi-Cal Peer Support Specialist.[102]

Parents Anonymous® [103]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[104]**
Peer support	H0038	Peer support services	Weekly 2-hour online Parents	Yes *(only if delivered through SMHS)*

[96] California Medi-Cal Peer Support Specialist Certification Training, Parents Anonymous
[97] Prevention Services – Parents Anonymous® training
[98] The California Evidence-Based Clearinghouse, Parents Anonymous, see section on Scientific Rating
[99] The California Evidence-Based Clearinghouse, Parents Anonymous
[100] Casey Family Programs: Interventions Shown to be Effective with Children and Families of Color Being Served with Family First Funding
[101] The California Evidence-Based Clearinghouse, Parents Anonymous, see section on Relevant, Published Peer-Reviewed Research ; Parents Anonymous, Research

			Anonymous® groups	

v. Potential Medi-Cal non-reimbursable services

Parents Anonymous®		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

D. The Incredible Years® [105]

Included within CYBHI EBP grant program.

i. **California Evidence-Based Clearinghouse Designation**[106] 3 – Promising Research Evidence for all three curricula offered through Incredible Years.

ii. Population of focus

The Incredible Years® provides a series of tailored interventions aimed at specific groups for each of its programs:

- The Incredible Years® Classroom Dinosaur Child Program (Prevention) is designed for children aged 3-8 in a classroom setting.[107]
- The Incredible Years® Teacher Classroom Management Program is designed for teachers working with children aged 3-8 in a classroom setting.[108]
- The Incredible Years® Preschool Basic Parent Training Program (Treatment) is designed for parents/caregivers of young children aged 3-6 in higher risk families or who are exhibiting high rates of conduct problems, attention-deficit/hyperactivity disorder (ADHD), or developmental delay.[109]

[105] All information contained in the Incredible Years® sections comes from publicly available sources. Please refer to each section for specific source details.
[106] The California Evidence-Based Clearinghouse, The Incredible Years Classroom Dinosaur Child Program (Prevention); The California Evidence-Based Clearinghouse, The Incredible Years Teacher Classroom Management Program; The California Evidence-Based Clearinghouse, The Incredible Years Preschool Basic Parent Training Program
[107] OJJDP Discretionary Grants
[108] The California Evidence-Based Clearinghouse, The Incredible Years Teacher Classroom Management Program
[109] The California Evidence-Based Clearinghouse, The Incredible Years Preschool Basic Parent Training Program

Studies on Incredible Years® have demonstrated effectiveness with children, caregivers, and school staff from various ethnic and racial backgrounds and have shown effectiveness with low-income families (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website)[110]

iii. Program description[111]

The Incredible Years® is a series of separate, multifaceted, and developmentally based curricula designed for parents, teachers, and children. The program aims to reduce risk factors and strengthen protective factors among parents, teachers, and children to prevent and manage children's emotional and behavioral concerns. It fosters positive relationships and attachment by teaching child-directed play, social and emotional coaching, academic and persistence coaching, interactive reading, praise, and incentive systems. The program includes proactive parenting, teaching developmentally appropriate strategies (e.g., establishing rules, creating routines, giving clear commands), and using positive discipline techniques (e.g., monitoring, ignoring, limit setting, redirection, time-outs). The three most frequently implemented curricula are:

The Incredible Years® Classroom Dinosaur Child Program (Prevention) is implemented by teachers as a preventive measure for an entire classroom of students. Teachers deliver the curriculum 2-3 times a week during circle time lessons that last 20 to 30 minutes. Following circle time lessons, students engage in small group practice activities and promotion of skills throughout the school day. The program covers various topics (e.g., academic achievement, understanding emotions, problem-solving, anger management, friendship skills, effective communication with peers).
The Incredible Years® Preschool Basic Parent Training Program (Treatment) is a group-based curriculum for parents that uses video modeling. It aims to enhance parent-child interactions and attachment, reduce harsh discipline, and foster parents' ability to promote children's social, emotional, and language development, as well as reduce both externalizing and internalizing behaviors. Additionally, the program focuses on developing parents' self-regulation skills and social support. Caregivers typically participate in weekly, 2-hour sessions. The Incredible Years® Teacher Classroom Management Program is a preventive intervention/training program designed for teachers (including teacher aides, school psychologists, and school counselors). Group leaders work with teachers to strengthen their classroom management strategies, promote prosocial behavior among children, improve school readiness, and reduce classroom aggression and noncooperation with peers and teachers. The program also assists teachers in working with parents to encourage

[110] The California Evidence-Based Clearinghouse, The Incredible Years

[111] The California Evidence-Based Clearinghouse, The Incredible Years Classroom Dinosaur Child Program (Prevention); The California Evidence-Based Clearinghouse, The Incredible Years Teacher Classroom Management Program; The California Evidence-Based Clearinghouse, The Incredible Years Preschool Basic Parent Training Program; Incredible Years

their involvement in school and promote consistency between home and school. Groups typically meet monthly for 6-hour sessions over the course of 6-8 months.

iv. Care delivery setting and provider qualifications[112]

The Incredible Years® is typically conducted in an adoptive home, birth family home, community-daily living setting, foster/kinship care, hospital, outpatient clinic, community-based agency/organization/provider, group or residential care, public child welfare agency, shelter, school setting, or virtual setting. See The Incredible Years® for a list of certified provider locations.

Teachers/group leaders must have a background in child development, knowledge of effective teaching practices, and experience teaching or working with groups of students. For the prevention program, it is preferred that leaders have at least a bachelor's degree in teaching, early childhood education, school psychology, school counseling, other helping profession, or equivalent experience. For group leaders, a master's level degree in a relevant profession or equivalent experience is preferred.

Becoming certified in the Incredible Years® program includes an initial 3-4 day in-person training workshop, followed by leading a full group cycle over 10-12 weeks to gain practical experience. Trainees receive ongoing supervision and support through regular meetings and submitting video recordings for feedback.

v. Summary of evidence from literature on program efficacy/impact

The Incredible Years® is deemed "promising" through peer-reviewed literature by the California Evidence-based Clearinghouse for Child Welfare,[113] Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs,[114] National Institute of Justice Crime Solutions,[115] and SAMHSA.[116] Blueprints for Healthy Youth Development has also rated The Incredible Years® as 'Promising'.[117]

Evidence suggests improvements in disruptive behaviors (e.g., tantrums, noncompliance, arguing), internalizing symptoms (e.g., sadness, anxiety, withdrawal),

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[112] The California Evidence-Based Clearinghouse, The Incredible Years Classroom Dinosaur Child Program (Prevention); The California Evidence-Based Clearinghouse, The Incredible Years Teacher Classroom Management Program; The California Evidence-Based Clearinghouse, The Incredible Years Preschool Basic Parent Training Program; Incredible Years – Training and Certification

[113] The California Evidence-Based Clearinghouse, The Incredible Years Classroom Dinosaur Child Program (Prevention); The California Evidence-Based Clearinghouse, The Incredible Years Teacher Classroom Management Program; The California Evidence-Based Clearinghouse, The Incredible Years Preschool Basic Parent Training Program

[114] OJJDP Model Programs

[115] National Institute of Justice, The Incredible Years – Child Training Program; National Institute of Justice, The Incredible Years BASIC – Parent Training Program; National Institute of Justice, The Incredible Years – Teacher Classroom Management Program

[116] SAMHSA

[117] Blueprints for Healthy Youth Development, Incredible Years – Child Treatment; Blueprints for Healthy Youth Development – Parent

attention/hyperactivity symptoms, negative behaviors towards teachers, parental stress, negative parenting, child social competence, and peer relationships.[118]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse the Incredible Years® services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[119] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[120]

The Incredible Years® [121]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[122]**
Dyadic psychoeducational service	H2027	Psychoeducational service, 15 minutes	Weekly 2-hour caregiver(s) group-based parent intervention session	No
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Therapeutic intervention	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes

vii. Potential Medi-Cal non-reimbursable services

The Incredible Years® [123]

[118] The California Evidence-Based Clearinghouse, The Incredible Years Classroom Dinosaur Child Program (Prevention); The California Evidence-Based Clearinghouse, The Incredible Years Teacher Classroom Management Program; The California Evidence-Based Clearinghouse, The Incredible Years Preschool Basic Parent Training Program
[119] Specialty Mental Health Services Medi-Cal Billing Manual
[120] Non-Specialty Mental Health Services (NSMHS), DHCS
[121] Analysis by Manatt Health from Jan 2022 to Feb 2023
[122] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[123] Analysis by Manatt Health from Jan 2022 to Feb 2023

Service components of the model	Illustrative services provided	Additional notes where applicable
Implementation	Hiring and training staff	N/A
School curriculum	~20-30-minute circle time lessons and small group practice activities during school	N/A
Wraparound services	Housing support services, nutritional program	N/A

E. Parent-Child Interaction Therapy (PCIT)[124]

Included within CYBHI EBP grant program, FFPSA Five-Year State Prevention Plan, and BH-CONNECT.

i. California Evidence-Based Clearinghouse Designation[125]

1 – Well-Supported by Research Evidence.

ii. Population of focus

PCIT is a specialized behavior management intervention for children of an appropriate developmental age (often ages 2-7 years)**[126]** with behavioral problems and their caregivers.[127] PCIT is medically necessary and clinically appropriate for young children with oppositional or defiant behavior, aggression, frequent or severe tantrums, or symptoms related to child behavioral health conditions such as attention-deficit/hyperactivity disorder, anxiety, and trauma.

Studies on PCIT have previously demonstrated effectiveness with children and caregivers from various races/ethnicities and in various settings (e.g., virtually, in rural communities) (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).[128]

iii. Program description[129]

[124] All information contained in the Parent-Child Interaction Therapy sections comes from publicly available sources. Please refer to each section for specific source details.
[125] The California Evidence-Based Clearing House, PCIT, see section on Scientific Rating
[126] Under SMHS, a LMHP may determine that a child of an appropriate developmental age may receive the service; the child does not necessarily need to be aged 2-7.

[127] The California Evidence-Based Clearing House, PCIT, see section on About This Program
[128] Rural Health Psychiatry and Behavioral Sciences, Rural and Remote Health
[129] PCIT

PCIT is conducted through coaching sessions wherein a caregiver wearing a wireless headset interacts with their child in a playroom while the PCIT therapist observes through a one-way mirror from an observation room or virtually. The PCIT therapist provides in-the-moment coaching to caregivers via the wireless headset to teach caregivers strategies that will promote positive behaviors and to develop skills to manage a child's behavior. PCIT focuses on decreasing child behavior challenges (e.g., dysregulation, externalizing behaviors, difficulty maintaining engagement or complying with prompts from primary caregivers), increasing positive parent behaviors (e.g., therapeutic play, effective commands), and improving the caregiver-child relationship.

There is no time limit for treatment, but the intervention duration and session time for PCIT typically consists of weekly, hour-long sessions over 14 weeks, in the presence of both caregiver and child. PCIT is implemented in two phases: (1) Child-Directed Interaction (CDI); and (2) Parent-Directed Interaction (PDI). During the CDI phase, caregivers follow along as the child leads a play activity. The first treatment phase emphasizes establishing warmth in the parent-child relationship through the application of skills proven to help children feel calm and secure in their relationships with their caregivers, and to feel good about themselves. Completion of the first treatment phase encourages increased attention span, self-esteem, prosocial behaviors, and feelings of security, safety, and attachment; it simultaneously seeks a decrease in activity level, negative attention-seeking behaviors, and frequency and intensity of tantrums. The goals of the first phase include outcomes such as decreased frequency, severity, and/or duration of tantrums; decreased negative attention-seeking behavior; decreased parental frustration; increased pro-social behaviors; and increased feelings of security and attachment to a caregiver.

In the PDI phase, caregivers learn to use effective commands and implement behavior management strategies. The second phase of treatment involves the caregiver's acquisition of strategies to help children accept limits, comply with directions, and demonstrate appropriate behavior in public. Completion of the second treatment phase encourages increased compliance, respect, and caregiver confidence during discipline; outcomes additionally include decreased defiance, destructive behavior, and aggressive behavior. The goals of the second phase include outcomes such as decreased frequency, severity, and/or duration of aggressive behavior; decreased defiance; increased compliance with adult requests; improved behavior in public; and increased parental calmness and confidence during discipline. Throughout each phase, parent/caregivers are given homework to complete between sessions to enhance skills learned.

iv. Care delivery setting and provider qualifications

PCIT is typically conducted in an outpatient clinic or community-based agency/organization/provider where observations of the child's play and organic

interactions between the child and caregiver may take place.[130] PCIT can also be effectively implemented via telehealth.

According to the program, providers are required to have a firm understanding of behavioral principles and adequate prior training in cognitive-behavior therapy, child behavior therapy, and therapy process skills (e.g., facilitative listening).[131] In addition to completing 40 hours of hands on PCIT training and clinical case observation, the provider is also required to have specified levels of graduate mental health education, training, and licensure. They must also complete Continuing Education requirements to be recertified every two years. See PCIT International for a list of Certified PCIT therapists.[132]

v. Summary of evidence from literature on program efficacy / impact

PCIT is considered "well-supported" through randomized controlled trials (RCTs) and peer-reviewed literature with sustained effects 1 year post-intervention.[133] The treatment is recognized by the Title IV-E Prevention Services Clearinghouse,[134] National Child Traumatic Stress Network[135] as a trauma-informed intervention. It has also been recognized by the California Evidence-based Clearinghouse for Child Welfare,[136] and the Federal Administration on Children, Youth and Families in the Child Welfare Information Gateway[137] as a best practice for the prevention and treatment of child conduct problems and child maltreatment. Blueprints for Healthy Youth Development has also rated PCIT as 'Promising' as a treatment for young children with emotional and behavioral problems.[138]

Evidence suggests a reduction in hyperactivity, aggression, disruptive behavior (e.g., noncompliance, tantrums, arguing), and reduction in caregiver stress, alongside improvements in caregiver-child relationship and positive parenting practices.[139]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse PCIT services if delivered through Medi-Cal FFS or MCPs as NSMHS. The following provider types are eligible to use these codes: Clinical Nurse Specialist, Licensed Clinical Social Worker

[130] The California Evidence-Based Clearing House, PCIT
[131] PCIT therapist training guidelines
[132] Under SMHS, eligible mental health providers must be trained and certified by either PCIT International or the UC Davis CAARE Center to provide PCIT. For more details, please consult BHIN 25-XXXX.

[133] The California Evidence-Based Clearing House, PCIT, see section on Scientific Rating
[134] Title IV-E Prevention Services Clearinghouse, PCIT
[135] National Child Traumatic Stress Network
[136] The California Evidence-Based Clearing House, PCIT
[137] Child Welfare Information Gateway
[138] Blueprints for Healthy Youth Development
[139] The California Evidence-Based Clearing House, PCIT, see section on Relevant, Published Peer-Reviewed Research

(LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologist, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), and psychiatrist.[140]

Parent-Child Interaction Therapy (PCIT)[141]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[142]**
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Weekly ~1 hour child-caregiver treatment session (individually)	Yes, with modifier 22
	90834	Psychotherapy with patient, 45 minutes		Yes, with modifier 22
	90847	Family psychotherapy (with patient present), 50 minutes	Weekly ~1 hour child-caregiver treatment session (both present)	Yes, with modifier 22

County BHPs (SMHS)

Under BH-CONNECT and FFPSA, PCIT must be covered by county BHPs as part of EPSDT.[143] Licensed Mental Health Professionals (LMHPs), including waivered and registered professionals, and Clinical Trainees[144] acting within the scope of their license and training may use the below CPT/HCPCS codes to reimburse PCIT services if delivered by county BHPs as SMHS.

[140] Non-Specialty Mental Health Services (NSMHS), DHCS
[141] Analysis by Manatt Health from Jan 2022 to Feb 2023
[142] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[143] BH-CONNECT waiver application
[144] LMHPs and Clinical Trainees are defined on page 2l of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan.

Parent-Child Interaction Therapy (PCIT)				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[145]**
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Weekly ~1 hour child-caregiver treatment session (individually)	Yes, with modifier 22
	90833	Add-on for psychotherapy with patient when performed with an evaluation and management service, 30 minutes		Yes, with modifier 22
	90834	Psychotherapy with patient, 45 minutes		Yes, with modifier 22
	90836	Add-on for psychotherapy with patient when performed with an evaluation and management service, 45 minutes		Yes, with modifier 22
	90837	Psychotherapy with patient, 60 minutes		Yes, with modifier 22
	90838	Add-on for psychotherapy with patient and/or family member when performed with an evaluation and management service, 60 minutes	Weekly ~1 hour child-caregiver treatment session (both present)	Yes, with modifier 22
	90847	Family psychotherapy (with patient present), 50 minutes		Yes, with modifier 22

[145] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

	T2021	Therapy substitute, 15 minutes	Therapy substitute (as needed)	Yes, with modifier 22

vii. Potential Medi-Cal non-reimbursable services

Parent-Child Interaction Therapy (PCIT)[146]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A

F. Strong African American Families (SAAF)[147]

Included within CYBHI EBP grant program.

i. California Evidence-Based Clearinghouse Designation[148]

1 – Well-Supported by Research Evidence.

ii. Population of focus

SAAF is designed for African American youth aged 10-14 years and their caregivers.[149]

Studies on SAAF have shown effectiveness in rural communities (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[150]

SAAF is a prevention program designed to support African American youth and their caregivers navigate the transition to adolescence. Through building positive parenting practices and family relationships, it aims to prevent risk behaviors during adolescence (e.g., substance use). Additionally, the program aims to reshape adolescents' perceptions of peers engaging in risky behaviors, such as alcohol consumption, to reduce their likelihood of imitating these behaviors.

SAAF is organized into seven sessions, typically implemented over the course of seven weeks. Families meet weekly for two-hour sessions led by trained facilitators

[146] Analysis by Manatt Health from Jan 2022 to Feb 2023
[147] All information contained in the Strong African American Families® sections comes from publicly available sources. Please refer to each section for specific source details.
[148] The California Evidence-Based Clearinghouse, SAAF, see section on Scientific Rating
[149] The California Evidence-Based Clearinghouse, SAAF, see sections on About this Program
[150] The California Evidence-Based Clearinghouse, SAAF, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery

and participate in youth, caregiver, and family sessions. Topics covered during these sessions include:[151]

1) Youth Session: Teaches youth skills including goal setting, self-identity, resisting early sexual activity, adhering to values, handling peer pressure and understanding parents, coping with unfair situations, building healthy friendships, and making good decisions.

2) Caregiver Session: Includes parenting skills around supporting youth, implementing practical parenting strategies, managing daily parenting tasks, fostering children's academic potential, protecting against risky behaviors, fostering racial pride, and maintaining strong connections.

3) Family Session: Includes conversations around supporting youth goals, sharing values, supporting youth development, addressing concerns, understanding one another, responding to peer pressure, fostering racial pride, and expressing appreciation.

iv. Care delivery setting and provider qualifications

SAAF is typically conducted in a community daily living setting, community-based agency/organization/provider, or school setting.[152]

Facilitators for the program generally have some level of higher education (e.g., some college courses), facilitation experience (e.g., group facilitation and/or teaching a structured class/program), and cultural competence gained through working with African American youth and their caregivers.[153]

According to Center for Family Research, SAAF requires facilitators to complete a three full day in-depth training through the Center for Family Research (CFR), which covers detailed review and practice of session activities.[154] Here, facilitators receive ongoing technical assistance, two sets of program DVDs, access to the video streaming site, printed curriculum materials, and PDF copies of all necessary materials. Additionally, participants gain access to resource materials, the Impact Implementation Support Platform, and structured coaching for full certification. Participants are trained on all session contents for Youth/Teen, Caregiver, and Family sessions. At least three people are needed to implement the program, though 5-8 people are recommended, with a maximum of 20 trainees for certification.[155]

[151] University of Georgia, Center for Family Research SAAF
[152] The California Evidence-Based Clearinghouse, SAAF, see sections on Program Delivery; Manuals and Training; and Implementation Information
[153] The California Evidence-Based Clearinghouse, SAAF, see sections on Program Delivery; Manuals and Training
[154] Center for Family Research – SAAF Program Training
[155] The California Evidence-Based Clearinghouse, SAAF, see sections on Program Delivery; Manuals and Training

v. Summary of evidence from literature on program efficacy / impact

SAAF is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1 year post intervention.[156] It is recognized by the California Evidence-based Clearinghouse for Child Welfare,[157] National Institute of Justice Crime Solutions,[158] and SAMHSA.[159] Blueprints for Healthy Youth Development has also rated SAAF as 'Promising'.[160]

Evidence suggests families who participated in SAAF experienced increases in regulated-communicative parenting, targeted parenting behaviors, adaptive universal and racially specific parenting, and youth intrapersonal competencies. [161] Some studies also showed a decrease in alcohol use and risky sexual behavior among African American youths.[162]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse SAAF services if they are one of the following provider types: Physician or other licensed practitioner of the healing arts within their scope of practice under state law, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP),or Psychiatrist.[163]

Strong African American Families[164]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[165]**
CHW services	98960	Education and training for patient		Yes

[156] The California Evidence-Based Clearinghouse, SAAF, see section on Scientific Rating
[157] The California Evidence-Based Clearinghouse, SAAF
[158] National Institute of Justice, SAAF
[159] SAMHSA
[160] Blueprints for Healthy Youth Development, SAAF
[161] The California Evidence-Based Clearinghouse, SAAF, see sections on Relevant Published, Peer-Reviewed Research
[162] The California Evidence-Based Clearinghouse, SAAF, see sections on Relevant Published, Peer-Reviewed Research
[163] Non-Specialty Mental Health Services (NSMHS), DHCS
[164] Analysis by Manatt Health from Jan 2022 to Feb 2023
[165] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

		self-management, individual	Weekly 2-hour session with child and caregiver(s)	
	98961	Education and training for patient self-management, group (2-4)		Yes
	98962	Education and training for patient self-management, group (5-8)		Yes
Dyadic psychoeducational service	H2027	Psychoeducational service, 15 minutes		No

vii. Potential Medi-Cal non-reimbursable services

Strong African American Families [166]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

G. Positive Indian Parenting (PIP)[167]

Included within CYBHI EBP grant program.

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight.

ii. Population of focus

[166] Analysis by Manatt Health from Jan 2022 to Feb 2023
[167] All information contained in the Positive Indian Parenting sections comes from publicly available sources. Please refer to each section for specific source details.

PIP is designed for American Indian/Alaska Native caregivers, as well as Non-Native American parents/caregivers raising American Indian/Alaska Native children in a birth, foster, or adoptive family.[168]

iii. Program description[169]

PIP is a culturally-based parenting training program designed for American Indian/Alaska Native caregivers. The primary goal of PIP is to empower parents by integrating traditional indigenous practices into modern parenting, fostering safe and supportive environments for their children. Parenting skills incorporate concepts from oral traditions, focusing on effective communication and behavior management to support self-discipline in children. The program is adaptable to include teachings from various tribes and local regions, ensuring cultural relevance and resonance.

PIP contains eight sessions (once per week for 2-3 hours) where caregivers engage in discussions, activities, and skill-building exercises that draw on traditional stories, teachings, and practices. The program is interactive and participatory, providing caregivers with a supportive environment to learn, share experiences, and develop new parenting strategies that honor their cultural traditions. The eight modules delivered by trained facilitators include:[170]

1) Orientation/Traditional Parenting: Introductory module that provides an overview of the program, explaining its goals and structure. It emphasizes the importance of traditional parenting practices and how these can be integrated into modern parenting.
2) Lessons of the Storyteller: Focuses on the role of storytelling in teaching and guiding children, where caregivers learn how to use storytelling as a powerful tool for education and connection with their children.
3) Lessons of the Cradleboard: Includes lessons that can be drawn from the use of cradleboards (e.g., importance of nurturing, protection, and the physical and emotional needs of infants and young children).
4) Harmony in Child Rearing: Teaches caregivers how to create a balanced and peaceful home environment through fostering positive relationships, communication, and cooperation within the family.
5) Traditional Behavior Management: Includes traditional methods of guiding and managing children's behavior using natural and logical consequences, the role of community and extended family in behavior management, and the importance of consistency and fairness.
6) Lessons of Mother Nature: Teaches parents how to use the environment as a source of wisdom and guidance in parenting. It emphasizes the importance of

[168] Center for Native Child and Family Resilience
[169] Title IV-E Prevention Services Clearinghouse, PIP; Center for Native Child and Family Resilience
[170] PIP Reference Manual

observing and learning from nature and incorporating outdoor activities into family life.

7) Praise in Traditional Parenting: Focuses on the role of praise and positive reinforcement in traditional parenting. It highlights the importance of recognizing and celebrating children's achievements and efforts, building their self-esteem, and encouraging positive behavior.
8) Choices in Parenting/Graduation: Allows parents to reflect on the knowledge and skills they have gained throughout the program. It emphasizes the importance of making informed and conscious choices in parenting, drawing on both traditional and contemporary practices.

iv. Care delivery setting and provider qualifications

PIP is delivered in the parent's/caregiver's home or in community settings; sessions are conducted either individually or with groups of parents/caregivers.[171]

Facilitators of PIP are trained and certified by the National Indian Child Welfare Association (NICWA) through a three-day workshop focused on adapting the curriculum to fit tribal cultures.[172] This training includes customizing the curriculum with tribal themes, understanding child development, and modifying sessions with guest speakers and emotional support for parents. Facilitators come from various professional backgrounds and co-facilitate with a Native facilitator if non-Native. The program uses a train-the-trainer model, with NICWA lead trainers instructing tribal facilitators, who then train their colleagues.

v. Summary of evidence from literature on program efficacy / impact

Although there are no formal evaluations of PIP to date, the curriculum is based on extensive child welfare practice experience. PIP is recognized as an effective practice by the First Nations Behavioral Health Association.[173] In addition, according to the Oregon Addictions & Mental Health Division's Evidence-Based Programs, "clear acceptance of this curriculum has been demonstrated through implementation in communities across this country." [174]

vi. Potential Medi-Cal non-reimbursable services

Positive Indian Parenting (PIP)[175]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**

[171] Title IV-E Prevention Services Clearinghouse, PIP
[172] NICWA
[173] Tribal Justice
[174] Oregon Addictions & Mental Health Division Evidence-Based Programs Tribal Practice Approval Form, PIP
[175] Analysis by Manatt Health from Jan 2022 to Feb 2023

Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

H. Effective Black Parenting Program (EBPP)[176]

Included within CYBHI EBP grant program.

i. California Evidence-Based Clearinghouse Designation[177]

3 – Promising Research Evidence.

ii. Population of focus

EBPP is designed for African American families with children aged 17 and younger who may be at risk for maltreatment.[178]

Studies on EBPP suggest that it may be effective across populations from varying socioeconomic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[179]

EBPP is a group-based parent training program for African American caregivers that is designed to strengthen parenting skills through a culturally relevant framework. The program incorporates African proverbs to reinforce the parenting lessons and cultural heritage. Topics covered include fostering high self-esteem, discipline, racial pride, alongside practical skills like managing school and health habits. The program also addresses contemporary issues such as low self-esteem and drug use among African American children, using culturally relevant examples and visual aids to facilitate learning and discussion.

The EBPP program is a 14-week course, with each session lasting approximately 2 hours. Throughout the program, parents develop a range of skills and insights aimed at fostering their children's success and well-being. In the initial sessions, they are introduced to the "Pyramid of Success for Black Children," where they assess their goals for their children and learn to instill high self-esteem, pride in their heritage, self-discipline, and strong study habits. The program emphasizes the importance of

[176] All information contained in the Effective Black Parenting Program sections comes from publicly available sources. Please refer to each section for specific source details.
[177] The California Evidence-Based Clearinghouse, EBPP, see section on Scientific Rating
[178] The California Evidence-Based Clearinghouse, EBPP, see sections on About This Program
[179] The California Evidence-Based Clearinghouse, EBPP, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; DCCTF EBPP; Walden University

using praise to reinforce positive behaviors, understanding social learning theory, and setting clear expectations with tools like behavior charts.

As the program progresses, parents explore both traditional and modern discipline methods, focusing on consistency and patience, and learn to establish clear, fair family rules tailored to their children's developmental stages. This includes practical exercises to apply these rules effectively and fostering a secure, supportive family environment.

In later sessions, parents are taught about the benefits of non-physical discipline, and methods such as ignoring minor misbehaviors and using time-outs for rule violations. They also learn motivational strategies like the point system to encourage respectful behavior and explore drug prevention tactics, emphasizing communication and setting clear expectations.

iv. Care delivery setting and provider qualifications

EBPP is typically conducted in a birth family home, foster/kinship care, outpatient clinic, or community-based agency/organization/provider.[180]

Instructors range from paraprofessional prevention specialists and parent involvement coordinators to children service workers with bachelor's level degrees and Doctorate-level psychologists.[181] To become a provider of EBPP, participants complete a training led by the Center for the Improvement of Child Caring (CICC).[182] This training includes a 3 to 5-day in-person workshop covering the EBPP curriculum, teaching methodologies, and cultural competencies essential for working with African American families. Trainees engage in interactive learning through role-playing, group discussions, and practice facilitation sessions. Successful completion of the training and assessment leads to certification, after which providers receive ongoing support, including refresher courses, advanced workshops, and technical assistance to help with program implementation and continuous professional development.

v. Summary of evidence from literature on program efficacy/impact

EBPP is considered "promising" by peer-reviewed literature and is recognized by the California Evidence-based Clearinghouse for Child Welfare.[183]

Evidence on EBPP suggests a reduction in parental rejection and improvement in quality of family relationships and child behavior outcomes (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

[180] The California Evidence-Based Clearinghouse, EBPP, see sections on Program Delivery; Manuals and Training; and Implementation Information
[181] The California Evidence-Based Clearinghouse, EBPP, see sections on Program Delivery; Manuals and Training
[182] Center for the Improvement of Child Caring – EBPP Training
[183] The California Evidence-Based Clearinghouse, EBPP, see sections on Scientific Rating

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse EBPP services if they are one of the following provider types: Physicians or other licensed practitioners of the healing arts within their scope of practice under state law,[184] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[185]

Effective Black Parenting Program (EBPP)[186]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[187]**
CHW services	98960	Education and training for patient self-management, individual	Weekly 3-hour session with parents on skill-building	Yes
	98961	Education and training for patient self-management, group (2-4)		Yes
	98962	Education and training for patient self-management, group (5-8)		Yes
Psychoeducation	H2027	Psychoeducational service, 15 minutes		No

vii. Potential Medi-Cal non-reimbursable services

Effective Black Parenting Program (EBPP)[188]

[184] Medi-Cal Coverage of CHW Services
[185] Non-Specialty Mental Health Services (NSMHS), DHCS
[186] Analysis by Manatt Health from Jan 2022 to Feb 2023
[187] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[188] Analysis by Manatt Health from Jan 2022 to Feb 2023

Service components of the model	Illustrative services provided	Additional notes where applicable
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

I. Homebuilders[189]

Included within FFPSA Five-Year State Prevention Plan.

i. California Evidence-Based Clearinghouse Designation[190]

2 – Supported by Research Evidence for family stabilization programs, interventions for neglect, post-permanency services, and reunification programs.

3 – Promising Research Evidence for post-reunification services.

ii. Population of focus

Homebuilders is a home-and community-based intensive family preservation services treatment program for families with children aged 0-17 at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities.[191]

Studies on Homebuilders have demonstrated its effectiveness with youths and their families from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[192]

Homebuilders provides families with intensive in-home counseling, skill building, and support services to teach skills (e.g., child behavior management, effective discipline, mood management, communication) to prevent placement or to successfully reunify with their children. Therapists use evidence-based treatment practices such as motivational interviewing, behavioral parent training, cognitive-behavior therapy strategies.

[189] All information contained in the Homebuilders program sections comes from publicly available sources. Please refer to each section for specific source details.
[190] The California Evidence-Based Clearinghouse, Homebuilders, see section on Scientific Rating
[191] The California Evidence-Based Clearinghouse, Homebuilders, see section on About This Program
[192] The California Evidence-Based Clearinghouse, Homebuilders, see section on Program Overview; Program Goals; Essential Components; and Program Delivery; National Institute of Justice, Homebuilders

The recommended duration for treatment is three to five 2-hour sessions per week over 4-6 weeks, with up to two "booster sessions." Families are seen within 24 hours of referral to the program, and therapists are also available 24/7 for crisis intervention. Homebuilder therapists have typical caseloads of two families at a time, although it can be as high as five families.

Therapists engage in continuous and comprehensive assessments (e.g., safety, domestic violence, suicide risk, crisis planning) that specifically target behaviors, considering family strengths, values, and obstacles to achieving goals. They work together with family members and other individuals involved to establish intervention goals and create tailored service plans to each family's needs, strengths, lifestyle, and culture. These goals and plans concentrate on addressing factors that directly contribute to the risk of placing children outside of their homes or facilitating reunification. Throughout the intervention process, therapists develop safety plans and employ clinical strategies aimed at ensuring the well-being and security of the individuals involved.

Other essential elements include helping the family access (and learn how to access) goods and services that are directly related to achieving the family's goals and coordinating with community services and systems affecting the family.

A homework component usually includes collecting information to understand progress, practicing skills, and implementing interventions.

iv. Care delivery setting and provider qualifications

An essential element of the Homebuilders model is that services are typically delivered in an adoptive or birth family home, or "natural environment."[193]

Therapists require a bachelor's or master's degree in psychology, social work, counseling, or a related field.[194] In addition, a therapist who has only a bachelor's degree must also have two years of experience working with families. Supervisors have the same qualifications as therapists with an additional two years of experience providing Homebuilders and one year of supervisory/management experience. The Homebuilders training program consists of 5 days initial training, 8 days of intermediate/advanced training, and 7 additional days of training for supervisors.

v. Summary of evidence from literature on program efficacy / impact

Homebuilders is "supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[195] It is recognized by the California

[193] The California Evidence-Based Clearinghouse, Homebuilders, see sections on Program Delivery; Manuals and Training; and Implementation Information
[194] The California Evidence-Based Clearinghouse, Homebuilders, see sections on Program Delivery; Manuals and Training
[195] The California Evidence-Based Clearinghouse, Homebuilders, see section on Scientific Rating

Evidence-based Clearinghouse for Child Welfare,[196] Title IV-E Prevention Services Clearinghouse,[197] and National Institute of Justice Crime Solutions.[198]

Evidence suggests that Homebuilders can increase the number of children who remained at home and those who return to their families sooner. For example, one study found that ~70% of children in the program remained at home a year later compared to ~45% of children in the control group.[199]

J. Brief Strategic Family Therapy (BSFT)[200]

Included within FFPSA Five-Year State Prevention Plan

i. California Evidence-Based Clearinghouse Designation[201]

1 – Well-Supported by Research Evidence for disruptive behavior treatment (child & adolescent).

3 – Promising Research Evidence for substance abuse treatment (adolescent).

ii. Population of focus

BSFT adopts a structural family systems framework to support families with maladaptive interactions resulting in at least one youth (aged 6-18 years) with externalizing (e.g., substance abuse, delinquency, truancy, bullying) and/or internalizing (e.g., depression, anxiety) symptomatology.[202]

Studies on BSFT have demonstrated its effectiveness with youths and their families from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[203]

BSFT uses a structured, problem-focused, directive, and practical approach to treating child/adolescent conduct problems. Treatment is typically delivered in weekly therapy sessions lasting 60-90 minutes over 12-16 weeks depending on the severity of the problems. The four steps of the intervention consist of:

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[196] The California Evidence-Based Clearinghouse, Homebuilders
[197] Title IV-E Prevention Services Clearinghouse, Homebuilders
[198] National Institute of Justice, Homebuilders
[199] The California Evidence-Based Clearinghouse, Homebuilders
[200] All information contained in Brief Strategic Family Therapy program sections comes from publicly available sources. Please refer to each section for specific source details.
[201] The California Evidence-Based Clearinghouse, BSFT, see section on Scientific Rating
[202] The California Evidence-Based Clearinghouse, BSFT, see section on About This Program
[203] The California Evidence-Based Clearinghouse, BSFT, see sections on Program Overview; Program Goals; Essential Components; and Implementation Information; BSFT

1) Organizing a therapist-family work team.

2) Diagnosing the nature of family strengths and problematic relationships.

3) Developing a treatment strategy aimed at capitalizing on strengths and correcting problematic family relations to increase family competence.

4) Implementing change strategies and reinforcing family behaviors that sustain new levels of family competence.

The model addresses cognitive, behavioral, and affective aspects of family life and includes three intervention components:

- Joining – forming a therapeutic alliance with all family members to disarm defenses.

- Systemic diagnosis – eliciting and observing family interactions (Enactments) to identify interactional patterns that are associated with problematic youth behavior. The therapy is organized around 6 diagnostic dimensions (organization, resonance, developmental stages, life context, identified patient, conflict resolution).

- Restructuring – designing and executing a treatment plan with interventions to be performed during the session. Plans use "Highlights, Reframes, and assigning Tasks" to elicit more effective and adaptive family interactions related to problem behaviors. The treatment plan is aimed at capitalizing on strengths and correcting problematic family relations to increase family competence.

BSFT involves the family or other support systems in the individual's treatment. Services are also directly provided to parents / caregivers to address loss of parental authority, lack of guidance to youth, ineffective communication, lack of conflict resolution skills, negativity and hostility within the family, lack of positive bonding, and negative role-modeling.

Homework is encouraged after a therapist has successfully led the family through a new and improved interactional pattern within that session. Homework may involve communication skills, cooperation, parental guidance, and bonding activities.

Goals for the child / adolescent include reducing behavior problems while improving self-control, reducing associations with antisocial peers, reducing drug use, and developing prosocial behaviors. Goals for the family include improving maladaptive patterns of family interactions; improving family communication, conflict-resolution, and problem-solving skills; improving family cohesiveness, collaboration, and parent-child bonding; and improving effective parenting, including successful management of children's behavior and positive affect in the parent-child interactions.

iv. Care delivery setting and provider qualifications

BSFT is typically conducted in an adoptive home, birth family home, community daily living setting, foster/kinship care, hospital, outpatient clinic, community-based agency/organization/provider, group or residential care, school setting, or virtual setting.[204]

Therapists typically have at least a master's degree in social work, marriage and family therapy, psychology, or a related field and training and/or experience with basic clinical skills common to behavioral interventions. Practitioners that have a bachelor's degree with at least 5 years of clinical experience may also be eligible. BSFT therapists are required to participate in a structured program of training with subsequent fidelity monitoring for adherence.

v. Summary of evidence from literature on program efficacy / impact

BSFT is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[205] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare,[206] Title IV-E Prevention Services Clearinghouse,[207] and Office of Juvenile Justice and Delinquency Prevention (OJJDP) Blueprints Project.[208]

Evidence suggests youth and families who participated in BSFT showed 75% reduction in marijuana use, 58% reduction in association with antisocial peers, and 42% improvement in conduct disorder.[209] Families also showed increases in family participation in therapy, improvements in maladaptive patterns of family interactions, improvements in family communication, conflict-resolution, and problem-solving skills, improvements in family cohesiveness, collaboration, and child/family bonding, and reductions of alcohol use among parents while reducing adolescents' substance use.[210]

K. Family Check-Up (FCU)[211]

Included within FFPSA Five-Year State Prevention Plan

[204] The California Evidence-Based Clearinghouse, BSFT, see sections on Program Delivery; Manuals and Training; and Implementation Information
[205] The California Evidence-Based Clearinghouse, BSFT, see section on Scientific Rating
[206] The California Evidence-Based Clearinghouse, BSFT
[207] Title IV-E Prevention Services Clearinghouse, BSFT
[208] OJJDP
[209] BSFT
[210] BSFT
[211] All information contained in the Family Check-Up program sections comes from publicly available sources. Please refer to each section for specific source details.

i. California Evidence-Based Clearinghouse Designation[212]

1 – Well-Supported by Research Evidence

ii. Population of focus

FCU model is a family-centered intervention for caregivers of children (2-17 years old) in the middle or lower socioeconomic level.[213]

Studies on FCU's program have previously demonstrated effectiveness with children and caregivers from various races/ethnicities and have shown effectiveness in rural communities (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[214]

The FCU model is a family-centered intervention that aims to improve family management and address issues related to child and adolescent adjustment. This is achieved by reducing negative and coercive parenting behaviors and promoting positive parenting practices. The intervention can be tailored to address the specific needs of each child and family.

FCU consists of two phases:

1) An initial assessment and feedback that includes a 1-hour clinical interview conducted between the provider and caregiver/family; a child and family assessment that is multimethod (video, questionnaires) and involves multiple reporters (parent, child, teacher); and a 1-hour feedback session between the provider and caregiver/family.

2) Parent management training (Everyday Parenting) – sessions between the provider and caregiver/family that uses behavioral intervention strategies to emphasize positive behavior reinforcement, setting healthy boundaries, and building relationships. Interventions are tailored to address the specific needs of each child and family and can be integrated into many service settings (see below).

After completing the feedback session in phase 1, the parent/caregiver and provider determine whether follow-up intervention services through phase 2 are necessary. Phase 1 of FCU typically consists of three sessions that are ~1 hour each and 1-2 weeks apart. Phase 2 may vary in intensity but typically consists of one 1-hour session every two weeks for a minimum of four sessions. As a health promotion and

[212] The California Evidence-Based Clearinghouse, FCU, see section on Scientific Rating
[213] The California Evidence-Based Clearinghouse, FCU, see section on About This Program
[214] The California Evidence-Based Clearinghouse, FCU, see sections on Program Overview; Program Goals; Essential Components; and Implementation Information; University of Oregon FCU

prevention strategy, FCU can be brief (2 to 3 sessions) while as a treatment approach, follow-up sessions can range from 3 to 15 direct contact hours.

Phase 2 follow-up may also include family counseling, individualized services for parent and children, or other support services. FCU uses the modular, skills-based Everyday Parenting Curriculum to develop positive parenting skills.

FCU typically includes a homework component during Phase 2 in which families are given worksheets to guide their practice of new skills.

iv. Care delivery setting and provider qualifications

FCU is typically conducted in an adoptive home, birth family home, foster/kinship care, hospital, outpatient clinic, community-based agency/organization/provider, or school setting.[215]

Treatment may be administered by community practitioners in schools, community health centers, and government agencies; paraprofessionals may also be eligible but require more intensive post-training consultation.[216] A Master's degree (MSW, MS, MA, and M.Ed.) and relevant clinical experience is required.

v. Summary of evidence from literature on program efficacy / impact

FCU is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1 year post intervention. [217] It has also been recognized by the California Evidence-based Clearinghouse for Child Welfare,[218] Title IV-E Prevention Services Clearinghouse[219], Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs,[220] National Institute of Justice Crime Solutions,[221] and SAMHSA.[222] Blueprints for Healthy Youth Development has also rated FCU for toddlers as 'Promising'.[223]

Evidence suggests youth who received FCU in adolescence demonstrated 30% reduction in marijuana use, 54% reduction in tobacco use, 26% reduction in alcohol use, 38% reduction in arrests, and 77% fewer school absences. Studies also indicated that FCU helped reduce antisocial behavior, depression, and bullying in school.[224]

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[215] The California Evidence-Based Clearinghouse, FCU, see sections on Program Delivery; Manuals and Training; and Implementation Information
[216] The California Evidence-Based Clearinghouse, FCU, see sections on Program Delivery; Manuals and Training
[217] The California Evidence-Based Clearinghouse, FCU, see section on Scientific Rating
[218] The California Evidence-Based Clearinghouse, FCU
[219] Title IV-E Prevention Services Clearinghouse, FCU
[220] OJJDP Model Programs
[221] National Institute of Justice, FCU
[222] SAMHSA
[223] Blueprints for Healthy Youth Development, FCU Toddler
[224] University of Oregon FCU

Chapter 6: Trauma-informed programs and practices

These trauma-informed programs and practices aim to increase access to services that address behavioral health needs and Adverse Childhood Experiences (ACEs). Research indicates that 36 percent of children in California have been exposed to one or more ACEs[225] and 63.5 percent of all adults were exposed before age 18.[226]

Priority Populations of Focus: Populations identified by CRDP and OHE

Outcomes/Key Metrics: The goal is these EBPs is to expand access to early interventions, support the resilience of children and youth by mitigating the adverse effects of ACEs, build knowledge of trauma-informed support and communication, increase the capacity of child-serving service systems on trauma-informed practices, improve the understanding of how community trauma and racism impact child and youth well-being, and improve grief support for children and youth with COVID-related trauma among other outcomes.

Example EBPs: Example EBPs in this theme include but are not limited to Child-Parent Psychotherapy; Cognitive Behavioral Interventions for Trauma in Schools; Dialectical Behavioral Therapy; Family-Centered Treatment; Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems; and Trauma-Focused Cognitive Behavioral Therapy.

A. Family Acceptance Project (FAP)[227]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight

ii. Population of focus

FAP is an intervention that focuses on LGBTQ+ youth. The program has been integrated into Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and serves trauma exposed children (aged 6-17 years) and their caregivers,[228]

[225] California Health and Human Services Agency's and the California Department of Public Health's Let's Get Healthy Initiative
[226] California Health and Human Services Agency's and the California Department of Public Health's Let's Get Healthy Initiative
[227] All information contained in the Family Acceptance Project® sections comes from publicly available sources. Please refer to each section for specific source details.
[228] The California Evidence-Based Clearinghouse, The Family Acceptance Project, see sections on About This Program

According to the FAP website (see Family Acceptance Project, publications), its program has been applied to racially, culturally, and religiously diverse families, rural families, and families living on tribal reservations.[229,230]

iii. Program description[231]

FAP is a research, intervention, education, and policy program that aims to prevent health and behavioral health risks, while promoting well-being for LGBTQ+ children and youth. This program is family-centered— it educates families about the impact of their responses to their child's sexual orientation, gender identity, and gender expression. The FAP model uses a strengths-based approach to recognize and build on the positive aspects of the family relationship. FAP aims to address important issues LGBTQ+ children and youth face: suicide, homelessness, drug use, and HIV.

The FAP model has been integrated into Trauma Focused Cognitive Behavioral Therapy (TF-CBT) to promote recovery for LGBTQ+ children and youth who have experienced trauma. It can be applied in both individual family and group formats and treatment duration is based on the needs of the family to ensure long-term, sustainable, and positive improvements in the family dynamic. Central components to the FAP model include:

1) Improving caregivers' understanding of how their behaviors, attitudes, and communication can impact their child's mental health.
2) Offering resources and counseling to strengthen family support and decrease invalidating behaviors and attitudes.
3) Developing research-based education, training, and assessment materials for health, mental health, and school-based providers, child welfare, juvenile justice, family service workers, clergy and religious leaders, parents and caregivers designed to help individuals learn to support LGBTQ+ children.

iv. Care delivery setting and provider qualifications

FAP can be conducted clinically in formal mental health settings or non-clinically-clinically in a wide range of programs and services in schools, foster care, juvenile justice and homeless programs, primary care and hospital-based care, community-based organizations, pastoral care and ministries, and by families themselves[232]

San Francisco State University is the sole provider of training on how to use FAP's family support strategies, resources, and Family Support Model.[233] Participants can

[229] The Family Acceptance Project - Publications
[230] The Family Acceptance Project – Adaptation for American Indian Families
[231] San Francisco State University – The Family Acceptance Project; Engaging Families to Support
[232] The Family Acceptance Project
[233] The Family Acceptance Project, Training

choose between eight trainings that are tailored to meet family, provider, community, and institutional needs, with each training typically lasting one full day.

v. Summary of evidence from literature on program efficacy / impact

FAP has been recognized by the National Child Traumatic Stress Network as an effective trauma-informed intervention.[234] It has also been recognized in the American Foundation for Suicide Prevention's Best Practices Registry as a best practice for suicide prevention.[235]

Evidence suggests FAP can be successful in preventing suicide, substance abuse, homelessness, HIV, and other risks that LGBTQ+ youth face.[236] The program may also promote self-esteem, health, and well-being among participants.[237]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse FAP services if they are one of the following provider types: Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[238]

Family Acceptance Project (FAP)[239]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[240]**
Dyadic psychoeducational service	H2027	Psychoeducational service, 15 minutes	Family Support Model delivered in a psychoeducation program	No

[234] National Child Traumatic Stress Network
[235] Family Acceptance Project
[236] Journal of Pediatrics; Journal of Child and Adolescent Psychiatric Nursing
[237] Journal of Pediatrics
[238] Non-Specialty Mental Health Services (NSMHS), DHCS
[239] Analysis by Manatt Health from Jan 2022 to Feb 2023
[240] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

vii. Potential Medi-Cal non-reimbursable services

Family Acceptance Project (FAP)[241]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Community	Community engagement strategies	N/A
Implementation	Hiring and training staff	N/A
Religious/spiritual	Faith-based education materials	N/A
Wraparound services	Housing support services, nutritional program	N/A

B. Multisystemic Therapy (MST) [242]

Included within CYBHI EBP grant program, FFPSA Five-Year State Prevention Plan, and BH-CONNECT

i. California Evidence-Based Clearinghouse Designation[243]

1 – Well-Supported by Research Evidence

ii. Population of focus

MST is a family- and community- based intervention for youth (ages 12-17)[244] with serious mental health needs and/or substance use challenges that are at risk of entering the child welfare system or being homeless and/or engaged with the juvenile justice system.[245]

Studies on MST have previously demonstrated its effectiveness with youths and their families from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

MST is not recommended for youth living independently; youth who are actively suicidal, homicidal, or psychotic; youth whose psychiatric problems are the primary

[241] Analysis by Manatt Health from Jan 2022 to Feb 2023

[242] All information contained in the Multisystemic Therapy program sections comes from publicly available sources. Please refer to each section for specific source details.

[243] The California Evidence-Based Clearinghouse, MST, see section on Scientific Rating

[244] Under SMHS, a LMHP may determine a child of an appropriate developmental age may receive the service; the youth does not need to be ages 12-17.

[245] The California Evidence-Based Clearinghouse, MST, see section on About This Program

reason leading to referral; juvenile sex offenders; or youth with moderate to severe difficulties with social communication and interaction.

iii. Program description[246]

MST is an intensive family- and community-based treatment that utilizes therapy sessions to reduce emerging high-risk behaviors, including criminogenic behavior, anti-social activities, substance use, and other behaviors that may lead to juvenile justice involvement, out-of-home placement, or other severe system consequences within their family, school, or community. criminal activity, substance use, and juvenile justice involvement. For parents / caregivers, the goal is to learn skills to independently address difficulties in raising children and adolescents as well as skills to cope with other family, peer, and neighborhood challenges.

The treatment intensity varies based on youth and family needs (e.g., brief check-ins to 2-hour sessions, ranging from daily to weekly) over the course of 3-5 months. Each therapist typically oversees a maximum caseload of six families. At least one therapist on the treatment team should be available 24 hours a day, 7 days a week to provide crisis management. During initial therapy sessions, the therapist identifies strengths and growth opportunities of the adolescent, the family, and their interactions with extrafamilial environments (e.g., peers, school, parental workplace). The therapist and family members work together to identify and target emerging issues and ways to address them in different environments (e.g., in the community, at home)

Providers use an analytical model that looks at a range of risk factors across family, peer, school, and community contexts. Providers are then able to identify factors that may be influencing a youth's clinical problem(s) (e.g., depression, anxiety) and help design potential interventions. All intervention techniques are evidence-based or evidence-informed.

Youth are taught skills to help cope with their environments (e.g., family, school, and neighborhood). The program also supports caregivers in developing skills to help improve family well-being and cohesion.

Homework may be assigned for parent management training, anger management treatment, SUD treatment, and family communication training.

There are rigorous quality assurance mechanisms in place to ensure the program is delivered properly and that youth achieve desired outcomes

[246] The California Evidence-Based Clearinghouse, MST, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; MST Services

iv. Care delivery setting and provider qualifications

MST is typically conducted in an adoptive home, birth family home, foster/kinship care, and/or school setting.[247]

MST can be administered by a team of eligible staff members, including therapists and supervisors.[248] Teams are typically comprised of one clinical supervisor with a minimum of two and a maximum of four therapists. The supervisor is responsible for facilitating one group supervision meeting per week and providing individual supervision clinician meetings and additional trainings as needed. The supervisor may also have primary or shared responsibility for program management tasks as part of their administrative responsibility for the MST team. The MST supervisor may be part-time if only supervising one MST team, but may be full-time if they supervise two MST teams or carry two MST cases and have additional MST responsibilities. Each team typically has a caseload of approximately 30-60 families per year and each therapist typically oversees a maximum caseload of six families.

Under SMHS, LMHPs (including waivered or registered professionals) and Clinical Trainees acting within the scope of their license and training may provide MST. All providers must also be trained and certified by MST Services to claim for MST.

All staff members, therapists, and supervisors undergo a standard 5-day orientation and subsequently have additional weekly telephone consultations and quarterly on-site booster trainings.[249]

v. Summary of evidence from literature on program efficacy/impact

MST is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[250] MST is recognized by the California Evidence-based Clearinghouse for Child Welfare,[251] Title IV-E Prevention Services Clearinghouse[252], United Nations Office on Drugs and Crime (UNODC), Centers for Medicare & Medicaid services (CMS), US Department of Justice Office of Justice Programs, and the National Institutes of Health (NIH).[253] Blueprints for Healthy Youth Development has also rated MST as 'Model Plus'.[254]

Evidence suggests youth who receive MST show a decrease in recidivism rates, an improvement in family cohesion and peer relations, a decrease in incarceration, a

[247] The California Evidence-Based Clearinghouse, MST, see sections on Program Delivery, Manuals and Training; and Implementation Information
[248] The California Evidence-Based Clearinghouse, MST, see sections on Program Delivery, Manuals and Training
[249] Under SMHS, eligible mental health providers must be trained and certified by MST Services to provide MST under Medi-Cal.

[250] The California Evidence-Based Clearinghouse, MST, see section on Scientific Rating
[251] The California Evidence-Based Clearinghouse, MST
[252] Title IV-E Prevention Services Clearinghouse, MST
[253] MST Services
[254] Blueprints for Healthy Youth Development, MST

decrease in substance use, and a decrease in days in out-of-home placement.[255] Studies also show that of juvenile offenders who participated in MST, there were 54% fewer arrests, 75% fewer violent felony arrests, and 54% fewer out-of-home placements after they received treatment; of abused and neglected children who participated in MST, 95% had no re-abuse incidents, 86% live at home, and 91% report no PTSD after they receive treatment.[256]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse MST services if delivered through Medi-Cal FFS or MCPs as NSMHS. The following provider types are eligible to use these codes: Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[257]

Multisystemic therapy (MST)[258]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[259]**
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	MST therapy session with family (up to two hours)	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes
	90837	Psychotherapy with patient, 60 minutes		Yes
	H2033	Multisystemic therapy, per 15 minutes	MST therapy session with family (per 15 minutes)	Yes

[255] The California Evidence-Based Clearinghouse, MST, see section on Relevant, Peer-Reviewed Published Research
[256] MST Services
[257] Non-Specialty Mental Health Services (NSMHS), DHCS
[258] Analysis by Manatt Health from Jan 2022 to Feb 2023
[259] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

County BHPs (SMHS)

Under BH-CONNECT and FFPSA, MST must be covered by county BHPs as part of EPSDT.[260] LMHPs, including waivered and registered professionals, and Clinical Trainees[261] acting within the scope of their license and training may use the below CPT/HCPCS codes to reimburse MST services if delivered by county BHPs as SMHS. MST services are reimbursed a partial or full monthly bundled rate depending upon the number of face-to-face and/or telehealth encounters with the Medi-Cal member during the month. Please review the SMHS Billing Manual[262] for details regarding how to submit claims for this EBP.

Multisystemic therapy (MST)[263]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[264]**
	H2033	Multisystemic therapy, per 15 minutes	MST therapy session with family	Yes

vii. Potential Medi-Cal non-reimbursable services

Multisystemic therapy (MST)[265]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

[260] BH-CONNECT waiver application

[261] LMHPs and Clinical Trainees are defined on page 2l of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan.

[262] MedCCC - Library

[263] Analysis by Manatt Health from Jan 2022 to Feb 2023

[264] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

[265] Analysis by Manatt Health from Jan 2022 to Feb 2023

C. Crossover Youth Practice Model (CYPM)[266]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[267]

3 – Promising Research Evidence

ii. Population of focus

CYPM is tailored to youth (ages 11-17) who are at risk of or are fluctuating between the child welfare and juvenile justice systems.[268]

Evidence on the CYPM suggests that CYPM may be effective with families across a range of racial and ethnic backgrounds(See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[269]

CYPM is multi-system approach designed to support young individuals who are simultaneously involved in the child welfare and juvenile justice systems. These individuals, who are often referred to as "crossover youth", face unique challenges that require a coordinated, multi-system approach to ensure their well-being and successful transition. CYPM addresses these complex needs through improving collaboration between these systems to improve integrated services and supports. Through this organized approach, CYPM aims to reduce delinquency and justice system involvement of crossover youth.

The Crossover Youth Practice Model (CYPM) is implemented in three structured phases:[270]

(1) Phase I – assemble an implementation team that includes representatives from the judiciary, education, mental health, and law enforcement sectors. This phase has serves a dual purpose:

- Early Identification and Prevention: Educating professionals on crossover youth and enhancing their ability to recognize opportunities to facilitate early collaboration and intervention for youth at the crossover point.

[266] All information contained in the Crossover Youth Practice Model® sections comes from publicly available sources. Please refer to each section for specific source details.
[267] The California Evidence-Based Clearinghouse, CYPM, see section on Scientific Rating
[268] The California Evidence-Based Clearinghouse, CYPM, see section on About this Program
[269] The California Evidence-Based Clearinghouse, CYPM, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery
[270] Center for Juvenile Justice Reform – CYPM

- Effective Practices in Charging Decisions: Working with prosecutors and defense attorneys to develop strategies for information-sharing. This is designed to ensure that those making charging decisions have a comprehensive understanding of the youth's history and the circumstances.

(2) Phase II – Child welfare and juvenile justice caseworkers work closely with the youth and their family to perform joint assessments and develop coordinated case plans, reducing redundant evaluations and sharing information. This phase also emphasizes efficient decision-making across systems and improved case management by advising jurisdictions to implement dedicated dockets or a one judge/one family system for crossover youth.

(3) Phase III – Agencies continuously evaluate the progress of the youth and their family while jointly implementing and adapting the case plan as needed. Core activities include regular assessments by child welfare and juvenile justice caseworkers, placement providers, community-based providers, school personnel, and family members to ensure the plan's effectiveness and address any issues promptly. Collaborative efforts focus on achieving youth permanency, facilitating smooth transitions between the child welfare and juvenile justice systems, and providing adequate notice to relevant parties before case closure. Permanency planning starts early on and involves practices like roundtables and benchmark conferences to support family reunification and long-term stability.

iv. Care delivery setting and provider qualifications

CYPM is typically conducted in a justice setting (e.g., juvenile detention, jail, prison, courtroom) or public child welfare agency (e.g., Department of Social Services).[271]

The model is implemented county-wide and involves multiple youth-serving organizations where staff educational requirements are set by agencies and departments responsible for implementing the practice.[272]

Before implementing CYPM, jurisdictions can evaluate their current capabilities using the OJJDP Best Practices Rubric for Integrated Systems and implementation support is offered over a 12-18 month period (e.g., developing local policies and manuals, data monitoring).[273]

v. Summary of evidence from literature on program efficacy / impact

[271] The California Evidence-Based Clearinghouse, CYPM, see section on Program Delivery, Manuals and Training; Implementation Information
[272] The California Evidence-Based Clearinghouse, CYPM, see section on Program Delivery, Manuals and Training; Implementation Information
[273] Center for Juvenile Justice Reform – CYPM Implementation

According to the California Evidence-Based Clearinghouse, CYPM is deemed "promising" by peer-reviewed literature.[274] It has also been recognized by the United States Department of Justice (DOJ) Office of Justice Programs, National Institute of Justice, and the Department of Justice's Office of Juvenile Justice and Delinquency Prevention.[275]

Evidence suggests reduced recidivism, out-of-home placement, and number of crossover youth (i.e., dually involved with child welfare and juvenile justice system), as well as increased family decision making and involvement, youth and parent satisfaction, and interagency data information exchange.[276] A 2016 study found that recidivism rates were 31.6% for crossover youth who participated in CYPM compared to 48% percent for crossover youth who did not participate.[277]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse CYPM services if they are one of the following provider types: Community-based ECM providers.[278]

Crossover Youth Practice Model[279]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[280]**
Enhanced care management	G9012	Enhanced care management in-person provided by non-clinical staff	Coordinated cross-systems case management	No

vii. Potential Medi-Cal non-reimbursable services

Crossover Youth Practice Model [281]

[274] The California Evidence-Based Clearinghouse, CYPM, see section on Scientific Rating
[275] Center for Juvenile Justice Reform – CYPM
[276] Center for Juvenile Justice Reform – CYPM
[277] Children and Youth Services Review
[278] ECM Policy Guide
[279] Analysis by Manatt Health from Jan 2022 to Feb 2023
[280] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[281] Analysis by Manatt Health from Jan 2022 to Feb 2023

Service components of the model	Illustrative services provided	Additional notes where applicable
Identification	Outlining a process for identifying crossover youth	As CYPM spans the domains of juvenile justice and child welfare, it is anticipated that its components may become billable under Medi-Cal by ECM providers once the CalAIM Justice-Involved Initiative services are live in 2024.
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

D. Attachment and Biobehavioral Catch-Up (ABC)[282]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[283]

1 – Well-Supported by Research Evidence

ii. Population of focus

ABC serves trauma exposed and/or maltreated children (aged 6-24 months old) and their caregivers.[284]

Studies on ABC's program have demonstrated its effectiveness with families from various racial and ethnic backgrounds and it has also yielded positive results in infants and youth in foster care (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[285]

ABC is a home-visiting program designed to improve parenting practices to foster secure attachment and enhance behavioral and emotional regulation in young children who have experienced early adversity. ABC's program aims to achieve this goal through helping caregivers interpret and respond to their children's behavioral cues with increased nurturing and sensitive reactions and sensitivity. Components of

[282] All information contained in the Attachment and Biobehavioral Catch-Up sections comes from publicly available sources. Please refer to each section for specific source details.
[283] The California Evidence-Based Clearinghouse, ABC, see section on Scientific Rating
[284] The California Evidence-Based Clearinghouse, ABC, see section on About this Program
[285] The California Evidence-Based Clearinghouse, ABC, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; ABC Intervention

the intervention include teaching parents how to engage positively with their children, following the child's lead with delight, and reducing overwhelming or frightening behaviors (e.g., yelling, intrusive behaviors).

Delivered in the caregivers' home environment over ten one-hour sessions on a weekly basis, a key component of the intervention is the parent coach's provision of immediate feedback, known as "in the moment" comments. These comments focus on enhancing the caregiver's awareness and execution of targeted behaviors (e.g., responding with delight, providing nurturing care). Additionally, during these sessions, both the parent coach and caregiver review video clips of their interactions with the child, allowing the coach to reinforce positive behaviors, celebrate progress, and pinpoint areas for improvement. The intervention also includes homework assignments that encourage caregivers to practice the learned behaviors and monitor both their own and their child's responses outside of ABC sessions.

iv. Care delivery setting and provider qualifications

ABC's program is typically conducted in an adoptive home, birth family home, or foster/kinship care. See Attachment & Biobehavioral Catch-up for a list of parent coaches.[286]

Provider qualifications

The program is administered through parent coaches. No educational level is required, though parent coaches must pass a screening prior to training.[287]

v. Summary of evidence from literature on program efficacy / impact

ABC's program is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[288] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare[289] and SAMHSA.[290]

Evidence suggests that for children, ABC may result in lower cortisol values, fewer behavior problems, less avoidance, and lower rates of disorganized attachment.[291] Evidence also suggests that for caregivers, ABC may result in better parenting quality.[292]

vi. Potential Medi-Cal covered benefits/services

[286] The California Evidence-Based Clearinghouse, ABC, see section Program Delivery
[287] The California Evidence-Based Clearinghouse, ABC, see section Program Delivery
[288] The California Evidence-Based Clearinghouse, ABC, section on Scientific Rating
[289] The California Evidence-Based Clearinghouse, ABC
[290] SAMHSA
[291] The California Evidence-Based Clearinghouse, ABC, section on Relevant, Published Peer-Reviewed Research
[292] The California Evidence-Based Clearinghouse, ABC, section on Relevant, Published Peer-Reviewed Research

Eligible providers may use the below CPT/HCPCS codes to reimburse ABC services if they are one of the following provider types: certified Medi-Cal Peer Support Specialist.[293]

Attachment and Behavioral Catch-up (ABC)[294]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[295]**
Behavioral health prevention education services (peer support)	H0025	Behavioral health prevention education service	Weekly ~1-hour home visitation session with parent coach and caregiver(s)/child	Yes
Peer support	H0038	Peer support services		Yes

vii. Potential Medi-Cal non-reimbursable services

Attachment and Behavioral Catch-up (ABC)[296]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

E. Child Parent Psychotherapy (CPP)[297]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[298]

2 – Supported by Research Evidence

[296] Analysis by Manatt Health from Jan 2022 to Feb 2023
[297] All information contained in the Child Parent Psychotherapy sections comes from publicly available sources. Please refer to each section for specific source details.
[298] The California Evidence-Based Clearinghouse, CPP, see section on Scientific Rating

ii. Population of focus

CPP is an intervention for caregivers and their children (ages 0-5 years) who have experienced a trauma or mental health, attachment, and/or behavioral problems.[299]

Studies on CPP have demonstrated its effectiveness with children and caregivers from various racial and ethnic backgrounds, and have yielded positive results across communities from varying socioeconomic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[300]

CPP is an intervention for young children (ages 0-5 years) who have experienced early trauma, (e.g., maltreatment, exposure to domestic violence), and are exhibiting mental health, attachment, and/or behavioral issues. The treatment framework of CPP's program is grounded in attachment theory and include dyadic sessions (i.e., include both child and caregiver). The overarching goal of CPP's program is improving children's cognitive, behavioral, and social functioning by strengthening the caregiver-child relationship.

CPP's program consists of weekly one-hour sessions. The length of treatment varies based on family's needs but often extends up to one year. During CPP sessions, the therapist focuses on how the caregiver and child interact, shares observations, and encourages specific changes to improve trust and foster adaptive coping skills. Throughout the treatment process, the caregiver and child collaborate to construct a narrative of the traumatic event and identify and address triggers that lead to dysregulated behaviors.

The caregiver and child work together through three intervention stages during CPP:[301]

1) Getting to know the family: Initial sessions with caregivers to understand the full scope of the family's situation, which includes assessing their challenges, recognizing strengths and cultural values, and learning about their personal history (e.g., past abuse suffered by the caregiver). Additionally, this stage involves linking families with necessary resources and creating a customized treatment plan that outlines how CPP will help the family.

2) Addressing the family needs: Weekly sessions are completed with both the child and the caregiver present. These sessions begin by introducing the child to the therapy setting, explaining the roles of everyone involved, and detailing what the

[299] The California Evidence-Based Clearinghouse, CPP, see section on About This Program
[300] The California Evidence-Based Clearinghouse, CPP, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery
[301] CPP – see section on What Happens During CPP

therapy sessions will entail. Therapeutic play is often used as a tool for younger children to express themselves and communicate during these sessions. The primary objectives during this stage are to foster a deeper understanding between the child and caregiver, address and work through challenging experiences, manage emotional and behavioral issues, and build a healing family narrative.

3) Wrapping up and future planning: Concluding sessions celebrate the family's progress and include reflective discussions about the contributions of caregivers to the family's transformation. This stage involves planning for the family's future needs after the completion of therapy, ensuring that the caregiver and child are prepared to continue their developmental journey with the tools and strategies they have learned.

iv. Care delivery setting and provider qualifications

CPP's program is typically conducted in an adoptive home, birth family home, foster/kinship care, outpatient clinic, community-based agency/organization/provider, or school setting.[302]

Practitioners require master's level training while supervisors require a master's degree with a minimum of 1 year training in CPP.[303] According to the CPP website, training includes an 12-18 month program designed to equip professionals with the skills needed to support families with trauma.[304] The training process begins with a team-based learning module that continues after the formal training ends, through ongoing collaboration within teams and with families. For larger systems such as government entities or health insurance companies, training sessions are coordinated with the CPP Dissemination & Implementation Team following a detailed application process that considers specific population needs, implementation goals, and logistical details to ensure sustainable CPP integration. Agency-specific training is arranged with designated CPP trainers to facilitate localized support and sustainability planning. CPP does not typically train individual providers unless they are part of an existing CPP team due to the importance of team support and reflective supervision that is integral to the model.[305]

v. Summary of evidence from literature on program efficacy / impact

CPP is considered "supported" through RCTs and peer-reviewed literature with sustained effects 1 year post intervention.[306] The treatment is recognized by the

[302] The California Evidence-Based Clearinghouse, CPP, see sections on Program Delivery; Manuals and Training; and Implementation Information
[303] The California Evidence-Based Clearinghouse, CPP, see sections on Program Delivery; Manuals and Training; and Implementation Information
[304] Child Parent Psychotherapy - Training
[305] Child Parent Psychotherapy - Training
[306] The California Evidence-Based Clearinghouse, CPP, see section on Scientific Rating

National Child Traumatic Stress Network[307] as a trauma-informed intervention. It has also been recognized by the California Evidence-based Clearinghouse for Child Welfare,[308] National Institute of Justice Crime [309]and [310311]

Evidence suggests a reduction in hyperactivity, aggression, disruptive behavior (e.g., noncompliance, tantrums, arguing), and reduction in caregiver stress; and improvements in caregiver-child relationship, and positive parenting practices.[312]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse CPP services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[313] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP),or psychiatrist.[314]

Child and Parent Psychotherapy (CPP)[315]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[316]**
Psychotherapy	90846	Family psychotherapy (without patient present), 50 minutes	Individual meeting with caregiver	No
	90847	Family psychotherapy (with patient present), 50 minutes	Weekly 1-1.5-hour child-caregiver treatment session (both present)	Yes

[307] National Child Traumatic Stress Network, CPP
[308] The California Evidence-Based Clearinghouse
[309] National Institute of Justice, CPP

[311] SAMHSA
[312] The California Evidence-Based Clearinghouse, CPP, see section on Relevant, Published Peer-Reviewed Research
[313] Specialty Mental Health Services Medi-Cal Billing Manual
[314] Non-Specialty Mental Health Services (NSMHS), DHCS
[315] Analysis by Manatt Health from Jan 2022 to Feb 2023
[316] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

	90849	Multiple-family group psychotherapy	Multiple-family group session (if applicable)	No

vii. Potential Medi-Cal non-reimbursable services

Child and Parent Psychotherapy (CPP)[317]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

F. Cognitive Behavioral Interventions for Trauma in Schools (CBITS)[318]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[319]

3 – Promising Research Evidence

ii. Population of focus

CBITS is designed for children and youth (ages 8-15 years) with exposure to trauma and symptoms of posttraumatic stress disorder related to the event, largely focusing on community violence exposure.[320]

Studies on CBITS have previously demonstrated its effectiveness with children and caregivers from various racial and ethnic backgrounds and have been applied to rural communities, refugee families, and justice-involved students (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[321]

[317] Analysis by Manatt Health from Jan 2022 to Feb 2023
[318] All information contained in the Cognitive Behavioral Interventions for Trauma in Schools sections comes from publicly available sources. Please refer to each section for specific source details.
[319] The California Evidence-Based Clearinghouse, CBITS, see section on Scientific Rating
[320] The California Evidence-Based Clearinghouse, CBITS, see section on About this Program
[321] The California Evidence-Based Clearinghouse, CBITS, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; Trauma Aware Schools, CBITS

CBITS is a school-based, group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems among students exposed to traumatic events (e.g., community and school violence, accidents, physical abuse, domestic violence). CBITS uses cognitive-behavioral therapy principles to facilitate behavioral health access and integration into the students' daily lives. The program has three main goals: reduce trauma-related symptoms, build resilience to better manage future stress and trauma, and enhance support networks through increased peer and parental involvement.

Spanning 10 weekly sessions and conducted in a group format, each session is designed to fit within a standard class period. Additional individual sessions focus on imaginal exposure (e.g., recitation of anxiety-provoking thoughts, images, or narratives) to traumatic memories, occurring between the second and sixth group meetings. These sessions employ a variety of techniques including cognitive restructuring, relaxation training, exposure therapy, and social problem-solving exercises. Activities are interactive, involving discussions and homework assignments that encourage application of the learned coping strategies outside of intervention sessions.

iv. Care delivery setting and provider qualifications

CBITS is delivered in a school setting (including Day Care, Day Treatment Programs, etc.).[322]

Providers are required to have a master's or doctorate degree in a clinical field CBITS training includes a two-day clinical workshop which covers an overview of child trauma, PTSD, and their impacts on mental health and academics, along with a review of CBITS's history and evidence base.[323] Training also includes detailed demonstrations and supervised practice for core concepts in child group and individual sessions, emphasizing cultural and contextual relevance, and reviews sessions for parents and teachers. Additionally, the training addresses implementation issues and site planning. The CBITS manual is available for download from the RAND website.[324]

v. Summary of evidence from literature on program efficacy / impact

CBITS is deemed "promising" through RCTs and peer-reviewed.[325] The treatment is recognized by the National Child Traumatic Stress Network[326] as a trauma-informed intervention. It has also been recognized by the California Evidence-based

[322] The California Evidence-Based Clearinghouse, CBITS, see sections on Program Delivery; Training and Manuals; and Implementation Information
[323] Blue Prints Program for Healthy Youth Development, CBITS training
[324] RAND – CBITS resources
[325] The California Evidence-Based Clearinghouse, CBITS, see section on Scientific Rating
[326] National Child Traumatic Stress Network, CBITS

Clearinghouse for Child Welfare,[327] Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs,[328] National Institute of Justice Crime Solutions,[329] and[330]

Evidence suggests CBITS may lower symptoms of PTSD, depression, and psychosocial dysfunction in those who receive treatment.[331]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse CBITS services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[332] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[333]

Cognitive and Behavioral Interventions for Trauma in Schools (CBITS)[334]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[335]**
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Individual student session	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes
	90837	Psychotherapy with patient, 60 minutes		Yes
	90839	Psychotherapy for crisis, first 60 minutes		Yes

[327] The California Evidence-Based Clearinghouse, CBITS, see section on About this Program
[328] OJJDP Model Programs
[329] National Institute of Justice, CBITS
[330] SAMHSA; Blueprints for Healthy Youth Development, CBITS
[331] The California Evidence-Based Clearinghouse, CBITS, see section on Relevant, Published Peer-Reviewed Research
[332] Specialty Mental Health Services Medi-Cal Billing Manual
[333] Non-Specialty Mental Health Services (NSMHS), DHCS
[334] Analysis by Manatt Health from Jan 2022 to Feb 2023
[335] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

	90840	Psychotherapy for crisis, each additional 30 minutes after the first 60 minutes of service is rendered		Yes
	90853	Group therapy, 90 minutes	Weekly group session with other students (if at least 90 minutes)	Yes

vii. Potential Medi-Cal non-reimbursable services

Cognitive and Behavioral Interventions for Trauma in Schools (CBITS)[336]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

G. Dialectical Behavior Therapy (DBT)[337]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[338]

3 – Promising Research Evidence

ii. Population of focus

DBT can be used as treatment for children and youth who experience significant trouble managing their emotions, thoughts, and behaviors, including chronic suicidal ideation and behaviors.[339]

[336] Analysis by Manatt Health from Jan 2022 to Feb 2023
[337] All information contained in the Dialectical Behavior Therapy sections comes from publicly available sources. Please refer to each section for specific source details.
[338] The California Evidence-Based Clearinghouse, DBT, see section on Scientific Rating
[339] The California Evidence-Based Clearinghouse, DBT, see section on About this Program

Studies of DBT adapted for youth have demonstrated effectiveness across various racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[340]

DBT is a cognitive-behavioral treatment that was initially developed to treat adults diagnosed with borderline personality disorder who are chronically suicidal. DBT has been effectively adapted for youth to address various emotional and behavioral challenges, such as intense emotions, impulsive behaviors, self-harm, and suicidal thoughts. These adaptations include developmentally appropriate techniques and family involvement is emphasized through skills training sessions for caregivers. DBT comprises of four skill modules, each designed to address specific challenges and promote emotional and behavioral health:[341]

1) Mindfulness: Enhances adolescents' self-awareness and presence in the current moment. Through various exercises, youth learn to observe, describe, and participate in their thoughts, emotions, and sensations without judgment. This component is important for developing the ability to make more thoughtful decisions and respond to situations effectively rather than reactively.

2) Distress Tolerance: Teaches youth strategies to manage heightened emotions and challenging situations without engaging in unhelpful behaviors. Skills taught in this module include techniques for distraction, self-soothing, and improving the moment, along with strategies for weighing the pros and cons of tolerating distress versus acting impulsively.

3) Emotion Regulation: Focuses on helping youth understand and manage their emotions to decrease the frequency of emotional outbursts and reduce susceptibility to emotional distress. Youth are taught to identify and label their emotions, increase the occurrence of positive emotional events, and implement distress tolerance strategies to manage emotional intensity.

4) Interpersonal Effectiveness: Aims to improve communication skills, enhance relationships, and maintain self-respect. Youth practice making effective requests, asserting themselves by saying "no", and managing interpersonal conflicts, which are essential for building and sustaining healthy relationships.

DBT includes four key components designed to support and enhance the treatment process for clients[342]:

[340] The California Evidence-Based Clearinghouse, DBT, see sections on Program Overview
[341] Child Mind Institute, DBT
[342] Cleveland Clinic, DBT

1) Skills Training Group: Operates similarly to an educational class, where youth are taught behavioral skills by a group leader. The group meets weekly for about 2.5 hours and the full curriculum takes 24 weeks to complete.

2) Individual Therapy: Helps youth apply learned skills to personal challenges, in weekly individual sessions that last ~45 minutes. These sessions run concurrently with the skills training groups, ensuring consistent progress and application of skills.

3) Phone Coaching: Provides youth with real-time coaching to help them utilize DBT skills during challenging situations in their daily lives outside of individual and group settings.

4) Consultation Team: Serves as a support system for the therapists to ensure they remain motivated and competent in providing care for complex cases. The team, consisting of individual therapists and group leaders, meets weekly to discuss client care and therapeutic strategies.

iv. Care delivery setting and provider qualifications

DBT's program is offered through a variety of settings (e.g., outpatient clinic, community-based organization, hospital, residential program) and involves both in-person individual, in-person group, and telephone communication with the participant.[343]

Providers (e.g., psychologists, counselors, social workers, marriage and family therapists, addiction counselors, psychiatrist) must have a master's degree in a mental-health related field.[344] While not required, providers can obtain DBT certification, which typically includes attending a comprehensive training program, having supervised practice hours, and passing a certification exam.[345]

v. Summary of evidence from literature on program efficacy / impact

DBT is deemed "promising" through RCTs and peer-reviewed with sustained effects 1-year post-intervention.[346] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare[347] and is considered a "gold standard" treatment for those with Borderline Personality Disorder.[348]

[343] Evergreen Certifications, DBT
[344] The California Evidence-Based Clearinghouse, DBT, see sections on Manuals and Trainings
[345] The California Evidence-Based Clearinghouse, DBT, see sections on Manuals and Trainings
[346] The California Evidence-Based Clearinghouse, DBT, see section on Scientific Rating
[347] The California Evidence-Based Clearinghouse, DBT
[348] University of Washington Behavioral Research & Therapy Clinics, DBT

Evidence suggests lower rates of self-harm and suicide attempts, fewer days hospitalized, and improved emotion regulation abilities in those who have received DBT.[349]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse DBT services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[350] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[351]

Dialectical Behavior Therapy (DBT)[352]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[353]**
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Weekly individual therapy sessions	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes
	90837	Psychotherapy with patient, 60 minutes		Yes
	90839	Psychotherapy for crisis, first 60 minutes	Individual therapy session for crisis Telephone crisis coaching	Yes
	90840	Psychotherapy for crisis, each additional 30 minutes after the first 60 minutes of service is rendered		Yes

[349] The California Evidence-Based Clearinghouse, DBT, see section on Relevant, Published Peer-Reviewed Research
[350] Specialty Mental Health Services Medi-Cal Billing Manual
[351] Non-Specialty Mental Health Services (NSMHS), DHCS
[352] Analysis by Manatt Health from Jan 2022 to Feb 2023
[353] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

	90846	Family psychotherapy (with patient present), 50 minutes	Family therapy session	No
	90847	Family psychotherapy (with patient present), 50 minutes		Yes
	90849	Multiple-family group psychotherapy	Multiple-family therapy session	Yes
	90853	Group therapy, 90 minutes	Weekly ~2.5-hour skills training group	Yes

vii. Potential Medi-Cal non-reimbursable services

Dialectical Behavior Therapy (DBT)[354]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

H. Family Centered Treatment (FCT)[355]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[356]

3 – Promising Research Evidence

ii. Population of focus

FCT is a trauma-focused home-based family intervention for caregivers and youth (ages 0-17 years) who are at-risk for out-of-home placements (e.g., foster care), have trauma exposure, challenging behavior, or are working toward reunification.[357] It is

[354] Analysis by Manatt Health from Jan 2022 to Feb 2023
[355] All information contained in the Family Centered Treatment sections comes from publicly available sources. Please refer to each section for specific source details.
[356] The California Evidence-Based Clearinghouse, FCT, see section on Scientific Rating
[357] The California Evidence-Based Clearinghouse, FCT, see section on About This Program

also designed to serve youth that are concurrently involved in the child-welfare and juvenile justice system.[358]

Studies of FCT have previously demonstrated effectiveness with children and caregivers from various racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[359]

FCT is a trauma-focused therapy model designed for home-based family interventions that aims to keep families together and prevent out-of-home placements. Central to FCT's approach is understanding the behaviors rather than solely addressing symptoms. FCT asserts that this approach, that seeks to understand the root of emotional expression and experience, is particularly important for youth and families with histories of trauma.

FCT caregivers and youth participate in two multi-hour sessions each week for 6 months and on-call 24/7 crisis intervention is also provided. For children, the focus is on addressing behavioral issues, building coping mechanisms, and promoting a sense of security in the family environment. For caregivers, the focus is on promoting skills that can provide a supportive foundation to the child (e.g., communication strategies).

FCT is comprised of Four Phases:[360]

- Joining and Assessment Phase – FCT providers focus on building a trusting and collaborative relationship with the family. The primary goal is to understand the family dynamics, strengths, and challenges through standardized assessment tools that include interviews, questionnaires, and observations. Initial goals for the treatment are set based on these findings.
- Restructuring Phase –FCT providers work collaboratively with the family to identify and modify unhelpful patterns of behavior and family dynamics. This includes teaching skills that promote healthier relationships and problem-solving abilities.
- Valuing Changes Phase –Families are encouraged to reflect on their journey and recognize the specific improvements in their behaviors and family dynamics. They are also asked to think about the benefits these changes bring to their daily lives, such as improved communication, stronger relationships, and better problem-solving abilities.
- Generalization Phase – This phase focuses on ensuring that the positive changes are long-lasting and sustainable This includes developing a plan to prevent

[358] The California Evidence-Based Clearinghouse, FCT, see section on About This Program
[359] The California Evidence-Based Clearinghouse, FCT, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery
[360] FCT

relapse of challenging behaviors, equipping families with the tools to handle future issues, and ensuring they have access to ongoing support if needed.

iv. Care delivery setting and provider qualifications

FCT's program is typically conducted in an adoptive home, birth family home, or foster/kinship care.[361]

Credential requirements are state-specific, but most providers are master's level professionals with huma service degrees (e.g., psychology, social work, counseling, marriage and family therapy).[362] According to the Family Centered Treatment website, the training and certification process includes a self-paced online (covering essential FCT topics), combined with supervised field-based practice, where providers receive continuous feedback and undergo rigorous performance evaluations by certified trainers to ensure competency.[363]

v. Summary of evidence from literature on program efficacy / impact

FCT is deemed "promising" through peer-reviewed literature with sustained effects 1 year post intervention.[364] The treatment is recognized by the National Child Traumatic Stress Network[365] as a trauma-informed intervention. It has also been recognized by the California Evidence-based Clearinghouse for Child Welfare[366] and SAMHSA.[367]

Evidence suggests that within the first year of receiving FCT services, there is a 24% reduction in number of youth in residential placement, 20% reduction in length of residential placement for average youth, 30% reduction in length of average residential placement, 39% reduction in days spent in pending placement for average youth, 27% reduction in the days spent in the average pending placement, and 23% reduction in the length of average community detention.[368] In addition, studies have shown that FCT participants had a lower risk of adult conviction and incarceration.[369]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse FCT services if they are one of the following provider types: Clinical Nurse Specialist, Medical

[361] The California Evidence-Based Clearinghouse, FCT, see sections on Program Delivery; Manuals and Training; and Implementation Information
[362] The California Evidence-Based Clearinghouse, FCT, see sections on Program Delivery; Manuals and Training
[363] Family Centered Treatment - Implementation
[364] The California Evidence-Based Clearinghouse, FCT, see section on Scientific Rating
[365] FCT Partners
[366] The California Evidence-Based Clearinghouse, FCT
[367] SAMHSA
[368] FCT Results
[369] The California Evidence-Based Clearinghouse, FCT, see section on Relevant, Published Peer-Reviewed Research

Doctor/Doctor of Osteopathy,[370] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[371]

Family Centered Treatment (FCT)[372]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[373]**
Psychotherapy	90846	Family psychotherapy (without patient present), 50 minutes	Weekly family session at participant's home/community	No
	90847	Family psychotherapy (with patient present), 50 minutes		Yes
	90849	Multiple-family group psychotherapy	Group family session	Yes

vii. Potential Medi-Cal non-reimbursable services

Family Centered Treatment (FCT)[374]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

[370] Specialty Mental Health Services Medi-Cal Billing Manual
[371] Non-Specialty Mental Health Services (NSMHS), DHCS
[372] Analysis by Manatt Health from Jan 2022 to Feb 2023
[373] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[374] Analysis by Manatt Health from Jan 2022 to Feb 2023

I. Functional Family Therapy (FFT) [375]

Included within CYBHI EBP grant program, FFPSA Five-Year State Prevention Plan, and BH-CONNECT

i. California Evidence-Based Clearinghouse Designation[376]

1 – Well-Supported by Research Evidence for disruptive behavior treatment (child & adolescent)

2 – Supported by Research Evidence for alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, and substance abuse treatment (adolescent)

ii. Population of focus

FFT's program is focused towards youths (ages 11- 18 years)[377] who are at-risk or have moderate to severe problems such as conduct disorder, violent acting-out, and/or substance abuse.[378] Younger siblings of referred adolescents often also become a part of the intervention process.

Studies on FFT have demonstrated its effectiveness with youths and their families from various racial and ethnic backgrounds and have indicated effectiveness in youths who were juvenile offenders and youths with a SUD (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[379]

FFT's program is a multi-systemic intervention designed for at-risk youth who experience challenges with externalizing behaviors (e.g., physical aggression, oppositional behavior, substance use). The program also requires the engagement of the youth/family members' social system (e.g., family, teachers, healthcare providers). The program provides caregiver and youth services that focus on reducing adolescent behavioral problems, conduct disorder, substance abuse and recidivism, and improving parenting behaviors.

The program is offered on average through 12 to 14 one-hour sessions (though this can range from 8 to 30 depending on the severity of the case) spread over a three-

[375] All information contained in the Functional Family Therapy program sections comes from publicly available sources. Please refer to each section for specific source details.
[376] The California Evidence-Based Clearinghouse, FFT, see section on Scientific Rating
[377] Under SMHS, a LMHP may determine a youth of an appropriate developmental age may receive the service; the youth does not necessarily need to be ages 11-18 years.

[378] The California Evidence-Based Clearinghouse, FFT, see section on About This Program
[379] The California Evidence-Based Clearinghouse, FFT, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; FFT LLC

month period. FFT is phased with steps that build upon each other. The five phases consist of: (1) Engagement; (2) Motivation; (3) Relational Assessment; (4) Behavior Change; and (5) Generalization.

1) In the Engagement phase, therapists work to enhance family members' perceptions of therapist effectiveness and credibility and maximize the family's initial expectation of positive change.

2) In the Motivation phase, therapists work to create motivation for long-term change.

3) In the Relational Assessment phase, therapists complete a relational (functional) assessment of family relationships to provide a foundation for changing behaviors.

4) In the Behavior Change phase, therapists utilize formal strategies to reduce or eliminate adverse behaviors by improving family function and individual skill development.

5) In the Generalization phase, therapists help families maintain individual and family change and facilitate change in multiple systems.

Homework is provided as needed throughout treatment and particularly during the Behavior Change phase to build on skills taught during sessions.

iv. Care delivery setting and provider qualifications

FFT is typically conducted in a community-based settings where the family and/or caregiver may be involved, including the adoptive home, birth family home, foster/kinships care, community-based agency/organization/provider, or school setting.[380]

Various professionals (e.g., paraprofessionals under supervision, trained probation officers, mental health technicians, graduated mental health professionals) can administer FF, while supervisors must be licensed behavioral health providers.

Summary of evidence from literature on program efficacy/impact

FFT is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[381] It is also backed by the Family First Prevention Services Act (FFPSA) and has been recognized by the Title IV-E Prevention

[380] The California Evidence-Based Clearinghouse, FFT, see sections on Program Delivery, Manuals and Training; and Implementation Information
[381] The California Evidence-Based Clearinghouse, FFT, see section on Scientific Rating

Services Clearinghouse[382], Office of Juvenile Justice and Delinquency Prevention, The Center for Disease Control and Prevention, the American Youth Policy Forum, the US Department of Justice, and the California Evidence-based Clearinghouse for Child Welfare.[383] Blueprints for Healthy Youth Development has also rated FFT as 'Promising' as a treatment for young children with emotional and behavioral problems.[384]

Evidence suggests a decrease in recidivism rate, improvements in family interaction process measures, a decrease in substance use, and a decrease in youth behavioral problems.[385] Studies also show that of youths who participated in FFT treatment, 77% have no new offenses 18 months post-referral, 89% have no drug charges 18 months post-referral, and 95% attend school/work at treatment close.[386]

v. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse MST services if delivered through Medi-Cal FFS or MCPs as NSMHS. The following provider types are eligible to use these codes: Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[387]

Functional Family Therapy (FFT)[388]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[389]**
Psychotherapy	90846	Family psychotherapy (with patient present), 50 minutes	~1 hour treatment session with patient present	No

[382] Title IV-E Prevention Services Clearinghouse, FFT
[383] The California Evidence-Based Clearinghouse, FFT
[384] Blueprints for Healthy Youth Development, FFT
[385] The California Evidence-Based Clearinghouse, FFT, see section on Relevant, Peer-Reviewed Published Research
[386] FFT LLC
[387] Non-Specialty Mental Health Services (NSMHS), DHCS
[388] Analysis by Manatt Health from Jan 2022 to Feb 2023
[389] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

	90847	Family psychotherapy (with patient present), 50 minutes	~1 hour treatment session without patient present	Yes
	90849	Multiple-family group psychotherapy	Multiple-family group psychotherapy (if applicable)	Yes
	H0036	Community psychiatric supportive treatment, per 15 minute	15 min community psychiatric supportive treatment session	Yes

County BHPs (SMHS)

Under BH-CONNECT and FFPSA, MST must be covered by county BHPs as part of EPSDT.[390] LMHPs, including waivered and registered professionals, and Clinical Trainees acting within the scope of their license and training may use the below CPT/HCPCS codes to reimburse FFT services if delivered through county BHPs as SMHS.

	Functional Family Therapy (FFT)[391]		
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**
Psychotherapy	H0036	Community psychiatric supportive treatment, per 15 minute	15 min community psychiatric supportive treatment session

vi. Potential Medi-Cal non-reimbursable services

Functional Family Therapy (FFT)[392]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**

[390] BH-CONNECT waiver application
[391] Analysis by Manatt Health from Jan 2022 to Feb 2023
[392] Analysis by Manatt Health from Jan 2022 to Feb 2023

Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

J. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)[393]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[394]

1 – Well-Supported by Research Evidence

ii. Population of focus

MATCH-ADTC assists children and adolescents (ages 6-15 years) and their caregivers who struggle with anxiety, depression, conduct problems, and/or traumatic stress.[395]

Studies on MATCH-ADTC have previously demonstrated effectiveness with children and caregivers from various racial and ethnic backgrounds and have been applied to rural communities (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[396]

MATCH-ADTC is a cognitive-behavioral treatment program designed for children and youth who experience anxiety, depression, post-traumatic stress, and disruptive behavior problems, including those associated with Attention Deficit/Hyperactivity Disorder (ADHD).

MATCH-ADTC combines 33 procedures into a single, flexible system that can be applied to multiple challenges. Clinicians use proven tools to develop a treatment plan that is tailored to each individual's needs. This approach allows clinicians to address co-occurring issues and adjust the treatment if there are therapeutic roadblocks. The MATCH-ADTC protocol provides clear step-by-step instructions, activities, example scripts, time-saving tips, monitoring forms, and easy-to-read

[393] All information contained in the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems sections comes from publicly available sources. Please refer to each section for specific source details.
[394] The California Evidence-Based Clearinghouse, MATCH-ADTC, see section on Scientific Rating
[395] The California Evidence-Based Clearinghouse, MATCH-ADTC, see section on About This Program
[396] The California Evidence-Based Clearinghouse, MATCH-ADTC, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; NH Children's Behavioral Health Resource Center, MATCH-ADTC

explanatory handouts and worksheets for individual sessions with the youth and their caregivers.

For children and youth, the focus of the program is to increase positive functioning and adaptive skills, and reduce mental health symptoms related to anxiety, depression, conduct problems, and traumatic stress. For caregivers, the focus is on increasing skills and strategies to manage the youth's behaviors and reduce youth's mental health symptoms.

The program does not have a fixed duration, but on average takes ~7 months for completion.

iv. Care delivery setting and provider qualifications

MATCH-ADTC is delivered in an adoptive home, birth family home, foster/kinship care, outpatient clinic, community-based agency/organization/provider, school setting, or virtual setting.[397]

Providers need sufficient credentials for therapeutic service delivery in a community mental health or child welfare system (e.g., master's level training in a behavioral health field).[398] Training for MATCH-ADTC typically includes a 5-day workshop for direct service providers, a 2-day workshop for agency supervisors, ongoing consultation meetings over six months (18 for providers, 12 for supervisors) and undergo a portfolio review to ensure competency.[399]

v. Summary of evidence from literature on program efficacy / impact

MATCH-ADTC is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1 year post intervention.[400] The treatment is recognized by the National Child Traumatic Stress Network[401] as a trauma-informed intervention. It has also been recognized by the California Evidence-based Clearinghouse for Child Welfare[402] and National Institute of Justice Crime Solutions.[403]

Evidence suggests youths who received treatment had fewer diagnoses and faster rates of improvement.[404]

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[397] The California Evidence-Based Clearinghouse, MATCH-ADTC; see sections on Program Delivery; Manuals and Training; and Implementation Information
[398] The California Evidence-Based Clearinghouse, MATCH-ADTC; see sections on Program Delivery; Manuals and Training
[399] MATCH-ADTC training
[400] The California Evidence-Based Clearinghouse, MATCH-ADTC, see section on Scientific Rating
[401] National Child Traumatic Stress Network, MATCH-ADTC
[402] The California Evidence-Based Clearinghouse, MATCH-ADTC
[403] National Institute of Justice, MATCH-ADTC
[404] The California Evidence-Based Clearinghouse, MATCH-ADTC, see section on Relevant, Published Peer-Reviewed Research

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse MATCH-ADTC services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[405] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[406]

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)[407]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[408]**
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Weekly individual youth session	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes
	90837	Psychotherapy with patient, 60 minutes		Yes
	90839	Psychotherapy for crisis, first 60 minutes		Yes
	90840	Psychotherapy for crisis, each additional 30 minutes after the first 60 minutes of service is rendered		Yes
	90846	Family psychotherapy (without patient present), 50 minutes	Weekly family session	No

[405] Specialty Mental Health Services Medi-Cal Billing Manual
[406] Non-Specialty Mental Health Services (NSMHS), DHCS
[407] Analysis by Manatt Health from Jan 2022 to Feb 2023
[408] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

	90847	Family psychotherapy (with patient present), 50 minutes		Yes
	90849	Multiple-family group psychotherapy	Multi-family group session (if applicable)	Yes
	90853	Group therapy, 90 minutes	Group session (if applicable)	Yes

vii. Potential Medi-Cal non-reimbursable services

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)[409]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

K. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)[410]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[411]

1 – Well-Supported by Research Evidence for trauma treatment client-level interventions (child & adolescent)

ii. Population of focus

TF-CBT is an intervention that serves trauma exposed children ages 3-18 years who are experiencing significant posttraumatic stress disorder (PTSD) symptoms and their caregivers.[412]

[409] Analysis by Manatt Health from Jan 2022 to Feb 2023
[410] All information contained in the Trauma-Focused Cognitive Behavioral Therapy sections comes from publicly available sources. Please refer to each section for specific source details.
[411] The California Evidence-Based Clearinghouse, TF-CBT, see section on Scientific Rating
[412] The California Evidence-Based Clearinghouse, TF-CBT, see section on About This Program

Studies on TF-CBT have previously demonstrated effectiveness with children and caregivers from various racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website). In addition, Family Acceptance Project (FAP)[413] is an intervention that targets LGBTQ+ youth and has been integrated into TF-CBT.

iii. Program description[414]

TF-CBT is a child and parent psychotherapy program for children who have developed emotional or behavioral difficulties following exposure to a traumatic event (e.g., loss of a loved one, physical abuse, sexual abuse, domestic or community violence). The program aims to improve child PTSD symptoms, parenting skills, child adaptive functioning, and reduce shame related to trauma. Treatment includes an integration of both cognitive and behavioral interventions with traditional child-abuse therapies and has been adapted to address LGBTQ+ community needs (e.g., The Family Acceptance Project).[415]

TF-CBT typically spans 12 to 20 sessions, tailored to the trauma's severity, the child's needs, and parental involvement. TF-CBT for youth with complex trauma is structured into three phases: stabilization, trauma processing, and integration. The initial stabilization phase focuses on building coping skills and establishing a trusting therapeutic relationship. During this phase, both youth and caregivers learn about trauma's impact and develop self-regulation techniques, such as relaxation and mindfulness, to manage stress and emotional responses. This phase helps prepare youth and caregivers for the second phase of treatment.

The second phase, trauma processing, involves creating a trauma narrative. Youth gradually explore and articulate their traumatic experiences, integrating specific events, thoughts, and emotions into a coherent story. This phase helps them process and make sense of their trauma, reducing its emotional impact. Caregivers are included to support understanding and communication.

The final phase consolidates the skills learned and generalizes them to everyday life, fostering safety and trust in relationships. Youth apply coping strategies to real-life situations, supported by caregivers and other trusted adults. This phase emphasizes maintaining safety, preventing re-traumatization, and preparing for future challenges. The gradual exposure throughout the treatment ensures youth gain mastery over trauma reminders, enhancing their overall resilience and well-being.

iv. Care delivery setting and provider qualifications

[413] See Chapter 6.vii for more detail on FAP
[414] The California Evidence-Based Clearinghouse, TF-CBT, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; TF-CBT; TF-CBT – Practice components
[415] See Chapter 6.vii for more detail on FAP

TF-CBT is delivered in a birth family home, community daily living setting, outpatient client, community-based agency/organization/provider, or group or residential care.[416]

Mental health professionals with at least a master's degree, relevant experience working with children and families, and training in TF-CBT is required for providers. According to the program, certification for eligible providers can be achieved through completion of the TF-CBT Web course and participation in a live TF-CBT training or learning collaborative.[417] Additionally, providers engage in follow-up consultation or supervision, complete TF-CBT treatment with three children, use standardized instruments to assess progress, and pass a knowledge-based test with a score of 80% or higher.

v. Summary of evidence from literature on program efficacy / impact

TF-CBT is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1 year post intervention.[418] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare,[419] National Institute of Justice Crime Solutions,[420] and SAMHSA.[421]

Evidence suggests children who received treatment had fewer PTSD symptoms, improvements in fear and anxiety, reduced sexually inappropriate behavior, and less shame. Caregivers also demonstrated more effective parenting behaviors.[422]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse TF-CBT services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[423] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[424]

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) [425]

[416] The California Evidence-Based Clearinghouse, TF-CBT, see sections on Program Delivery; Manuals and Training; and Implementation Information
[417] TF-CBT - Training
[418] The California Evidence-Based Clearinghouse, TF-CBT, see section on Scientific Rating
[419] The California Evidence-Based Clearinghouse, TF-CBT, see section on Scientific Rating
[420] National Institute of Justice, TF-CBT
[421] SAMHSA
[422] The California Evidence-Based Clearinghouse, TF-CBT, see section on Relevant, Published Peer-Reviewed Research
[423] Specialty Mental Health Services Medi-Cal Billing Manual
[424] Non-Specialty Mental Health Services (NSMHS), DHCS
[425] Analysis by Manatt Health from Jan 2022 to Feb 2023

Service components of the model	CPT/HCPCS code (see appendix linked for more info)	CPT/HCPCS code description	Illustrative services provided	CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[426]
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Weekly individual child or individual caregiver session	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes
	90837	Psychotherapy with patient, 60 minutes		Yes
	90839	Psychotherapy for crisis, first 60 minutes		Yes
	90840	Psychotherapy for crisis, each additional 30 minutes after the first 60 minutes of service is rendered		Yes
	90846	Family psychotherapy (without patient present), 50 minutes	Weekly family session (conjoint child and caregiver)	Yes
	90847	Family psychotherapy (with patient present), 50 minutes		Yes
	90849	Multiple-family group psychotherapy	Multi-family group session (if applicable)	Yes
	90853	Group therapy, 90 minutes	Group session (if applicable)	Yes

vii. Potential Medi-Cal non-reimbursable services

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) [427]

[426] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

[427] Analysis by Manatt Health from Jan 2022 to Feb 2023

Service components by model	Illustrative services provided	Additional notes where applicable
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

Chapter 7: Early childhood wraparound services

These practices center around early childhood wraparound services aimed at building family strength and overall well-being. 65 percent of California's children (ages 0-3 years) have one or more risk factors for behavioral health conditions,[428] and less than 50 percent of young children with emotional, behavioral, or relationship disturbances receive any treatments. [429]

Priority Populations of Focus: Populations identified by CRDP and OHE, with a priority focus on parents and caregivers with young children (e.g., 0-5 years of age)

Outcomes/Key Metrics: The goal of these EBPs is to increase access to home visiting services and consultation services, improve coordination of services between pregnant and parenting/ caregiving people and their support systems, improve parent/caregiver and child health, reduce ACEs, and reduce emergency department visits and substantiated child abuse calls due to child maltreatment among other outcomes.

Example EBPs: Example EBPs in this theme include but are not limited to Healthy Families America, Nurse Family Partnership, and Infant and Early Childhood Mental Health Consultation.

A. Healthy Families America (HFA)[430]

Included within CYBHI EBP grant program and FFPSA Five-Year State Prevention Plan

i. California Evidence-Based Clearinghouse Designation[431]

1 – Well-Supported by Research Evidence

ii. Population of focus

HFA's program provides home-visiting interventions for pregnant women and families with children (ages 0-5 years).[432] The program is designed to work with families who have histories of trauma, intimate partner violence, mental health issues, substance use disorder, and/or other life stressors.

Studies on HFA's program suggests its effectiveness with children and families from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website). In addition, according to HFA, its program

[428] Center for Disease Control and Prevention
[429] Let's Get Healthy
[430] All information contained in the Healthy Families America program sections comes from publicly available sources. Please refer to each section for specific source details.
[431] The California Evidence-Based Clearinghouse, HFA, see section on Scientific Rating
[432] The California Evidence-Based Clearinghouse, HFA, see section on About This Program

has yielded positive results across communities from varying socioeconomic backgrounds.[433]

iii. Program description[434]

HFA services are provided voluntarily and intensively. Families receive weekly home visits lasting 50-60 minutes, which gradually decrease in frequency e.g., biweekly, monthly, quarterly) based on the family's readiness. Visits can begin prenatally or after birth. Services are offered for a minimum of three years and can be offered up to five years.

Furthermore, HFA sites may have the option to enroll families referred from Child Welfare/Children's Protective Services for children up to 24 months of age, subject to approval from the National Office.

The program aims to build and strengthen child-caregiver relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors.

There are 12 critical elements to the HFA model:

1) Initiate services early, ideally during pregnancy.
2) Use a validated tool (Family Resilience and Opportunities for Growth (FROG) Scale) to identify family strengths and concerns.
3) Offer services voluntarily and use personalized, family-centered outreach efforts to build trust.
4) Offer services intensely and over the long-term, with well-defined progress criteria and a process for increasing or decreasing frequency of service.
5) Celebrate diversity and honor the dignity of families and colleagues by educating and encouraging self and others and continuously striving to improve relationships. Sites also work their organization and community to identify and address existing barriers and increase access to services.
6) Focus on services that support caregiver(s) as well as the child.
7) Link all families to a medical provider and additional services (e.g., financial, food, housing, employment supports) to ensure optimal health and development.

[433] Healthy Families America
[434] The California Evidence-Based Clearinghouse, HFA, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery

8) Provide services in accordance with principles of ethical practice and with limited caseloads to ensure Family Support Specialists have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities.

9) Select service providers based on their personal characteristics, lived expertise and knowledge of the community they serve, ability to work with culturally diverse individuals and knowledge, and skills.

10) Provide service providers with intensive training specific to their role.

11) Provide staff with training on topics related to diversity and equity.

12) Provide ongoing, reflective supervision to service providers.

There is no homework component to HFA.

iv. Care delivery setting and provider qualifications

HFA is typically delivered to children and caregivers through the birth family home or virtual setting.[435] See Healthy Families America for a list of HFA sites.

The program is administered through various professionals (e.g., minimum requirements include high-school diploma and experience in working with children and families).[435] Supervisors must have advanced degrees (e.g., master's degree in related field or bachelor's degree with 3 years of relevant experience).

v. Summary of evidence from literature on program efficacy / impact

HFA is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention. [436] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare and the Title IV-E Prevention Services Clearinghouse[437]. The US Department of Health Human Services also recognizes HFA as one of seven proven home visiting models.[438]

Evidence suggests HFA promotes healthy child development; 48% of parents have fewer low-birthweight infants and 26% fewer children receive special education services. Participants in HFA also demonstrated enhanced family well-being; 27% fewer families were homeless, and there was less intimate partner violence.[439]

[435] The California Evidence-Based Clearinghouse, HFA, see sections on Program Delivery, Manuals and Training; and Implementation Information
[436] The California Evidence-Based Clearinghouse, HFA, see section on Scientific Rating
[437] Title IV-E Prevention Services Clearinghouse, HFA
[438] US Department of Health & Human Services, Home Visiting Evidence of Effectiveness
[439] Healthy Families America – Evidence of Effectiveness

i. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse HFA services if delivered through Medi-Cal FFS or MCPs as NSMHS. The following provider types are eligible to use these codes: Community-based enhanced care management providers,[440] and non-physician health care professionals.[441]

Healthy Families America (HFA)[442]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[443]**
Behavioral health prevention education services	H0025	Behavioral health prevention education service	Parent support groups	Yes
Enhanced care management	G9008	Enhanced care management	Family referrals as needed to community resources	No
Peer support	H0038	Peer support services	Weekly ~1 hour home visits	Yes *(only if delivered through SMHS)*
Psychoeducation by Community Health Worker (CHW)	98960	Education and training for patient self-management, individual		Yes

vi. Potential Medi-Cal non-reimbursable services

Healthy Families America (HFA)[444]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**

[440] ECM Policy Guide, DHCS
[441] Specialty Mental Health Service Table, DHCS
[442] Analysis by Manatt Health from Jan 2022 to Feb 2023
[443] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[444] Analysis by Manatt Health from Jan 2022 to Feb 2023

Home visits	Staff provides guidance on non-preventive and health topics (e.g., education, employment)	N/A
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

B. Nurse Family Partnership (NFP)[445]

Included within CYBHI EBP grant program and FFPSA Five-Year State Prevention Plan

i. California Evidence-Based Clearinghouse Designation[446]

1 – Well-Supported by Research Evidence

ii. Population of focus

NFP is a home-visiting program for socioeconomically disadvantaged, first-time mothers and their child, from birth until 2 years of age. [447] Mothers involved in the program are often at-risk for homelessness, addiction or substance use disorder, involvement with child welfare or juvenile or criminal justice systems, intimate partner violence, severe developmental disabilities, behavioral or mental health needs, or a high-risk pregnancy.

Studies on NFP have demonstrated its effectiveness with mothers and their child from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website). In addition, NFP yielded positive results across socioeconomically disadvantaged communities.[448]

iii. Program description[449]

NFP's program is an intensive, strengths-based, trauma- and violence-informed community health program. It aims to improve children's development and provide support and instructive parenting skills. Home visits include parent education (e.g., fetal and infant development), the involvement of family members and friends (e.g., in

[445] All information contained in the Nurse Family Partnership program sections comes from publicly available sources. Please refer to each section for specific source details.
[446] The California Evidence-Based Clearinghouse, NFP, see section on Scientific Rating
[447] The California Evidence-Based Clearinghouse, NFP, see section on About This Program
[448] NFP
[449] The California Evidence-Based Clearinghouse, NFP, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery

the pregnancy, birth, early care of the child, and support of the mother), and connecting family members with other health and human services.

Intervention begins during pregnancy and continues until 24-month postpartum. Participants in NFP have a 1:1 therapeutic relationship with a personal nurse that typically visits weekly for the first month after enrollment in the program, every other week until the baby is born, weekly for the first six weeks after birth, every other week until the child is 20 months, and monthly until the child's 2nd birthday. The duration of each visit is typically 60-90 minutes. The goal is for NFP participants to develop close, trust-based relationships with their nurses.

Nurses apply NFP visit guidelines across six domains: Personal Health, Environmental Health, Life Course Development, Maternal Role, Family and Friends, and Health and Human Services.

iv. Care delivery setting and provider qualifications

NFP's program is typically conducted in an adoptive home, birth family home, foster/kinship care, hospital, outpatient clinic, community-based agency/organization/provider, group or residential care, school setting, or virtual setting.[450]

Nurse home visitors are Registered Nurses (with a bachelor's degree in nursing) and Nurse Supervisors are also Registered Nurses (and may have a master's degree in nursing).[451] See Nurse-Family Partnership for a list of Registered Nurses.

v. Summary of evidence from literature on program efficacy / impact

NFP is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[452] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare,[453] Title IV-E Prevention Services Clearinghouse[454], National Institute of Justice Crime Solutions,[455] and Social Programs that Work (evidence rating 'top tier').[456] Blueprints for Healthy Youth Development has also rated NFP as 'Model.'[457]

Evidence suggests NFP may result in a 48% reduction in child abuse and neglect, 56% reduction in ER visits for accidents and poisonings, 67% less behavioral/intellectual

[450] The California Evidence-Based Clearinghouse, NFP, see sections on Program Delivery, Manuals and Training; and Implementation Information
[451] The California Evidence-Based Clearinghouse, NFP, see sections on Program Delivery, Manuals and Training
[452] The California Evidence-Based Clearinghouse, NFP, see section on Scientific Rating
[453] The California Evidence-Based Clearinghouse, NFP
[454] Title IV-E Prevention Services Clearinghouse, NFP
[455] National Institute of Justice, NFP
[456] Social Programs that Work, NFP
[457] Blueprints for Healthy Youth Development, NFP

problems at age 6, 61% fewer arrests of the mother, and 59% reduction in child arrests at age 15.[458]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse NFP services if delivered through Medi-Cal FFS or MCPs as NSMHS. The following provider types are eligible to use these codes: Community-based ECM providers,[459] and non-physician health care professionals.[460]

Nurse Family Partnership (NFP)[461]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[462]**
Enhanced care management	G9008	Enhanced care management	Nurse refers family members to other health and human services as needed	No
Peer support	H0038	Peer support services	Weekly ~1 hour home visits where Nurse supports mother in improving their personal life	Yes *(only if delivered through SMHS)*
Psychoeducation	98960	Education and training for patient self-management, individual	Weekly ~1 hour home visits where Nurse provides parent education (e.g., fetal and infant development)	Yes

[458] NFP Research Trials and Outcomes
[459] ECM Policy Guide, DHCS
[460] Specialty Mental Health Service Table
[461] Analysis by Manatt Health from Jan 2022 to Feb 2023
[462] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

vii. Potential Medi-Cal non-reimbursable services

Nurse Family Partnership (NFP)[463]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Home visits	Nurse provides guidance on non-preventive and health topics (e.g., education, employment)	N/A
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

C. Family Spirit[464]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[465]

3 – Promising Research Evidence

ii. Population of focus

Family Spirit is designed for at-risk or young adult mothers (below the age of 25) who are pregnant (ideally 28 weeks gestation or sooner), live in a Native American community, and/or have children under 3 years old.[466] However, the program can also be effective for other populations regardless of ethnicity/race (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[467]

Family Spirit is a culturally informed, strengths-based program designed to increase parenting knowledge and skills, reduce caregiver psychosocial risks (e.g., drug use, domestic violence), and improve socio-emotional development in children. The curriculum contains 63 lessons taught from pregnancy to when the child reaches age 3 using a combination of lessons, scenarios, and activities.

[463] Analysis by Manatt Health from Jan 2022 to Feb 2023
[464] All information contained in the Family Spirit sections comes from publicly available sources. Please refer to each section for specific source details.
[465] The California Evidence-Based Clearinghouse, FS, see section on Scientific Rating
[466] The California Evidence-Based Clearinghouse, FS, see section on About This Program
[467] The California Evidence-Based Clearinghouse, FS, see section on Program Overview; Program Goals;, Essential Components; and Program Delivery; Family Spirit

The program utilizes a home-visiting model delivered by trained community health workers, with the frequency and intensity of visits based on the family's needs and progress. However, sessions typically range from weekly to bimonthly home-visits (depending on the child's age), with each visit lasting between 45 minutes and 1.5 hours. The program lasts for 39 months. The curriculum is specifically tailored to the cultural contexts of Native American communities, incorporating traditional practices and values to ensure the content is meaningful and culturally applicable.

Lessons consist of six modules and follow structured educational materials tailored to developmental stages for the mother and child:

1) Prenatal Care
2) Infant Care
3) Your Growing Child
4) Toddler Care
5) My Family and Me
6) Healthy Living

iv. Care delivery setting and provider qualifications

Family Spirit is typically conducted in a birth family home, hospital, community-based agency/organization/provider, school setting, or other settings.[468] See Family Spirit for a list of sites.

Home-visitors are required to have at least a high school degree or equivalent and 2+ years of related work experience, while supervisors are required to have a college degree or equivalent, and relevant work experience (e.g., home visiting, case management, community networking, and staff supervision).[469]

Becoming a certified Family Spirit Health Educator or Supervisor consists of a three-phased training process.[470] The Pre-Training phase includes a virtual orientation to the Family Spirit Program, readiness discussions, and independent web-based curriculum tests. The Core Training phase provides an in-depth understanding of the Family Spirit model and curriculum content, available either in-person over four days or virtually over 32 hours across eight days. The Post-Training and Implementation Support phase offers ongoing assistance with monthly planning and support meetings for six months post-core training, followed by quarterly check-ins on technical assistance and program updates.

v. Summary of evidence from literature on program efficacy/impact

[468] The California Evidence-Based Clearinghouse, FS, see sections on Program Delivery; Manuals and Training; and Implementation Information
[469] The California Evidence-Based Clearinghouse, FS, see sections on Program Delivery; Manuals and Training
[470] Family Spirit Program – Training and Curriculum

Family Spirit is considered "promising" by peer-reviewed literature.[471] The program was developed, implemented, and evaluated by the Johns Hopkins Center for Indigenous Health in partnership with the Navajo, White Mountain Apache, and San Carlos Apache Tribes starting in 1995.[472] It is recognized by the California Evidence-based Clearinghouse for Child Welfare.[473]

According to the program, evidence suggests an increase in maternal knowledge and e in parent self-efficacy and a decrease in substance use, behavior problems in mothers, behavior problems in children (ages 0- 3 years), and a predicted lower risk of substance use and behavioral health problems in children over their life course.[474]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse Family Spirit services if they are one of the following provider types: Community-based ECM providers,[475] or non-physician health care professionals.[476]

Family Spirit[477]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[478]**
Enhanced care management	G9008	Enhanced care management	Family connections to community resources as needed	No
Peer support	H0038	Peer support services	Weekly to bimonthly home visit (45 minutes – 1.5 hours)	*Yes (only if delivered through SMHS)*
Psychoeducation	98960	Psychoeducational service by community health worker		Yes

[471] The California Evidence-Based Clearinghouse, FS, see section on Scientific Rating
[472] Family Spirit
[473] The California Evidence-Based Clearinghouse, FS
[474] Family Spirit, see section on Proven Impact
[475] ECM Policy Guide, DHCS
[476] Specialty Mental Health Service Table
[477] Analysis by Manatt Health from Jan 2022 to Feb 2023
[478] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

vii. Potential Medi-Cal non-reimbursable services

Family Spirit [479]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Home Visits	Sessions that do not meet minimum (or exceed maximum) length	Session may not be reimbursable if it does not meet the minimum duration of service required under a CPT/HCPCS code Only part of the session (not full session) may be reimbursable if session exceeds maximum service duration under a CPT/HCPCS code depending on the need
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

D. Parents as Teachers (PAT)[480]

Included within CYBHI EBP grant program and FFPSA Five-Year State Prevention Plan

i. California Evidence-Based Clearinghouse Designation[481]

3 – Promising Research Evidence

ii. Population of focus

PAT's program is designed for pregnant women and caregivers with children below the age of 3 years.[482]

Studies on PAT have previously demonstrated effectiveness with children and caregivers from various races/ethnicities (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[483]

[479] Analysis by Manatt Health from Jan 2022 to Feb 2023
[480] All information contained in the Parents as Teachers program sections comes from publicly available sources. Please refer to each section for specific source details.
[481] The California Evidence-Based Clearinghouse, PAT, see section on Scientific Rating
[482] The California Evidence-Based Clearinghouse, PAT, see section on About This Program
[483] Parents as Teachers

PAT's program is an early childhood parent education, family support, and well-being home- visiting model. The program is offered prenatally through kindergarten. Individuals participate in 12-24 home visits annually that are approximately 60 minutes each in duration. Each visit includes a focus on parent-child interaction, development-centered parenting, and family well-being and engages family / other support systems (e.g., other children, grandparents). The recommended program duration is at least 2 years.

Parent educators work with families using a comprehensive curriculum to increase knowledge of child development, improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. PAT can be integrated with Early Head Start, a home-visiting program that does not offer a behavioral health component.

There are four dynamic components of PAT: (1) Personal Visits, (2) Group Connections, (3) Resource Network, and (4) Child and Caregiver Screening:

1) Home visitation is a key component of Personal Visits. Home visits by parent educators are ~60 minutes and delivered at minimum once a month.

2) Parents can attend monthly (at a minimum) group connections with their children to obtain information and social support and share experiences with peers.

3) Families are connected to needed community resources.

4) Annual child health, hearing, vision, and developmental screenings are offered beginning within 90 days of enrollment. Some programs may also offer adult screenings to identify parental depression, substance abuse, and intimate partner violence.

PAT's approach includes homework component comprised of parent-child activities that reflect family needs.

iv. Care delivery setting and provider qualifications

PAT's program is typically conducted in an adoptive home, birth family home, foster/kinship care, outpatient clinic, community-based agency/organization/provider, school setting, or virtual setting.[484]

Parent educators must have a high school diploma or general equivalency degree (GED) and at least two years of previous supervised work experience with young children and/or parents. See Parents as Teachers for a list of program providers.

[484] The California Evidence-Based Clearinghouse, PAT, see sections on Program Delivery, Manuals and Training; and Implementation Information

v. Summary of evidence from literature on program efficacy / impact

PAT's program is deemed "promising" by peer-reviewed literature.[485] The treatment is recognized by the California Evidence-based Clearinghouse for Child Welfare,[486] Title IV-E Prevention Services Clearinghouse[487], Home Visiting Evidence of Effectiveness for Maternal, Infant, Early Child Home Visiting program (MIECHV),[488] and the Community-based Child Abuse Prevention's (CBCAP) Matrix of Evidence-Based Programs.[489]

Evidence suggests improved caregiver-child relationships, caregiver involvement, early detection of children's developmental delays and health concerns, prevention of child abuse and neglect, increased indicators of child health, improved adaptive behavior, self-control, and mental health in children, and enhanced knowledge of early childhood development and school readiness.[490]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse PAT services if delivered through Medi-Cal FFS or MCPs as NSMHS. The following provider types are eligible to use these codes: Community-based ECM providers,[491] and non-physician health care professionals.[492]

Parents as Teachers (PAT)[493]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[494]**
Enhanced care management	G9008	Enhanced care management	Family connections to community	No

[485] The California Evidence-Based Clearinghouse, PAT, see section on Scientific Rating
[486] The California Evidence-Based Clearinghouse, PAT
[487] Title IV-E Prevention Services Clearinghouse, PAT
[488] MIECHV
[489] CBCAP

[491] ECM Policy Guide, DHCS
[492] Specialty Mental Health Service Table
[493] Analysis by Manatt Health from Jan 2022 to Feb 2023
[494] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

			resources as needed	
Peer support	H0038	Peer support services	Monthly group connections	*Yes (only if delivered through SMHS)*
Psychoeducation	98960	Psychoeducational service by community health worker	Once a month home visitation for ~60 minutes	Yes

vii. Potential Medi-Cal non-reimbursable services

Parents as Teachers (PAT)[495]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

E. Infant and Early Childhood Mental Health Consultation (IECMHC)[496]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy/impact" for additional detail on scientific weight.

ii. Population of focus

IECMHC pairs mental health professionals with those who work with young children and their families (e.g., teachers), where each IECMHC program defines the supported population.[497]

[495] Analysis by Manatt Health from Jan 2022 to Feb 2023
[496] All information contained in the Infant and Early Childhood Mental Health Consultation sections comes from publicly available sources. Please refer to each section for specific source details.
[497] IECMHC

According to IECMHC's website (See IECMHC Equity), its program has previously demonstrated effectiveness with various races/ethnicities.[498]

iii. Program description[499]

IECMHC is a prevention-oriented intervention designed to support the social and emotional development of young children in early childcare settings. It pairs IECMHC consultants with caregivers, educators, and families to build their capacity to nurture and address children's mental health needs. IECMHC services can include programmatic consultation (e.g., to professionals within a setting), child and family consultation, and support for administrators related to policy development (e.g., expulsion policy).

The goals of IECMHC include improving children's social skills, reducing challenging behaviors, and decreasing stress for caregivers and families. IECMHC consultants provide support to children indirectly by working closely with the adults in children's lives, helping them create supportive environments that foster healthy development. This approach emphasizes relationship-building, early intervention, and the importance of healthy adult-child interactions. IECMHC consultants can also help reduce stress for staff, families, and children by providing various services such as, facilitating training sessions on stress reduction and mindfulness, leading wellness activities, sharing online resources, and organizing parent cafés for peer support. They also promote mental health by distributing helpful resources and connecting parents with local community services, including support groups, yoga and meditation spaces, and mental health treatment providers.

IECMHC services offer continuous support tailored to the needs of the specific setting and community, rather than a fixed duration of treatment. The modality includes a combination of observation, feedback, modeling, and coaching, ensuring that caregivers and adults who work closely with children are equipped with practical strategies to address and support children's mental health.

iv. Care delivery setting and provider qualifications[500]

Care delivery settings for IECMHC can include family childcare programs, preschools, Head Start programs, childcare centers, health care offices, child welfare agencies, Early Intervention programs, and home-visiting programs.[500]

[498] IECMHC Equity
[499] IECMHC Basics
[500] Designing an IECMHC Program

According to the program, IECMHC services can be delivered through an Independent IECMHC consultant, Targeted IECMHC Program, or Statewide IECMHC Program/Model, with varying qualifications based on its delivery model:[501]

- Independent IECMHC consultant – master's degree in mental health, license in mental health, at least three years post-master's degree experience
- Targeted IECMHC Program – master's degree in mental health or related field, clinical license (preferred) or eligibility for clinical license, at least two years of post-master's degree experience
- Statement IECMHC Program/Model – master's degree in mental health or related field, clinical license (preferred) or eligibility for clinical license, at least two years of post-master's degree experience

IECMHC training can be completed both in-person or virtually, and includes technical assistance (e.g., initial training that includes an orientation to the IECMHC model, in-depth competency development).[502] Ongoing professional development, reflective supervision, mentoring, and quality assurance systems are also provided to ensure fidelity to the model and to support workforce retention.[503]

v. Summary of evidence from literature on program efficacy / impact

The Center of Excellence for IECMHC is funded by the SAMHSA.[504] According to the program, evidence suggests a reduction in expulsions (e.g., daycare settings) and child behavior challenges, as well as improvements in children's social-emotional competency and relationships between staff and families.[505]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse IECMHC services if they are one of the following provider types: Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[506]

Infant and Early Childhood Mental Health Consultation (IECMHC)[507]

[501] Designing an IECMHC Program
[502] IECMHC Training
[503] IECMHC Training
[504] SAMHSA, Coe for IECMHC
[505] IECMHC CoE Evidence Synthesis
[506] Non-Specialty Mental Health Services (NSMHS), DHCS
[507] Analysis by Manatt Health from Jan 2022 to Feb 2023; Selected State Infant-Early Childhood Mental Health (IECMH) Medicaid Services Billing Codes and Eligibility, NCCP

Service components of the model	CPT/HCPCS code (see appendix linked for more info)	CPT/HCPCS code description	Illustrative services provided	CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[508]
Consultation	90899	Clinical care consultation, face-to-face	Weekly consultation service between IECMHC consultant and provider	No
Preventive services	H0025	Direct service prevention model		Yes
Psychotherapy	90847	Family psychotherapy (with patient present), 50 minutes	Weekly consultation service between IECMHC consultant and child and family	Yes

vii. Potential Medi-Cal non-reimbursable services

Infant and Early Childhood Mental Health Consultation (IECMHC)[509]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

[508] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

[509] Analysis by Manatt Health from Jan 2022 to Feb 2023

Chapter 8: Youth-driven programs

These practices center around youth-driven programs that provide California children and youth the opportunity to shape their behavioral health services. Research indicates that not only are youth peer coaches qualified to support other youth "because of their experience facing similar challenges," but this support is crucial for their peers suffering from serious mental health conditions.[510]

Priority Populations of Focus: Populations identified by CRDP and OHE with a priority focus on youth between the ages of 12-25

Outcomes/Key Metrics: The goal of these EBPs is to increase accessibility to peer-to-peer support and other related programs that are informed through youth voice, provide non-clinical access to BH support, improve engagement in other behavioral health-related services, improve self-reported well-being, and promote long-term recovery among other outcomes.

Example EBPs: Example EBPs include but are not limited to, peer support and youth drop-in centers (e.g., allcove™).

A. allcove™[511]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight.

ii. Population of focus

The allcove model is designed with, by, and for youth (ages 12 -25 years) with mild to moderate behavioral health and life needs.[512]

iii. Program description

The allcove model is a network of integrated youth mental health centers developed by the Stanford Center for Youth Mental Health and Wellbeing, which is modeled off an international program in Australia, Headspace. allcove centers offer a comprehensive range of services in a welcoming, non-stigmatizing environment. These services include mental health counseling, physical health care, substance use support, and resources for education and employment.

[510] UMass Med

[511] All information contained in the allcove sections comes from publicly available sources. Please refer to each section for specific source details.

[512] Allcove whitepaper downloadable from Stanford Medicine Department of Psychiatry and Behavioral Sciences

One central feature of allcove centers is their emphasis on early intervention. allcove aims to provide youth with support before mental health concerns escalate to crisis. Through integrated care in one location (i.e. a "one stop shop"), the model makes health and behavioral health care more accessible by reducing the stigma associated with seeking behavioral health care. Additionally, the centers are designed to be youth-friendly, with input from young people themselves guiding the creation of services and the overall atmosphere. This co-design approach ensures that the centers are not only relevant but also appealing to the youth they serve.

In addition to direct services, allcove centers are involved in outreach and education. They partner with local schools, community organizations, and youth groups to raise awareness about mental health and promote the available services. This community-oriented strategy is essential in reaching young people where they are and providing the support they need in a timely manner.

iv. Care delivery setting and provider qualifications

Allcove centers are available to youth through stand-alone sites. See Allcove for a list of center locations.

Allcove staff include licensed behavioral health providers and Medi-Cal professionals who are supported by a central team at Stanford Medicine[513]. Allcove also engages Youth Advisory Groups, which are composed of 12–15 youth advisors between the ages of 16–25.[514]

v. Summary of evidence from literature on program efficacy / impact

A 2015 independent evaluation of headspace (an Australian program on which allcove is modeled) suggests that "the 'headspace treatment' group resulted in a greater reduction in psychological distress when compared with both the 'other treatment' and 'no treatment' matched groups over time. Both results are statistically significant."[515]

A 2021 longitudinal study published in the Medical Journal of Australia suggests "the majority of young people who access mental health services through headspace centers experience no measurable long-term improvement in function."[516]

vi. Potential Medi-Cal covered benefits/services

[513] allcove whitepaper downloadable from Stanford Medicine Department of Psychiatry and Behavioral Sciences
[514] allcove whitepaper downloadable from Stanford Medicine Department of Psychiatry and Behavioral Sciences
[515] University of New South Wales
[516] The Medical Journal of Australia

N/A – allcove are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply.[517]

vii. Potential Medi-Cal non-reimbursable services

allcoves[518]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Family support	Connecting family member to resources/support	While drop-in center locations themselves may not be eligible to receive Medi-Cal reimbursement for operation and maintenance, it is possible that services (e.g., mental health services provided by licensed providers) provided at drop-in centers could be billed through Medi-Cal.
Mental health	Visit for mental health services	
Physical health	Visit for physical health services	
Substance use	Visit for substance use	
Peer support	Connecting with peers	
Community	Visit for community services (e.g., finding a quiet space, getting social support)	N/A
Education and employment support	Visit for education and employment support	N/A
Implementation	Hiring and training staff, operation and maintenance of center	N/A

B. Drop-in centers for homeless youth[519]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight.

ii. Population of focus

[517] Analysis by Manatt Health from Jan 2022 to Feb 2023
[518] Analysis by Manatt Health from Jan 2022 to Feb 2023
[519] A All information contained in the drop-in centers sections comes from publicly available sources. Please refer to each section for specific source details.

Drop-in centers for homeless youth provide support for youth who are not securely in a home and may suffer from a mental health disorder(s). The target age is defined by each center and may vary.[520]

Some evidence has also suggested that drop-in centers may be effective for LGBTQIA+ homeless youth.[521]

iii. Program description[522]

Drop-in centers serve youth who often face multiple challenges, including unstable housing, mental health issues, substance use, and limited access to education and employment opportunities. These drop-in centers are safe spaces that address the basic needs of youth experiencing homelessness (food, hygiene, and clothing), as well as more resource-intense needs (e.g., physical and mental health services). Drop-in centers adopt a "come as you are" approach, creating accepting environments where individuals can seek help without fear of judgment. This inclusive approach encourages people to access the support they need, regardless of their situation, fostering a sense of comfort and belonging. This welcoming posture can be important for those individuals who may not be comfortable accessing services at more traditional sites.

Youth drop-in centers provide various services designed to meet the multifaceted needs of young people. Mental health and substance use support is a central component and counseling is available to help youth navigate their behavioral health challenges in a safe and supportive environment. Physical health services, including medical check-ups, vaccinations, and health education, are also offered, serving youth who might otherwise lack access to regular healthcare.

Peer support programs are another essential service, enabling young people to connect with peers who have shared similar experiences, fostering a sense of community and validation. Additionally, educational and vocational assistance is provided, helping youth pursue their educational and career aspirations through resources, tutoring, job training, and college application guidance. Social services, such as assistance with food, clothing, housing, and financial support, are also available to help support the lives of these young people, allowing them to focus on personal development and future goals.

The treatment modality at youth drop-in centers is holistic and youth-centered, addressing the physical, emotional, and social needs of each individual. Operating on a trauma-informed care model, the centers recognize the impact of past traumas on current behavior and health and aim to ensure that services are delivered sensitively

[520] Penny Lane Centers – What is a Drop-In Center?
[521] See Chapter 5.ix for more detail on Drop-in centers for LGBTQIA+ youth
[522] Facilitators and barriers of drop-in center use among homeless youth; Engaging Youth Experiencing Homelessness: National Health Care for the Homeless Council; SAMHSA TIP – Behavioral Health Services for People Who Are Homeless

to avoid re-traumatization and promote healing. Furthermore, a leading practice is to build a collaborative model with drop-in centers becoming referral sources to specialized behavioral health clinics (e.g., centers that specialized in serving LGBTQIA+ youth[523]).

iv. Care delivery setting and provider qualifications

Drop-in centers for homeless youth are typically available through stand-alone sites.[524]

The CA Department of Social Services has stipulated a set of licensing standards for Youth Homelessness Prevention Centers and Runaways and Homeless Youth shelters.[525] The qualifications for the center administrator include a degree in behavioral science and/or experience in social work or childcare and training requirements also stipulate completion of the Runaway and Homeless Youth Training and Technical Assistance Center (RHYTTAC) courses.[526]

v. Summary of evidence from literature on program efficacy / impact

Some evidence shows that homeless youth are twice as likely to utilize drop-in centers compared to shelters.[527] A study examining the impact of interventions on youth homelessness also demonstrated that drop-in centers were more effective in supporting a robust care continuum and linking youth to services compared to crisis shelters.[528]

Studies have also demonstrated other impacts of drop-in centers. For example, a study of 172 homeless youth accessing services through an urban drop-in center found significant reductions in substance use, improved mental health outcomes, and a decrease in homelessness 12 months post-baseline.[529] Another study suggested youth who visited drop-in centers showed an increase in the percentage of days being housed from 23% to 43%, an increase in the percentage of days employed from 16% to 21%, and a decrease in the percentage reporting psychological distress from 96% to 65%.[530]

vi. Potential Medi-Cal covered benefits/services

[523] See Chapter 6.ix for more detail on Drop-in centers for LGBTQIA+ youth
[524] Penny Lane Centers – What is a Drop-In Center?
[525] Youth Homelessness Prevention Center Interim Licensing Standards, Version 2
[526] Youth Homelessness Prevention Center Interim Licensing Standards, Version 2
[527] Facilitators and barriers of drop-in center use among homeless youth
[528] Outcomes among homeless youth at an urban drop-in center
[529] Impact of interventions on homeless youth
[530] Outcomes among homeless youth at an urban drop-in center

N/A – Drop-in centers for homeless youth are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply. [531]

vii. Potential Medi-Cal non-reimbursable services

Drop-in centers for homeless youth[532]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Basic necessities	Showers, laundry services, clothing, etc.	While drop-in center locations themselves may not be eligible to receive Medi-Cal reimbursement for operation and maintenance, it is possible that services provided at drop-in centers could be billed through Medi-Cal.
Case Management	Case management for homeless youth	
Education and Employment support	Visit for education and employment support	
Implementation	Hiring and training staff, operation and maintenance of center	
Mental health	Visit for mental health services	
Peer support	Connecting with peers/support groups	N/A
Physical health	Visit for physical health services	N/A
Wraparound services	Housing support services, nutritional program	Some services may be optionally reimbursable by MCPs as defined Community Supports (e.g., housing transition navigation services, day habilitation programs, sobering centers)[533]

C. Drop-in centers for LGBTQIA+ youth[534]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

[531] Analysis by Manatt Health from Jan 2022 to Feb 2023
[532] Analysis by Manatt Health from Jan 2022 to Feb 2023
[533] Medi-Cal Community Supports/ILOS
[534] All information contained in the drop-in centers for LGBTQIA+ sections comes from publicly available sources. Please refer to each section for specific source details.

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight.

ii. Population of focus

Drop-in centers for LGBTQIA+ youth are physical safe spaces that provide an array of services for LGBTQIA+ youth, their families, friends, and allies. The target age is defined by each center and may vary.[535]

Some evidence suggests that drop-in centers may be effective for LGBTQIA+ homeless youth.[536]

iii. Program description[537]

Drop-in centers for LGBTQIA+ youth offer a range of supportive services, including housing assistance, access to food pantries, peer support, gender-affirming clothing, connections to community-based mental health care, and individualized case management. These centers address the common challenges LGBTQIA+ youth face based on their sexual orientation, gender identity, or gender expression (SOGIE). By creating a welcoming and stigma-free environment, these centers promote mental and emotional well-being, facilitate social connections, provide educational and vocational support, enhance health and wellness, and empower youth to advocate for their rights and equality.

Drop-in centers for LGBTQIA+ youth provide a variety of essential services aimed at supporting their well-being. These centers offer counseling and support groups that provide both professional and peer support, helping youth cope with challenges and build resilience. Educational workshops cover a broad spectrum of topics, from LGBTQIA+ history and rights to practical skills such as financial literacy and job readiness. Health services include sexual health education, HIV/STI testing, and information on safe practices, as well as mental health services or referrals when necessary. Regular social events and activities create opportunities for youth to connect, celebrate their identities, and enjoy themselves in a supportive environment. Additionally, these centers offer resource referrals to external services such as housing assistance and legal support, ensuring comprehensive care and support for LGBTQIA+ youth.

iv. Care delivery setting and provider qualifications

[535] Sacramento Q-Spot Youth Programs
[536] Homeless Queer Youth: National Perspectives on Research, Best Practices, and Evidence Based Interventions
[537] Sacramento Q-Spot Youth Programs; Q Spot LGBT Community Center, NJ; Providing services & supports to LGBTQ youth; LGBTQIA+2S Homelessness; SAMHSA LGBTQIA+BE CoE

Drop-in centers for LGBTQIA+ youth are available through stand-alone sites or partnerships (e.g., the SFLGBT Center has partnered with the UCSF Alliance Health Project, a clinical center of excellence, to provide behavioral health services).[538]

The drop-in center workforce may include a program director(s) and manager(s) working across community programs, employment and housing services, licensed primary care providers, mental health or substance use professionals, peers, case managers, and care coordinators.[539]

v. Summary of evidence from literature on program efficacy / impact

Currently, there is limited assessment of comparative effectiveness between competing service models (including drop-in centers) for LGBTQIA+ homeless youth.[540]

Community-based outreach services (including street outreach and drop-in centers) have demonstrated success in building trusting relationships as well as in coordinating resources across the care continuum. With the goal of homelessness prevention, most youth-serving agencies rely on outreach services, including drop-in centers, as a gateway toward family reconciliation and reunification.[541]

vi. Potential Medi-Cal covered benefits/services

N/A – Drop-in centers for LGBTQIA+ are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply.[542]

vii. Potential Medi-Cal non-reimbursable services

Drop-in centers for LGBTQIA+ youth[543]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Case Management	Case management for homeless LGBTQIA+ youth	While drop-in center locations themselves may not be eligible to receive Medi-Cal reimbursement for operation and maintenance, it is possible that services (e.g., mental health services provided by
Family support	Connecting family member to resources/support	
Mental health	Visit for mental health services	

[538] UCSF Alliance Health Project
[539] Sacramento Q-Spot Youth Programs
[540] All Our Children: NYC Commission
[541] Homeless Queer Youth: National Perspectives on Research, Best Practices, and Evidence Based Interventions
[542] Analysis by Manatt Health from Jan 2022 to Feb 2023
[543] Analysis by Manatt Health from Jan 2022 to Feb 2023

Physical health	Visit for physical health services	licensed providers) provided at drop-in centers could be billed through Medi-Cal.
Peer support	Connecting with peers	
Community	Visit for community services (e.g., LGBTQ+ library, art projects, video games)	N/A
Education and Employment support	Visit for education and employment support	N/A
Implementation	Hiring and training staff, operation and maintenance of center	N/A
Wraparound services	Housing support services, nutritional program	N/A

D. Across Ages[544]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[545]

3 – Promising Research Evidence

ii. Population of focus

Across Ages is a program for middle school youths (ages 9-13 years) who are at a high-risk for substance abuse.[546]

Studies on Across Ages have previously demonstrated effectiveness with youths from various races/ethnicities and has been applied to youths across populations from low-income families (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[547]

Across Ages is a multifaceted community-based substance use prevention program designed to support at-risk children and youth through intergenerational mentoring. The program pairs young adolescents with older adult mentors (e.g., ages 55+) to

[544] All information contained in the Across Ages sections comes from publicly available sources. Please refer to each section for specific source details.
[545] The California Evidence-Based Clearinghouse, Across Ages, see section on Scientific Rating
[546] The California Evidence-Based Clearinghouse, Across Ages, see section on About This Program
[547] The California Evidence-Based Clearinghouse, Across Ages, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; National Institute of Justice- Across Ages

provide guidance and companionship. These mentoring relationships, which include meeting for at least four hours per week throughout the year, are central to the program's approach to fostering resilience, improving academic performance, and promoting positive attitudes toward school and life. The goals of the Across Ages program are to reduce substance use, improve academic outcomes, foster positive relationships with family and peers, and enhance social skills. By providing a structured and supportive environment, the program ensures that youth are better equipped to face future challenges with resilience and confidence.

In addition to mentoring, Across Ages incorporates community service projects where youth interact with older generations, with the aim to foster empathy and social responsibility. The program also includes a classroom-based life skills curriculum known as Positive Youth Development, which promotes social competence through interactive methods such as instruction, videotapes, journals, role-playing, and homework assignments.

Family involvement is another important component of Across Ages, with workshops and events organized on weekends to strengthen family relationships. These workshops can include meals, entertainment, and free transportation, further encouraging parental engagement. Collaborative homework sessions and family-focused activities also help build a comprehensive support network around the youth.

iv. Care delivery setting and provider qualifications

Across Ages is typically conducted in a school or community setting.[548]

Mentors are adult volunteers aged 55 years and older. A 2-day training and follow-up technical assistance for is recommended for mentors.[549]

v. Summary of evidence from literature on program efficacy / impact

Across Ages is deemed "promising" by peer-reviewed literature.[550] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare[551] and the National Institute of Justice.[552]

Evidence on Across Ages suggests improved attitudes towards school, the future, and elders, improved feelings of well-being, and reactions to stress/anxiety, as well as reductions in absenteeism and frequency of drug use.[553]

[548] National Institute of Justice- Across Ages, see section on Implementation Information
[549] National Institute of Justice- Across Ages, see section on Implementation Information
[550] The California Evidence-Based Clearinghouse, Across Ages, see section on Scientific Rating
[551] The California Evidence-Based Clearinghouse, Across Ages, see section on Scientific Rating
[552] National Institute of Justice- Across Ages
[553] The California Evidence-Based Clearinghouse, Across Ages, see section on Relevant, Published Peer-Reviewed Research

vi. Potential Medi-Cal covered benefits/services

N/A - services provided through Across Ages are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply.[554]

vii. Potential Medi-Cal non-reimbursable services[555]

While the program can provide valuable mentoring support, it does not require mentors to have lived experience, a criterion that often qualifies for peer support codes.

Across Ages [556]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Classroom curriculum	Positive Youth Development curriculum to teach life and resistance skills	N/A
Community service	Biweekly visits to nursing homes	N/A
Implementation	Hiring and training staff	N/A
Parent workshops	Weekend events for parents, youth, and mentors	N/A
School support	Help on homework or school projects Going to sports events or cultural activities	N/A
Wraparound services	Housing support services, nutritional program	N/A

E. Fostering Healthy Futures – Preteen (FHF-P)[557]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[558]

[554] Analysis by Manatt Health from Jan 2022 to Feb 2023
[555] Analysis by Manatt Health from Jan 2022 to Feb 2023
[556] Analysis by Manatt Health from Jan 2022 to Feb 2023
[557] All information contained in the Fostering Healthy Futures- Preteen sections comes from publicly available sources. Please refer to each section for specific source details.
[558] The California Evidence-Based Clearinghouse, FHF-P, see section on Scientific Rating

1 – Well Supported by Research Evidence for mentoring programs (child & adolescent)

2 – Supported by Research Evidence for mental health prevention and/or early intervention (child & adolescent) programs, multi-problem approaches (child & adolescent), placement stabilization programs, trauma treatment – client-level interventions (child & adolescent)

ii. Population of focus

FHF-P is a program for pre-adolescent children (ages 9–11 years) who have current or previous child welfare involvement from documented adverse childhood experiences (ACEs). [559] Examples of ACEs include maltreatment; out-of-home placement; instability in housing, caregivers, or schools; or parental substance use, mental illness, or incarceration.[560]

Studies on the FHF-P program have previously demonstrated its effectiveness with youths and their families from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[561]

FHF-P is a 30-week program designed for children (ages 9-11 years) who have experienced maltreatment. This program provides structured mentoring and skills training aimed at fostering resilience, improving emotional regulation, enhancing social skills, and promoting healthy relationships. Spanning nine months, the program includes weekly individual mentoring sessions and group skills training. By focusing on both individual and group support, the FHF-P program helps children develop the skills they need to navigate life stressors and build a foundation for a healthier future.

Mentors, typically graduate-level students, offer consistent one-on-one support for approximately 2-4 hours per week, helping children set and achieve personal goals while providing emotional guidance and positive role modeling. Each group setting includes eight children, one supervisor, one co-leader, and one skills group assistant. These sessions are designed to be educational and engaging, utilizing interactive discussions, role-playing, games, and experiential learning activities to maintain motivation. The program's curriculum covers essential topics such as emotion recognition, problem-solving, anger management, and cultural identity. Each session begins with an hour focused on these skills, followed by a half-hour where

[559] The California Evidence-Based Clearinghouse, FHF-P, see section on About This Program
[560] CDC – Adverse Childhood Experiences
[561] The California Evidence-Based Clearinghouse, FHF-P, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; Fostering Healthy Futures

participants share a meal and socialize. Multicultural activities are integrated throughout the program to ensure inclusivity and cultural awareness.

iv. Care delivery setting and provider qualifications

The FHF-P program is typically conducted in an adoptive home, birth family home, community daily living setting, foster/kinship care, community-based agency / organization / provider, or group or residential care.[562]

According to the California Evidence-Based Clearinghouse:[563]

- Mentors are enrolled in a university Undergraduate, Master's or Doctorate level clinical program with a field placement or internship requirement that can be met through participation in the program.
- Intern and Group supervisors require either a Master's or Doctorate degree in a relevant field (i.e., social work, psychology) and be licensed or license eligible. They also should have prior supervisory experience.
- Group supervisors hold either a Master's or Doctorate degree and have significant clinical experience working with high-risk youth (preferably in a group setting).
- Group co-leaders are typically graduate students in a relevant discipline.
- Skills group assistant positions can be existing staff at implementing agencies, volunteers, or hourly student workers. Skills group assistants must have significant experience working with children and must be able to work with children who have been given breaks from group.

v. Summary of evidence from literature on program efficacy / impact

The FHF-P program is considered "well-supported" through RCTs and peer-reviewed literature[564]. It has been recognized by the California Evidence-based Clearinghouse for Child Welfare[565] and National Institute of Justice Crime Solutions.[566] Blueprints for Healthy Youth Development have also rated MST as 'Promising'.[567]

Studies on the FHF-P program suggests fewer placement changes, lower likelihood of placement in a residential treatment center, and reduced mental health symptoms y.[568] In one study that evaluated outcomes for children living in non-relative (i.e., outside of the family) foster care, the FHF cohort reported: 82% lower likelihood of placement in a residential treatment center; 44% fewer placement changes; 5 times

[562] The California Evidence-Based Clearinghouse, FHF-P, see sections on Program Delivery; Manuals and Training; and Implementation Information
[563] The California Evidence-Based Clearinghouse, FHF-P, see sections on Program Delivery; Manuals and Training; and Implementation Information
[564] The California Evidence-Based Clearinghouse, FHF-P, see section on Scientific Rating
[565] The California Evidence-Based Clearinghouse, FHF-P, see section on Scientific Rating
[566] National Institute of Justice, FHF-P
[567] Blueprints for Healthy Youth Development, FHF-P
[568] The California Evidence-Based Clearinghouse, FHF-P

higher likelihood of attaining permanency; significantly higher family reunification 1 year post intervention; lower rates of self-reported mental health symptoms for FHF youth (reported by youth, parents/caregivers, teachers).[569]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse Fostering Healthy Futures services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[570] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[571]

Fostering Healthy Futures – Preteen[572]			
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**
Psychotherapy	90853	Group therapy; 90 minutes	FHF-P skills group session for 1.5 hours/week

vii. Potential Medi-Cal non-reimbursable services

Fostering Healthy Futures – Preteen [573]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Mentoring	Graduate student mentorship of student for 2-4 hours/week	N/A
Wraparound services	Housing support services, nutritional program, transportation	N/A

[569] The California Evidence-Based Clearinghouse, FHF-P
[570] Specialty Mental Health Services Medi-Cal Billing Manual
[571] Non-Specialty Mental Health Services (NSMHS), DHCS
[572] Analysis by Manatt Health from Jan 2022 to Feb 2023
[573] Analysis by Manatt Health from Jan 2022 to Feb 2023

F. Transition to Independence (TIP) Model[574]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[575]

3 – Promising Research Evidence

ii. Population of focus

The TIP Model is a program for youth and young adults (ages 14-29 years) with emotional/behavioral difficulties, serious mental illness (SMI), multi-system involvement, out-of-home placements or homelessness, developmental trauma and delays, justice involvement, and/or co-occurring substance use challenges.[576]

Studies on the TIP model have demonstrated its effectiveness with youths and their families from various racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[577]

The TIP model is a coaching program designed to empower youth by engaging them in planning their futures. It offers culturally competent, non-stigmatizing, and trauma-informed services, incorporating families and other significant individuals in the youth's life in the process. The primary goal is to help young people become self-sufficient by setting and achieving goals in areas such as employment, education, living situations, personal well-being, and community involvement.

The model is structured around seven guidelines that emphasize building strong relationships through person-centered planning and future-focused engagement. These guidelines ensure that services are accessible, trauma-informed, and developmentally appropriate while promoting personal choice and responsibility through problem-solving and decision-making. Additionally, the model includes families and other important supporters, to help enhance competencies for self-sufficiency, and maintains a focus on outcomes at individual, program, and community levels.

Core practices within the TIP model include assessing strengths and needs, assisting in setting and achieving personal goals, providing practical skills training in real-life settings, and using structured methods for problem-solving and decision-making.

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[574] All information contained in the Transition to Independence sections comes from publicly available sources. Please refer to each section for specific source details.
[575] The California Evidence-Based Clearinghouse, TIP, see section on Scientific Rating
[576] The California Evidence-Based Clearinghouse, TIP, see section on About This Program
[577] The California Evidence-Based Clearinghouse, TIP, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; Stars Training Academy; Stars Training Academy – Orientation

The model also aims to reduce high-risk behaviors and situations through prevention planning, conflict resolution with mediation techniques, and incorporates trauma-informed care practices to acknowledge and address the impact of trauma.

Each participant's experience in the TIP model is highly individualized, with Transition Facilitators (TFs) adjusting support to match their specific needs. As such, the frequency and intensity of care can vary, with services typically lasting around 18 months. This tailored approach ensures that youth receive the appropriate level of support to successfully transition into adulthood.

iv. Care delivery setting and provider qualifications

The TIP model is typically conducted in an adoptive or birth family home, community daily living setting, foster/kinship care, outpatient clinic, community-based agency/organization/provider, group or residential care, justice setting, school seeing, virtual setting, or other settings.[578]

The TIP model program is delivered by transition teams consisting of Transition Facilitators, Peer Support Specialists, and Transition Program Supervisors. Each position has its own set of qualifications, including requirements on education, work experience, and licenses:[579]

- Transition Facilitator – typically has some combination of a bachelor's or master's degree in the social science or educational fields and relevant work experience
- Peer Support Specialist / Peer Provider / Peer Associate – typically has direct experience with mental health services (and/or foster care or multi-system involvement)
- Transition Program Supervisor – is required to have a master's degree in social science or educational fields and four years of relevant work experience

v. Summary of evidence from literature on program efficacy / impact

The TIP model is deemed "promising" by peer-reviewed literature.[580] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare.[581]

The Steps-to-Success Program (a TIP Model program) demonstrated improved outcomes (e.g., higher employment, greater postsecondary education, less

[578] The California Evidence-Based Clearinghouse, TIP, see section on Program Delivery; Manuals and Training; and Implementation Information
[579] The California Evidence-Based Clearinghouse, TIP, see section on Program Delivery; Manuals and Training; and Implementation Information
[580] The California Evidence-Based Clearinghouse, TIP, see section on Scientific Rating
[581] The California Evidence-Based Clearinghouse, TIP, see section on Scientific Rating

incarceration) for those with emotional/behavioral difficulties who completed STS relative with the comparison group.[582]

In addition, a multi-site study of transition support programs showed increased progress and decreased challenges in transition to adulthood from adolescence over four quarters of enrollment.[583]

vi. Potential Medi-Cal covered benefits/services

Eligible providers may use the below CPT/HCPCS codes to reimburse TIP services if they are one of the following provider types: certified Medi-Cal Peer Support Specialist.[584]

Transition to Independence Model[585]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[586]**
Peer support	H0038	Peer support services	Coaching session with Peer Support Specialist	Yes *(only if delivered through SMHS)*

vii. Potential Medi-Cal non-reimbursable services

Transition to Independence Model [587]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Education and employment support	Support provided for employment/career and educational opportunities	N/A
Group activities	Group activities for socializing (e.g., monthly dinner gatherings)	N/A

[582] Follow-Up Study of Student Exiters from Steps-to-Success
[583] Multisite study: Youth transitioning initiative
[584] Medi-Cal Peer Fee Schedule
[585] Analysis by Manatt Health from Jan 2022 to Feb 2023
[586] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[587] Analysis by Manatt Health from Jan 2022 to Feb 2023

Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

G. Peer respite[588]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight

ii. Population of focus

Peer respites provide support to individuals ages 18 years and older experiencing a psychiatric crisis or "pre-crisis," which may include acute emotional, psychological, or life circumstance stressors that could be precursors to suicidality or psychosis.[589]

Peer respites are intended to provide a safe and welcoming environment to black, indigenous, and other people of color (BIPOC) and LGBTQIA+ youth.[590]

iii. Program description[591]

Peer respite is a voluntary, short-term, residential program that provides community-based, non-clinical support and can serve as an alternative to hospitalization. This community-based alternative to traditional psychiatric emergency rooms or inpatient services offer support in a safe, home-like environment. Staffed and operated by people with lived experience, peer respite sites offer several non-clinical services (e.g., support groups for suicidality and substance use, meditation and mindfulness exercises, religious or spiritual engagement, Wellness Recovery Action Plan (WRAP) participation). The primary goals of peer respite include promoting wellness, increasing meaningful choices for recovery, and establishing supportive relationships. Additionally, these programs aim to reduce emergency hospitalizations and overall mental health system costs.

Peer respites guests can stay between 0-30 days, with most guests staying an average of 5-8 days. Peer respites provide peer-to-peer resources, with peers holding both leadership and practitioner roles, which promotes an alternative service delivery

[588] All information contained in the Peer Respite sections comes from publicly available sources. Please refer to each section for specific source details.
[589] LAPPA – Peer Respite
[590] SAMHSA Advisory Peer Support services in crisis care
[591] LAPPA – Peer Respite; Peer Respites: A Research and Practice Agenda

model that diverges from traditional mental health systems. In this vein, peer respites are required to meet three criteria:[592]

1) The respite must be 100% staffed by people with lived experience of extreme states and/or the behavioral health system
2) All leaders in the peer respite must have lived experience
3) The program must be operated by either a peer-run organization or an advisory group where at least 51% of the members have lived experience.

iv. Care delivery setting and provider qualifications

Services are delivered in peer respites. See National Empowerment Center for a directory of peer respites.

Individuals hired for program/house management positions and 100% of staff have "lived experience of extreme states" and/or experience within the mental health system.[593] To maintain high-quality support and uphold the program's values, the National Empowerment Center recommends continuous training for staff, professional development, and quality improvement practices to understand program effectiveness, guest satisfaction, and impact on mental health outcomes.[594]

v. Select excerpts from primary source literature on program efficacy / impact

There is limited, but promising research on the effectiveness of peer respite services. A study examining Medicaid enrollment and claims data from January 2009 through April 2016 found lower Medicaid expenditures (by $2,138 per month) and fewer hospitalizations (by 2.9 admissions per month) for those using peer respite services (n=401 respite center clients) relative to the comparison group (n=1,796 members).[595]

An evaluation of Second Story, a peer respite operating in Santa Cruz, CA, demonstrated 70% lower utilization of inpatient or emergency services relative to the comparison group and an overall cost reduction.[596]

vi. Potential Medi-Cal covered benefits/services[597]

N/A - services provided at peer respites are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply.

vii. Potential Medi-Cal non-reimbursable services

[592] LAPPA – Peer Respite
[593] LAPPA – Peer Respite
[594] National Empowerment Center – Programs and Services
[595] Psychiatric Services - The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization
[596] Psychiatric Services - Impact of the 2nd story peer respite program on use of inpatient and emergency services
[597] Analysis by Manatt Health from Jan 2022 to Feb 2023

Peer respite[598]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Peer support	Support groups	Peer support services delivered by non-Medi-Cal Peer Support Specialists are typically not reimbursable under Medi-Cal
Mindfulness	Meditation and mindfulness exercises	N/A
Arts	Arts and crafts	N/A
Religious / spiritual	Religious / spiritual services	N/A
WRAP	Participation in WRAP (Wellness Recovery Action Plan) activities	N/A
Wraparound services	Housing support services, nutritional program	N/A
Implementation	Hiring and training staff	N/A

H. Clubhouse Model[599]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight

ii. Population of focus

Clubhouses are community-based services designed for adults and youth with Serious Mental Illnesses (SMIs), where participants are referred to as "members", and membership is open to anyone who has a history of mental illness.[600] The concept of membership means that the individual has both shared ownership and responsibility for the success of the organization.

[598] Analysis by Manatt Health from Jan 2022 to Feb 2023
[599] All information contained in the Clubhouse Model sections comes from publicly available sources. Please refer to each section for specific source details.
[600] Clubhouse International

iii. Program description[601]

The Clubhouse Model is a non-clinical approach to mental health recovery, designed to create therapeutic communities where adults and young adults with serious mental illness (SMI) can actively participate. Membership is open to anyone with current or historical mental health concerns, and participation is both voluntary and unlimited in duration. The Clubhouse Model promotes a sense of shared ownership and responsibility, positioning each member as an important part of the community and emphasizing the potential for every individual to recover and lead a fulfilling life.

Central to the Clubhouse Model is the restorative power of work and work-mediated relationships. Members contribute to the daily operations of the Clubhouse through a structured system known as the "Work-Ordered Day." During traditional business hours, members and staff collaborate to manage the Clubhouse, which helps build skills and confidence. Members have the autonomy to choose their work activities and staff, re-enter the program at any time, and have access to lifetime service. This operating model supports goals in employment, education, housing, wellness, and social relationships, aiming to reduce hospitalizations and criminal justice involvement while enhancing overall life satisfaction. Educational support is another important component, where Clubhouses offer counseling, mentoring, tutoring, and group supports to help members achieve their educational goals.

Affiliated with Clubhouse International, these centers adhere to standards to ensure quality and consistency, which encompass membership, relationships, space, the Work-Ordered Day, employment, education, the functions of the house, and governance.[602]

iv. Care delivery setting and provider qualifications

Clubhouses are local community centers. See Clubhouse International for a list of Clubhouses.

The Clubhouse staff include personnel trained in Mental Health and Psychosocial Rehabilitation Programs, Communications, and Social Work.[603]

v. Summary of evidence from literature on program efficacy / impact

The Clubhouse model is supported through RCTs and peer-reviewed literature.[604] It has also been recognized by SAMHSA.[605]

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[601] Systematic review: Clubhouse model (2018); Clubhouse International; SAMHSA EBP Center
[602] Clubhouse International – Quality Standards
[603] Costs of clubhouses: an international perspective; Clubhouse careers
[604] Journal of Administration and Policy in Mental Health and Mental Health Services
[605] SAMHSA

Evidence suggests Clubhouses promote employment (by as much as twice the average employment rate at 42% compared with individuals in the public mental health system), reduce hospitalizations, improve quality of life, and improve social interactions.[606]

vi. Potential Medi-Cal covered benefits/services[607]

N/A - services provided at Clubhouses are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply.

vii. Potential Medi-Cal non-reimbursable services

Clubhouse Model [608]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Community support	Benefits assistance, linkage to other services, advocacy, transportation, financial management, etc.	Several states offer some form of reimbursement for Clubhouse services; however, California currently does not cover psychosocial rehabilitation (e.g., Clubhouse model)[609]
Education and employment support	Transitional, Supported, or Independent Employment programs Assistance with access to educational opportunities	
Implementation	Hiring and training staff	
Mental health	Access to medication and psychiatry, crisis intervention, etc.	
Social	Evening, weekend, and holiday social and recreational programming	
Wraparound services	Housing support services, nutritional program	N/A

I. Motivational Interviewing (MI)[610]

Included within the FFPSA Five-Year State Prevention Plan

[606] Clubhouse International
[607] Analysis by Manatt Health from Jan 2022 to Feb 2023
[608] Analysis by Manatt Health from Jan 2022 to Feb 2023
[609] KFF Clubhouse model
[610] All information on Motivational Interviewing was obtained from publicly available sources. For transparency and accuracy, each section specifies the public site from which the information was sourced.

i. California Evidence-Based Clearinghouse Designation[611]

1 – Well-Supported by Research Evidence

ii. Population of focus

MI can be used to promote behavior change in various populations and for a diverse range of issues (e.g., substance use disorder, children referred to the child welfare system, mental health, parenting).[612]

Studies on MI have previously demonstrated effectiveness with children and caregivers from various races/ethnicities (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[613]

MI is a counseling approach for facilitating behavior change and improving various outcomes related to physical, psychological, and lifestyle factors. It focuses on identifying ambivalence towards change and increasing motivation by guiding clients through five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. Through MI, participants are encouraged to reflect on their personal goals and how their current behaviors may hinder the achievement of those goals.

MI is typically delivered over 1-3 individual sessions lasting 30-50 minutes each. The treatment format can vary depending on the setting and use case (e.g., individual, group, telemedicine).

MI employs clinical strategies such as open-ended questioning and reflective listening to help clients identify reasons to change their behavior and reinforce that change is possible. Examples of types of open-ended questions include:

- What worries you about your substance use?
- How has your use of substances presented problems for you in the past?
- What kinds of things would need to happen to make you consider changing your substance use?

iv. Care delivery setting and provider qualifications

[611] The California Evidence-Based Clearinghouse, MI, see section on Scientific Rating
[612] The California Evidence-Based Clearinghouse, MI, see section on About This Program; MINT
[613] The California Evidence-Based Clearinghouse, MI, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; Title IV-E Prevention Services Clearinghouse, MI; MINT

MI is typically conducted in a hospital, outpatient clinic, community-based agency/organization/provider, or group or residential care.[614]

Various professionals can provide MI; there are no minimum qualifications.[615]

v. Summary of evidence from literature on program efficacy / impact

MI is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1 year post intervention. [616] It has also been recognized by the California Evidence-based Clearinghouse for Child Welfare,[617] Title IV-E Prevention Services Clearinghouse[618], National Institute of Justice Crime Solutions,[619] Title IV-E Prevention Services Clearing House, and SAMHSA.[620]

Evidence suggests reductions in drinking quantity, reductions in negative consequences from drinking without changes in frequency and increases in attendance of treatment sessions.[621]

Chapter 9: Early intervention programs and practices

These early intervention programs are aimed at addressing behavioral health needs more effectively earlier and reducing reliance on more intensive services. Research indicates that early behavioral health intervention can reduce premature death, social isolation, poor function, and increase educational and vocational prospects;[622] however, less than 5 percent of eligible children covered by Medi-Cal receive a single mental health service.[623] National research has shown that 50 percent of all mental health conditions appear before age 14.[624]

Priority Populations of Focus: Populations identified by CRDP

Outcomes/Key Metrics: The goal of these EBPs is to increase early identification of behavioral health concerns, improve or properly address behavioral health challenges preventing escalation to more intensive services, and improve coordination of services among other outcomes

Example EBPs: Example EBPs include but are not limited to early psychosis programs (e.g., Coordinated Specialty Care) and Youth Crisis Peer Mobile Response.

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[614] The California Evidence-Based Clearinghouse, MI, see sections on Program Delivery, Manuals and Training; and Implementation Information
[615] The California Evidence-Based Clearinghouse, MI, see sections on Program Delivery, Manuals and Training; and Implementation Information
[616] The California Evidence-Based Clearinghouse, MI, see section on Scientific Rating
[617] The California Evidence-Based Clearinghouse, MI, see section on Scientific Rating
[618] Title IV-E Prevention Services Clearinghouse, MI
[619] National Institute of Justice, MI
[620] SAMHSA
[621] The California Evidence-Based Clearinghouse, MI, see section on Relevant, Peer-Reviewed Published Research
[622] BMI Journals
[623] CA Children's Hospital Association
[624] SAMHSA

A. Familias Unidas[625]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[626]

1 – Well-Supported by Research Evidence

ii. Population of focus

Familias Unidas is designed for Hispanic adolescents (ages 12-16 years) and their parents, addressing youth drug use and risky sexual behaviors.[627]

iii. Program description[628]

Familias Unidas is a multi-level family-centered intervention designed to prevent drug use and sexual risk behaviors among Hispanic adolescents. The program empowers caregivers to engage in open discussions with their children about these issues, enhancing family communication and involvement. Families meet weekly over the course of 12 weeks and participate in either parent group sessions or family sessions.

Parent group sessions aim to increase parents' understanding of their role in safeguarding their adolescent from risky behaviors (e.g., substance use, unsafe sexual behavior) and to facilitate parental involvement. The parent group sessions, which typically consist of 12-15 parents, last 2 hours and are delivered across eight sessions.

In family sessions, parents and their adolescents participate in activities that strengthen family bonds and improve communication. These sessions focus on practicing the skills learned in the group sessions, such as effective communication, positive parenting techniques, and strategies for addressing drug use and sexual risk behaviors. The sessions are interactive, involving role-playing and discussions that help families apply these skills in real-life situations. Sessions last approximately 1 hour and are administered across four sessions.

Taken together, this format helps families work to improve parent-adolescent communication, parental involvement, and family functioning, and prevent or address behavioral issues, substance abuse, and other challenges faced by Hispanic adolescents.

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[625] All information contained in the Familias Unidas sections comes from publicly available sources. Please refer to each section for specific source details.

[626] The California Evidence-Based Clearinghouse, Familias Unidas, see section on Scientific Rating

[627] The California Evidence-Based Clearinghouse, Familias Unidas, see section on About This Program

[628] The California Evidence-Based Clearinghouse, Familias Unidas, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; University of Miami School of Nursing & Health Studies, Familias Unidas

iv. Care delivery setting and provider qualifications

Familias Unidas is typically conducted in a community-based agency/organization/provider or school setting.[629]

Program facilitators have a minimum of a bachelor's degree and are generally fluent in Spanish.[630] Training includes a 32-hour program that is completed over the course of four days where topics include theoretical framework, goals, outcomes, intervention strategies, and materials required for each session.[631] After delivering the intervention at least six times, facilitators can pursue additional training to become a Familias Unidas Trainer, which includes completing a 32-hour Training-of-Facilitators course and being observed by a master trainer during their initial training at their agency.[632]

v. Summary of evidence from literature on program efficacy / impact

Familias Unidas is considered "well-supported" through RCTs and peer-reviewed literature.[633] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare,[634] Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs,[635] National Institute of Justice Crime Solutions,[636] the Centers for Disease Control and Prevention Compendium of Evidence-Based HIV Behavioral Interventions,[637] and SAMHSA.[638] Blueprints for Healthy Youth Development has also rated Familias Unidas as 'Promising'.[639]

Evidence suggests a decrease in adolescent behavior problems, increase in parental investment, decrease in substance use, decrease in externalizing disorders, and decrease in unsafe sexual behavior.[640]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse Familias Unidas services if they are one of the following provider types: Clinical Nurse Specialist,

[629] The California Evidence-Based Clearinghouse, Familias Unidas, see sections on Program Delivery; Manuals and Training; and Implementation Information
[630] The California Evidence-Based Clearinghouse, Familias Unidas, see sections on Program Delivery; Manuals and Training; and Implementation Information
[631] Prevention Services, Familias Unidas, see section on Program or Service Delivery and Implementation
[632] Prevention Services, Familias Unidas, see section on Program or Service Delivery and Implementation
[633] The California Evidence-Based Clearinghouse, Familias Unidas, see section on Scientific Rating
[634] The California Evidence-Based Clearinghouse, Familias Unidas, see section on Scientific Rating
[635] OJJDP Model Programs
[636] National Institute of Justice, Familias Unidas
[637] CDC, Familias Unidas
[638] SAMHSA
[639] Blueprints for Healthy Youth Development, Familias Unidas, see section on Endorsements
[640] The California Evidence-Based Clearinghouse, Familias Unidas, see section on Relevant, Published Peer-Reviewed Research

Medical Doctor/Doctor of Osteopathy,[641] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[642]

Familias Unidas[643]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[644]**
Psychotherapy	90847	Family psychotherapy (with patient present), 50 minutes	Weekly 1-hour family session with adolescent	Yes
	90849	Multiple-family group psychotherapy	Weekly 2-hour parent group session	Yes

vii. Potential Medi-Cal non-reimbursable services

Familias Unidas[645]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

B. Resourceful Adolescent Program – Adolescent (RAP-A)[646]

Included within CYBHI EBP grant program

[641] Specialty Mental Health Services Medi-Cal Billing Manual
[642] Non-Specialty Mental Health Services (NSMHS), DHCS
[643] Analysis by Manatt Health from Jan 2022 to Feb 2023
[644] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[645] Analysis by Manatt Health from Jan 2022 to Feb 2023
[646] All information contained in the Resourceful Adolescent Program - Adolescent sections comes from publicly available sources. Please refer to each section for specific source details.

i. California Evidence-Based Clearinghouse Designation[647]

1 – Well-Supported by Research Evidence

ii. Population of focus

RAP-A is a universal resilience-building program for youth (ages 11-15 years).[648]

Studies on the RAP-A program have previously demonstrated its effectiveness with youths from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[649]

RAP-A is school-based resilience-building intervention designed to prevent depression and related behavioral health concerns among adolescents. This program is built on cognitive-behavioral principles and aims to enhance protective factors while reducing risk factors associated with behavioral health.

By drawing on the metaphor in the children's story the "Three Little Pigs," students develop their own "RAP-A house" by laying down different personal resource bricks (e.g., Personal Strength Bricks, Keeping Calm Bricks, Problem Solving Bricks). Cognitive-behavioral components provide techniques for keeping calm, cognitive restructuring, and problem solving, while interpersonal components stress the importance of promoting harmony and dealing with conflict and role disputes by developing an understanding of others' perspectives.

The program traditionally consists of 6-11 weekly group sessions (8- 16 students per group) in a school setting, with each session lasting approximately 50 minutes. It is usually run as an integral part of the school curriculum during class time. Sessions are focused on seven major areas:[650]

- The recognition and affirmation of existing strengths and resources
- Promoting self-management and self-regulation skills in the face of stress
- Cognitive restructuring
- Creating a personal problem-solving model
- Building and accessing psychological support networks
- Considering the other's perspective

[647] The California Evidence-Based Clearinghouse, RAP-A, see section on Scientific Rating
[648] The California Evidence-Based Clearinghouse, RAP-A, see section on About This Program
[649] The California Evidence-Based Clearinghouse, RAP-A, see sections on Program Overview; Program Goals; Essential Components; and Implementation Information
[650] Queensland University of Technology, RAP-A

- Keeping and making the peace

The RAP-A program was developed to meet the need for a universal resilience building program for teenagers that could be readily implemented in a school setting. It is also complemented by a parent program (RAP-P) which supports parents in establishing healthy home environments.

iv. Care delivery setting and provider qualifications

The RAP-A program is typically conducted in a community daily living setting, outpatient clinic, group or residential care, justice setting, or school setting.[651]

Facilitators of RAP-A, termed as group leaders, are recommended to have a tertiary degree and may be educational or mental health workers with specific training in RAP-A.[652] Providers who may function as group leaders include the following: psychologists, social workers, occupational therapists, psychiatrist, mental health nurses, school counselors, guidance officers, chaplains, teachers, community health workers.[653]

According to the program, training is a single full-day program, with additional training days available for those interested in adaptations (e.g., RAP-Parents, RAP-Parents Indigenous). While on-site training mainly takes place in Australia, international participants can access the program via video conferencing.[654]

v. Summary of evidence from literature on program efficacy / impact

The RAP-A program is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[655] It is recognized by the California Evidence-based Clearinghouse for Child Welfare.[656]

Evidence suggests lower levels of depressive symptomatology and hopelessness, reductions in anxiety and depression, and changes in self-esteem and coping skills.[657]

vi. Potential Medi-Cal covered benefits/services

N/A - services provided through RAP-A are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply.

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[651] The California Evidence-Based Clearinghouse, RAP-A, see sections on Program Delivery; Manuals and Training; and Implementation Information
[652] The California Evidence-Based Clearinghouse, RAP-A, see sections on Program Delivery; Manuals and Training; and Implementation Information
[653] The California Evidence-Based Clearinghouse, RAP-A, see sections on Program Delivery; Manuals and Training; and Implementation Information
[654] Resource Adolescent Program - Training
[655] The California Evidence-Based Clearinghouse, RAP-A, see section on Scientific Rating
[656] The California Evidence-Based Clearinghouse, RAP-A, see section on Scientific Rating
[657] The California Evidence-Based Clearinghouse, RAP-A, see section on Relevant, Published Peer-Reviewed Research

vii. Potential Medi-Cal non-reimbursable services

Resourceful Adolescent Program - Adolescent[658]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
School curriculum	Weekly ~50-minute group session during school class time	Session may not be reimbursable if it does not meet the minimum duration of service required under a CPT/HCPCS code Only part of the session (not full session) may be reimbursable if session exceeds maximum service duration under a CPT/HCPCS code depending on the need
Wraparound services	Housing support services, nutritional program	N/A

C. Residential Student Assistance Program (RSAP)[659]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[660]

3 – Promising Research Evidence

ii. Population of focus

The RSAP program serves adolescents (ages 12-18 years) living in residential facilities (e.g., foster care locations, psychiatric residences, correctional settings), many of whom have been previously neglected or abused and have experienced behavioral health challenges.[661] Youth involved in RSAP generally have a history of early substance use and/or have a parent with a substance use disorder.

Studies on the RSAP program have previously demonstrated its effectiveness with youths from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

[658] Analysis by Manatt Health from Jan 2022 to Feb 2023
[659] All information contained in the Residential Student Assistance Program sections comes from publicly available sources. Please refer to each section for specific source details.
[660] The California Evidence-Based Clearinghouse, RSAP, see section on Scientific Rating
[661] The California Evidence-Based Clearinghouse, RSAP, see section on About This Program

iii. Program description[662]

RSAP is an intervention program designed to address substance use among adolescents in residential settings. Implemented by trained substance use specialists, the program is designed to address the unique needs of the adolescent residential facility population. Components of RSAP include:

- Screening – residents are screened for personal and/or family problems resulting from substance use as well as other risk factors for substance use.
- Prevention Education Series – a 6-8 session Alcohol, Tobacco and Other Drug prevention interactive curriculum that consists of four topics and can be conducted once a week or on multiple days per week.
- Individual and group counseling – time-limited individual sessions and/or group counseling to residents following participation in the Prevention Education Series.
- Referral – residents who require treatment for a substance use disorder or other services are referred to appropriate agencies or practitioners.
- Facility Wide Awareness Activities – activities to raise awareness and change the norms (e.g., contests, bulletin boards, guest speakers).

An adolescent can participate in up to two times a week for a combination of activities, which includes screening, individual or group counseling, and Prevention Education Series. The initial screening typically lasts 15 minutes, while individual or group counseling sessions and prevention education series classes typically last 45 minutes.

The goal of the program is to prevent substance use initiation and reduce the frequency and quantity of use among adolescents in residential childcare facilities due to committing delinquent acts, being neglected or abused, experiencing chronic school problems, and/or having mental health and other behavioral health problems.

iv. Care delivery setting and provider qualifications

The RSAP program is typically conducted in a group or residential care, justice setting, or school setting.[663]

The program is delivered by trained substance abuse prevention specialists called Student Assistance Counselors (SAC), where the SAC ideally has a master's degree in social work, psychology, counseling, or a related discipline, though a bachelor's

[662] The California Evidence-Based Clearinghouse, RSAP, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery
[663] The California Evidence-Based Clearinghouse, RSAP, see sections on Program Delivery; Manuals and Training; and Implementation Information

degree is acceptable.[664] Knowledge of child and adolescent development, cultural competency, and experience working with youth are required.[665]

v. Summary of evidence from literature on program efficacy / impact

The RSAP program is considered "well-supported" through RCTs and peer-reviewed literature with sustained effects 1-year post-intervention.[666] It is recognized by the California Evidence-based Clearinghouse for Child Welfare[667] and National Institute of Justice Crime Solutions.[668]

Evidence on RSAP suggests a reduction in marijuana and tobacco use, demonstrating effectiveness both as a prevention program for nonusers and as an early intervention program for users.[669]

vi. Potential Medi-Cal covered benefits/services

N/A - services provided through RSAP are currently not reimbursable through Medi-Cal. No CPT/HCPCS codes apply.

vii. Potential Medi-Cal non-reimbursable services

Residential Student Assistance Program [670]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Counseling	45-minute individual or group counseling	N/A
Implementation	Hiring and training staff	N/A
Prevention	45-minute Prevention Education Series session	N/A
Screening	Initial screening for personal and/or family problems resulting from substance use	N/A

[664] The California Evidence-Based Clearinghouse, RSAP, see sections on Program Delivery; Manuals and Training; and Implementation Information
[665] The California Evidence-Based Clearinghouse, RSAP, see sections on Program Delivery; Manuals and Training; and Implementation Information
[666] The California Evidence-Based Clearinghouse, RSAP, see section on Scientific Rating
[667] The California Evidence-Based Clearinghouse, RSAP, see section on Scientific Rating
[668] National Institute of Justice, RSAP
[669] The California Evidence-Based Clearinghouse, RSAP, see section on Relevant, Published Peer-Reviewed Research
[670] Analysis by Manatt Health from Jan 2022 to Feb 2023

Wraparound services	Housing support services, nutritional program	N/A

D. Blues Program[671]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[672]

2 –Supported by Research Evidence

ii. Population of focus

The Blues Program is a manualized cognitive-behavioral prevention intervention for high school-aged youth grades 8th-12th (ages 13-19 years) experiencing depressive symptoms (e.g., low mood, loss of interest, negative thoughts, and decreased self-esteem).[673]

Studies on the Blues Program have previously demonstrated effectiveness with youth from various races/ethnicities (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[674]

The Blues Program is a school-based, group intervention program designed to reduce current depressive symptoms and prevent the future onset of major depressive disorders and use of alcohol and illicit substances. It focuses on teaching coping strategies for stress and negative life events, thereby promoting overall mental health and resilience. Since the Blues Program emphasizes depression prevention rather than treatment, adolescents are screened for major depression or suicidal ideation before they participate. If these concerns are present, a referral for appropriate treatment is recommended.

Group sessions consist of 6 weekly, 1-hour sessions with ~4-7 adolescents. Sessions focus on learning and practicing cognitive restructuring techniques, enabling rapport building, and encouraging active engagement in activities. The start of the session begins with a review of concepts and home practice assignments and ends with a homework assignment. The assigned homework reinforces learnings and skills

[671] All information contained in the Blues Program sections comes from publicly available sources. Please refer to each section for specific source details.
[672] The California Evidence-Based Clearinghouse, Blues Program, see section on Scientific Rating
[673] The California Evidence-Based Clearinghouse, Blues Program, see section on About This Program
[674] The California Evidence-Based Clearinghouse, Blues Program, see sections on Program Overview; Program Goals; Essential Components; and Program Delivery; Blues Program – About Blues

developed in the sessions, and guides participants on how to apply their newly acquired techniques to real-world situations.

iv. Care delivery setting and provider qualifications

The Blues Program is typically conducted in a school setting.[675]

The Blues Program sessions are by 1-2 facilitators from a variety of backgrounds with varying levels of clinical training.[676] Additionally, it is recommended that at least one group leader has a Master's level degree in a mental-health related discipline and facilitators who do not have the equivalent of Master's-level training in a behavioral health discipline are strongly encouraged to have support and clinical supervision when delivering treatment.

According to the program, training for facilitators includes an 8-hour initial course, typically split over two half-days, available in both group and virtual formats.[677] During the training, participants learn cognitive-behavioral strategies and practical implementation techniques. Facilitators seeking certification submit session recordings for evaluation. Additionally, advanced training is available for those aspiring to become Trainers of Trainers, which involves further observation and assessment to ensure adherence to program standards.

v. Summary of evidence from literature on program efficacy / impact

The Blues Program is considered "supported" through RCTs and peer-reviewed literature with sustained effects 1 year post intervention.[678] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare,[679] and the Blueprints for Healthy Youth Development has also rated the Blues Program as 'Model'.[680]

Evidence suggests reductions in depressive symptoms, reductions in substance use, improvements in social adjustment, and increases in perceived friend social support.[681]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

[675] The California Evidence-Based Clearinghouse, Blues Program, see sections on Program Delivery; Manuals and Training; and Implementation Information
[676] The California Evidence-Based Clearinghouse, Blues Program, see sections on Program Delivery; Manuals and Training; and Implementation Information
[677] Blues Program - Training
[678] The California Evidence-Based Clearinghouse, Blues Program, see section on Scientific Rating
[679] The California Evidence-Based Clearinghouse, Blues Program, see section on Scientific Rating
[680] Blueprints for Healthy Youth Development, Blues Program
[681] The California Evidence-Based Clearinghouse, Blues Program, see section on Relevant, Published Peer-Reviewed Research

Eligible providers may use the below CPT/HCPCS codes to reimburse Blues Program services if they are one of the following provider types: Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[682] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[683]

Blues Program[684]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[685]**
Psychotherapy	90853	Group psychotherapy	Weekly group session with other students	Yes

vii. Potential Medi-Cal non-reimbursable services

Blues Program[686]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

[682] Specialty Mental Health Services Medi-Cal Billing Manual
[683] Non-Specialty Mental Health Services (NSMHS), DHCS
[684] Analysis by Manatt Health from Jan 2022 to Feb 2023
[685] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[686] Analysis by Manatt Health from Jan 2022 to Feb 2023

E. Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA)[687]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation[688]

3 – Promising Research Evidence

ii. Population of focus

CIFFTA is a multi-component treatment for adolescents (ages 11-18 years) and their family/caregivers.[689]

Studies on the CIFFTA program have demonstrated its effectiveness with youths and their families from a range of racial and ethnic backgrounds (See Section on Relevant, Published Peer-Reviewed Research on the CEBC website).

iii. Program description[690]

CIFFTA is a family-centered therapy that adapts to individual needs through flexible decision-rules and integrates culture-related content (e.g., addressing discrimination, acculturation, immigration-related stress). The treatment relies on an adaptive and flexible modular design that can be tailored to the unique experiences and needs of diverse adolescents (e.g., race, ethnicity, LGBTQIA+). The CIFFTA program aims to address disruptive behaviors, reduce substance use and risky sexual behaviors, improve mood and anxiety symptoms, address race/ethnicity-related stressors (e.g., immigration and acculturation), and mitigate adverse impact of justice involvement.

The CIFFTA program is delivered as a mix of individual treatment, family treatment, and psychoeducational components. Adolescent therapy works with one adolescent at a time and focuses on motivational interviewing, goal setting in multiple domains, generalization of skills learning in psychoeducational modules, coaching to increase success of interactions, and monitoring of harmful behaviors. Family therapy works with one family at a time and focuses on engaging family members, increasing family motivation to enter treatment, instilling hope and validating distress/stressors, buffering race/ethnicity-related concerns, repairing ruptured relationships, reunifying separated family members, increasing protective/supportive interactions, reducing

[687] All information contained in the Culturally Informed and Flexible Family-Based Treatment for Adolescent sections comes from publicly available sources. Please refer to each section for specific source details.
[688] The California Evidence-Based Clearinghouse, CIFFTA, see section on Scientific Rating
[689] The California Evidence-Based Clearinghouse, CIFFTA, see section on About This Program
[690] The California Evidence-Based Clearinghouse, CIFFTA; see sections on Program Overview; Program Goals; Essential Components; and Implementation Information; University of Miami, CIFFTA

risky and harmful interactions, and generalizing skills learning in psychoeducational modules.

Treatment is typically 1-2 sessions per week over the course of 12–24-weeks and involves a mix of individual and family sessions, some of which are therapy and some of which are psychoeducational. Sessions may also include outside systems (e.g., health, school, juvenile justice, child welfare) as needed.

iv. Care delivery setting and provider qualifications

The CIFFTA program is typically delivered in a birth family home, outpatient clinic, or community-based agency/organization/provider.[691]

Providers are Master's-level counselors trained in Social Work, Counseling, Psychology, or a related field.[692] Online and in-person training/coaching is available for the CIFFTA program. The first initial training is conducted through an online adaptive platform featuring simulated clients, quizzes, and skill practice, requiring 15-20 hours depending on the participants experience. Next, an in-person session is completed for advanced coaching and organizational readiness, which ranges from 20-50 hours, tailored to the facilitator's skill level.

v. Summary of evidence from literature on program efficacy / impact

The CIFFTA program is considered "promising research evidence" through RCTs and peer-reviewed literature.[693] It has been recognized by the California Evidence-based Clearinghouse for Child Welfare[694]**[693]** and is also accepted in SAMHSA's National Registry for Evidence Based Programs and Practices (NREPP).[695]

Studies on the CIFFTA program suggests a decrease in substance use behaviors, improvement in parental practices, improvement in distressing psychiatric symptoms, and a decrease in behavior and conduct challenges. [696]

vi. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse CIFFTA services if they are one of the following provider types: Clinical Nurse Specialist, Medical

[691] The California Evidence-Based Clearinghouse, CIFFTA, see sections on Program Delivery; Manuals and Training; and Implementation Information
[692] The California Evidence-Based Clearinghouse, CIFFTA, see sections on Program Delivery; Manuals and Training; and Implementation Information
[693] The California Evidence-Based Clearinghouse, CIFFTA, see section on Scientific Rating
[694] Strong African American Families Program (SAAF)
[695] SAMHSA
[696] The California Evidence-Based Clearinghouse, CIFFTA, see section on Relevant, Published Peer-Reviewed Research

Doctor/Doctor of Osteopathy,[697] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[698]

Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA)[699]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[700]**
Psychotherapy	90832	Psychotherapy with patient, 30 minutes	Weekly individual adolescent therapy session	Yes
	90834	Psychotherapy with patient, 45 minutes		Yes
	90837	Psychotherapy with patient, 60 minutes		Yes
	90839	Psychotherapy for crisis, first 60 minutes		Yes
	90847	Family psychotherapy (with patient present), 50 minutes	Weekly family therapy session with adolescent	Yes

vii. Potential Medi-Cal non-reimbursable services

Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA)[701]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Wraparound services	Housing support services, nutritional program	N/A

[697] Specialty Mental Health Services Medi-Cal Billing Manual
[698] Non-Specialty Mental Health Services (NSMHS), DHCS
[699] Analysis by Manatt Health from Jan 2022 to Feb 2023
[700] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[701] Analysis by Manatt Health from Jan 2022 to Feb 2023

Implementation	Hiring and training staff	N/A

F. Coordinated Specialty Care (CSC)[702]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight.

ii. Population of focus

CSC primarily serves adolescents and youth adults, typically 15-25 years of age, with first-episode psychosis (FEP).[703]

The program has been applied in rural settings[704] and to youth from various racial and ethnic backgrounds.[705]

iii. Program description[706]

CSC is a recovery-focused treatment program designed for individuals experiencing their first episode of psychosis or those with serious mental illness (SMI). It emphasizes shared decision-making and involves a multidisciplinary team who collaborate with the individual to develop a personalized treatment plan. This approach is highly collaborative, involving not just the client, but also treatment team members and, when appropriate, family members, making them active participants in the treatment process.

Treatment is typically administered by a team of 4-6 clinicians who maintain a shared caseload of 30-35 patients. The duration of treatment can vary, with some programs averaging ~2 years. Some Medicaid programs may have qualifications on how many SMI patients a team can have in a caseload. The core services typically offered in CSC programs include:

1) Psychotherapy: Evidence-based cognitive or behavioral therapies to help individuals manage and reduce their symptoms. Health professionals (e.g.,

[702] All information contained in the Coordinated Specialty Care sections comes from publicly available sources. Please refer to each section for specific source details.
[703] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care
[704] Implementation and Fidelity Assessment of the NAVIGATE Treatment Program for First Episode Psychosis in a Multi-site Study
[705] Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes
[706] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care; SAMHSA - Coordinated Specialty Care for First Episode Psychosis

psychologists, social workers, mental health counselors, and rehabilitation counselors) often administer this service.

2) Medication Management: Prescription and ongoing monitoring of medications to ensure effective medication regimens for each person. Psychiatrists and nurse practitioners are primarily responsible for pharmacotherapy and coordination with primary healthcare.

3) Family Education and Support: Outreach and educational efforts to help families support their loved ones with FEP. With the individual's consent, family members are involved in the treatment process to create a supportive home environment that promotes recovery.

4) Service Coordination and Case Management: Effective coordination with other medical and behavioral health to ensure that individuals have access to a wide range of services (e.g., medical care, social support, educational opportunities). Case managers can assist in navigating these services, reducing barriers to access.

5) Supported Employment and Education: Educational and vocational support that includes skill-building activities, educational coaching, tutoring, and assistance with job search and applications.

iv. Care delivery setting and provider qualifications

CSC programs are typically delivered in community mental health-care settings or early intervention specialty clinics.[707]

Treatment is administered by a team of specialists (e.g., program director, prescriber, individual resiliency trainer, family education clinician, supported employment and education specialist, case manager) with a variety of training.[708]

v. Summary of evidence from literature on program efficacy / impact

CSC programs have demonstrated effectiveness across multiple trials, including a meta-analysis which found that "in early psychosis, CSC is superior to [treatment as usual] across all meta-analyzable, highly relevant outcomes with small-to-medium effect sizes."[709]

[707] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care
[708] NAVIGATE; A New Method for Estimating Incidence of First Psychotic Diagnosis in a Medicaid Population
[709] Effectiveness of Coordinated Specialty Care for Early Psychosis

One randomized control study found that recipients of NAVIGATE, a CSC program, remained in treatment longer, experienced greater improvement in quality of life and psychopathology, and experienced greater involvement in work and school.[710]

vi. Medi-Cal or related policies under which an EBP could be reimbursed

CalBH-CBC – CalBH-CBC demonstration waiver includes establishing a county option to enhance community-based services through coverage of specific EBPs, including CSC, particularly for justice-involved or homeless individuals[711]

vii. Potential Medi-Cal covered benefits/services

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse CSC services if they are one of the following provider types: Community-based ECM providers,[712] Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy,[713] Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), or psychiatrist.[714]

Coordinated Specialty Care (CSC)[715]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[716]**
Enhanced care management	T1016	Case management, per 15 minutes	Case management	No
Psychotherapy	90837	Psychotherapy with patient, 60 minutes	Individual cognitive and behavioral psychotherapy session	Yes

[710] Comprehensive Versus Usual Community Care for First Episode Psychosis: Two-Year Outcomes from The NIMH RAISE Early Treatment Program
[711] CalBH-CBC waiver
[712] ECM Policy Guide, DHCS
[713] Specialty Mental Health Services Medi-Cal Billing Manual
[714] Non-Specialty Mental Health Services (NSMHS), DHCS
[715] Coordinated Specialty Care for First Episode Psychosis: Costs and Financing Strategies, SAMHSA
[716] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.

	90846	Family psychotherapy (with patient present), 50 minutes	Family cognitive and behavioral psychotherapy session	No
	90853	Group therapy, 90 minutes	Group cognitive and behavioral psychotherapy session	Yes
Peer Support	H0038	Peer support services	Family education and support (e.g., workshops, support groups)	Yes *(only if delivered through SMHS)*

viii. Potential Medi-Cal non-reimbursable services

Coordinated Specialty Care (CSC)[717]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Education and employment support	Facilitation of client's return to work/school	N/A
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

G. Youth Mobile Crisis Response[718]

Included within CYBHI EBP grant program

i. California Evidence-Based Clearinghouse Designation

Not rated – see "Summary of evidence from literature on program efficacy / impact" for additional detail on scientific weight.

ii. Population of focus

[717] Analysis by Manatt Health from Jan 2022 to Feb 2023
[718] All information contained in the Youth Mobile Crisis sections comes from publicly available sources. Please refer to each section for specific source details.

Youth Mobile Crisis Response is a community-based intervention for youth who are experiencing a traumatic event, mental health symptoms, and/or behavioral health crisis.[719]

According to the Center for Law and Social Policy, youth mobile crisis services may reduce unnecessary arrests and promote better outcomes in Black youth through offering immediate, trauma informed mental health services.[720]

iii. Program description[721]

Youth Mobile Crisis services provide immediate, on-site intervention for young individuals experiencing acute behavioral health crises. Serving children and adolescents up to 18 years old, and sometimes extending to young adults, mobile crisis services are designed to address crises in community settings, such as homes and schools, rather than through hospital emergency rooms. This approach ensures rapid response and stabilization, with the goal to alleviate the immediate crisis and prevent future crises.

Youth Mobile Crisis services aim to avoid unnecessary hospitalization by resolving crises in the least restrictive environment possible. By stabilizing the youth's condition and ensuring safety, these services help reduce the burden on emergency medical facilities and prevent the youth from becoming involved with law enforcement. Additionally, these services provide essential support to schools by intervening in crises directly on-site, where educators often lack the specialized training to handle such situations. This intervention helps maintain a safe and supportive educational environment, ensuring that students receive the immediate care they need while minimizing disruption to the school setting.

The multidisciplinary teams involved in Youth Mobile Crisis services typically include mental health professionals such as social workers, counselors, peer specialists, psychiatrists, and sometimes nurses. Peer specialists play an important role in youth mobile crisis services by offering relatable support and understanding from their own lived experiences with behavioral health challenges. They engage with youth in a non-judgmental and empathetic manner, fostering trust and rapport quickly. By sharing their own recovery journeys, peer specialists provide hope and model coping strategies.

In addition to crisis intervention, these services include support through counseling and resource provision, helping families and youth better manage behavioral health

[719] SAMHSA Advisory Peer Support in Crisis Care
[720] Youth Mobile Response Services: An Investment to Decriminalize Mental Health
[721] SAMHSA Advisory Peer Support in Crisis Care; Mobile Crisis BHIN; SAMHSA - National Guidelines for Child and Youth Behavioral Health Crisis Care

challenges. They also develop individualized crisis plans that outline coping strategies and preventive measures, reducing the likelihood of future crises. Through these services, Youth Mobile Crisis services not only address the immediate crisis but also build a foundation for ongoing mental health stability and well-being for youth and their families.

iv. Care delivery setting and provider qualifications

Where available, youth-focused peer crisis response is deployed to the location of the youth in crisis (e.g., home, school). Several initial outreach options are available for those experiencing crises (e.g., 988 hotline and text messaging).[722]

The mobile crisis workforce includes licensed mental health or substance use professionals, peers, community health workers, care coordinators, dispatchers, and others (see BHIN 23-023 for more detail). [723] Peer support training in CA varies by county, with training ranging up to 12 weeks and requiring a certification upon completion of the curriculum (e.g., safety and crisis planning, service navigation and referrals, documentation skills and standards) [724]Additional training programs, curricula, and more, are required of other members of the Mobile Crisis Team.

v. Summary of evidence from literature on program efficacy / impact

Mobile crisis care is effective in providing relief to those in crisis, meeting people where they are most comfortable, and avoiding potential unnecessary law enforcement involvement, emergency department (ED) use, and hospitalization.[725]

There is growing literature to suggest that peer specialists in mobile crisis teams may help to: [726]

- Create trust in the community and enhance the therapeutic experience with knowledge that people with different lived experience cannot replicate.
- Facilitate timely and effective treatment that can reduce subsequent use of crisis and emergency department services.

There is limited evidence comparing Youth Mobile Crisis Response teams with peers versus without peers.

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[722] SAMHSA - National Guidelines for Child and Youth Behavioral Health Crisis Care
[723] BHIN 23-023
[724] SAMHSA National Guidelines for Behavioral Health Crisis Care; BHIN 21-041
[725] BHIN 22-064; SAMHSA National Guidelines for Behavioral Health Crisis Care; SAMHSA Guidelines for Crisis Care; Journal of Psychosocial Nursing
[726] SAMHSA Advisory Peer Support in Crisis Care; Mobile Crisis BHIN

vi. Potential Medi-Cal covered benefits/services[727]

Medi-Cal FFS and MCPs

Eligible providers may use the below CPT/HCPCS codes to reimburse Youth Mobile Crisis Response services if they are one of the following provider types: qualified mobile crisis team member (see BHIN 23-023 for more detail).[728]

Youth Mobile Crisis Response[729]				
Service components of the model	**CPT/HCPCS code (see appendix linked for more info)**	**CPT/HCPCS code description**	**Illustrative services provided**	**CPT/HCPCS code can potentially be used to bill for SMHS (Yes/No)[730]**
Mobile Crisis	H2011 (with Place of Service 15)	Mobile Crisis, per encounter	Mobile crisis intervention services	No

vii. Potential Medi-Cal non-reimbursable services

Youth Mobile Crisis Response [731]		
Service components of the model	**Illustrative services provided**	**Additional notes where applicable**
Implementation	Hiring and training staff	N/A
Wraparound services	Housing support services, nutritional program	N/A

[727] Analysis by Manatt Health from Jan 2022 to Feb 2023
[728] BHIN 23-023
[729] Analysis by Manatt Health from Jan 2022 to Feb 2023
[730] NSMHS are services provided to Medi-Cal members with mild to moderate mental health conditions. SMHS are services provided to Medi-Cal members with serious mental illness (SMI). Some CPT/HCPCS billing codes used for NSMHS may also apply to SMHS, but additional analysis is needed to confirm applicability. For more details, see the SMHS Medi-Cal Billing Manual and Medi-Cal Behavioral Health Fee Schedules for SMHS.
[731] Analysis by Manatt Health from Jan 2022 to Feb 2023

Chapter 10: Overview of CDEPs and reimbursement considerations

A. Introduction to CDEPs

Community defined evidence practices (CDEPs) are community-based interventions designed to meet the cultural, social, and linguistic needs of diverse populations. Unlike traditional evidence-based practices, which are often developed and validated in controlled research settings, CDEPs rely on the active participation and voices of local community members.[732] The California Reducing Health Disparities Project (CRDP) aims to reduce health disparities across California through scaling culturally competent care with CDEPs.[733].. In this vein, CRDP supports the evaluation of CDEPs through rigorously assessing these practices to ensure their effectiveness and cultural relevance.

For example, findings from the CRDP Phase II Statewide Evaluation report suggest that CDEPs were effective in reducing psychological distress and improving mental health outcomes among children and adolescents, particularly those with the highest levels of need.[734] Additionally, this report states significant improvements in protective factors and social connectedness among adolescent participants. For more information on the CDEPs evaluated, please refer to Chapter 6 of the CRDP Statewide Evaluation Report.

i. CDEP principles

CDEPs are grounded in several core principles that distinguish them from traditional evidence-based practices, including:[735]

1) Cultural Relevance: CDEPs design interventions that align with the cultural beliefs, values, and practices of the supported population. This includes incorporating cultural symbols, rituals, storytelling, and traditions into therapy. For example, The Gathering of Native Americans (GONA) intervention integrates traditional healing rituals and storytelling into behavioral health interventions.[736]

2) Community Involvement: CDEPs recognize community members as experts in their culture and actively involve them in designing, implementing, and evaluating behavioral health interventions. For example, Latino Service Providers offers Latinx

[732] California Pan-Ethnic Health Network
[733] Culture is Health – Evaluation framework
[734] The California Reducing Disparities Project Phase II, see Chapter 3 Implementation Pilot Projects
[735] Culture is Health - Statewide Evaluation Report Executive Summary
[736] Culture is Health – Gathering of Native Americans

youth (ages 16-25 years) opportunities to present mental health education and resources through community events and discussions known as pláticas.[737]

3) Holistic Approach: CDEPs emphasize the interconnectedness of physical, mental, emotional, and spiritual health. Interventions integrate traditional healing practices with conventional behavioral health treatments to provide whole person care. For example, The Native American Drum, Dance, and Regalia (NADDAR) program uses traditional healing practices such as drumming, dance, and wearing regalia to promote emotional, physical, and spiritual well-being by fostering cultural connection and community bonding.[738]

Grounded in these principles, CDEPs offer a range of services that are tailored to the needs of their community. Their offerings include psychotherapy (e.g., individual, group, and family psychotherapy); substance use and prevention services (e.g., screening, assessment, and counseling); assessment and screening services (e.g., emotional and behavioral health, developmental screening); case management (e.g., community-based wrap-around services, case management/coordinated care, referrals for additional services); peer and community support services; as well as non-traditional forms of therapy (e.g., art. music, equine).[739]

ii. Care delivery setting and provider qualifications

To ensure accessibility, CDEPs are offered through various settings. According to the CRDP Statewide Evaluation report, CDEPs are frequently implemented in:[740]

a) Community centers: Deliver services through community centers and organizations that function as central hubs within the community.

b) Healthcare facilities: Embed CDEPs within hospitals, clinics, and primary care offices to offer a holistic approach to patient care by addressing both mental and physical health needs.

c) Religious and faith-based institutions: Implement CDEPs within trusted community faith-based institutions.

d) Schools: Provide on-site counseling, peer support, and crisis intervention within educational environments.

Providers delivering CDEP services often share similar characteristics of the communities they serve (e.g., racial, ethnic, religious backgrounds) and use their lived

[737] Culture is Health – Latino Service Providers
[738] Culture is Health, Native American Drum, Dance, and Regalia
[739] California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities
[740] Culture is Health - Statewide Evaluation Report Executive Summary, see section on Mental Health Access

experiences to provide care that is culturally responsive and relevant.[741] These providers represent both licensed practitioners and those without traditional medical or behavioral health licenses (e.g., peer specialists, community health workers, trained facilitators, promotoras, and traditional healers).[742] Taken together, these professionals act as important connectors between formal healthcare services and the unique community needs.

B. Establishing Reimbursement Pathways for CDEPs

There is growing acknowledgment that CDEPs are important in addressing the unique mental health needs of diverse populations.[743] In response to this growing recognition, efforts are underway to develop standardized criteria for CDEPs, improve documentation and coding for billing, and create dedicated funding streams for culturally competent care.[744]

Several service components of CDEPs may align with recognized categories of mental health and substance use disorder treatments under Medi-Cal (refer to Chapter 2, Section B in this document for billing considerations), making them potentially eligible for reimbursement in the future. These service components may include:

Potential reimbursable components of CDEPs		
Service components of the model	**Illustrative services provided**	**Illustrative CDEP**[745]
Peer-led services	Individual, group, and family sessions led by peers, where participants share experiences and support each other in a culturally relevant context	Shifa for Today Peer Services is a culturally tailored mental health support program designed for Muslim communities where trained peer supporters offer emotional support, practical advice, and coping strategies[746]
Psychoeducation	Culturally tailored behavioral health education that integrates traditional practices to improve mental health	The Cambodian American Association offers culturally tailored psychoeducation services, including mental health awareness, stress

[741] The California Reducing Disparities Project Phase II, see Chapter 3.4.E
[742] California Pan-Ethnic Health Network
[743] Policy options for Community-Defined Evidence Projects
[744] CPEHN - Strategic Plan to Reduce Mental Health Disparities
[745] This is a non-exhaustive list of CDEPs and their service offerings; other CDEPs within the CRDP may provide comparable services.
[746] Shifa for Today

	literacy, reduce stigma, and enhance coping skills	management, substance use prevention, and cultural resilience workshops[747]
Parenting support services	Educational and supportive services to help parents improve parenting skills, enhance family relationships, and address specific cultural challenges	The Essence of MANA Program promotes wellness among Pacific Islanders in North San Mateo County through offering 12-week parenting workshops to address topics like domestic violence, substance abuse, and behavioral health[748]
Psychotherapy	Individual, group, or family therapy that incorporates traditional practices, cultural beliefs, attitudes, and values	Humanidad Therapy offers culturally responsive psychotherapy services, including individual, family, couples, group, and mindfulness-based therapies for children and families from Latinx backgrounds[749]
Trauma-informed services	Prevention and early intervention programs designed to address and treat the psychological effects of trauma through culturally-based strategies	Safe Passages offers a range of trauma-informed services designed to address the effects of chronic stress and trauma for African American youth (ages 16-21) involved in the justice system[750]
Case management/Care management	Case management and care management services that provide coordinated, culturally sensitive support tailored to the unique needs of diverse populations	Integrated Care Coordinators (ICC) Project enhances access to behavioral health services for Korean and Vietnamese communities through needs assessments, seamless connections to resources, culturally sensitive practices, and continuous care coordination[751]
Substance use treatment	Treatment programs (e.g., outpatient, residential) for substance use disorders that incorporate cultural practices	Friendship House operates three facilities, including an 80-bed adult residential substance abuse treatment program in San Francisco[752]
Wraparound care	Network of providers that offer comprehensive and	The Gender Health Center is a resource for trans-related needs, offering behavioral

[747] Culture is Health, The Cambodian American Association, see section on Approach to Programming
[748] Healthright360, Essence of MANA Program
[749] The California Reducing Disparities Project Phase II, see Chapter 3.6
[750] The California Reducing Disparities Project Phase II, see Chapter 3.6
[751] Culture is Health, Integrated Care Coordinators, see section on Approach to Program
[752] Culture is Health, Friendship House, see sections on About Us and Approach to Programming

	coordinated mental health and physical health care tailored to cultural needs	health services, healthcare navigation, and advocacy through culturally competent and affirmative care[753]
School-based mental health programs	Behavioral health services provided within schools, tailored to the cultural backgrounds of students	Integral Community Solutions Institute provides school-based mental health services for Latinx children, youth, and families affected by trauma, domestic violence, sexual assault, and human trafficking[754]
Home visiting programs	Home visiting services that focus on family well-being and preventing foster care placement	La Clinica de La Raza is a Latino-focused prevention & early intervention program in Alameda County that offers home-visiting services, consultation, and treatment support[755]

In contrast, certain services offered through CDEPs may not be reimbursable through Medi-Cal due to various factors including lack of standardization and non-recognition as direct medical or therapeutic interventions.[756] Services offered through CDEPs that might not be eligible for reimbursement include:[757]

Potential non-reimbursable components of CDEPs		
Service components of the model	**Illustrative services provided**	**Illustrative CDEP[758]**
Non-traditional therapy	Activity-based therapy (e.g., art, music, equine) aimed at improving physical and mental health	The Emanyatta Project provides Equine Assisted Psychotherapy that is designed to provide culturally specific behavioral health support to African American children and families[759]
Behavioral health outreach	Community events, educational workshops, and informational materials to educate communities about behavioral health services	GONA offers several community events (e.g., Family Fun, Native Youth Spring Series, Veterans Celebration) that focus on cultural engagement[760]

[753] Culture is Health, Gender Health Center, see section on Approach to Programming
[754] The California Reducing Disparities Project Phase II, see Chapter 3.6
[755] Culture is Health, La Clinical de La Raza, see sections on About Us and Current News
[756] Policy options for Community-Defined Evidence Projects
[757] Non-Specialty Mental Health Services: Psychiatric and Psychological Services
[758] This is a non-exhaustive list of CDEPs and their service offerings; other CDEPs within the CRDP may provide comparable services.
[759] The Village Project – see section on Current Services
[760] Culture is Health, GONA, see section on community events

Stress management services	Stress reduction techniques such as mindfulness, meditation, or relaxation exercises	The Sunnyside Mindfulness Club, through the Integral Community Solutions Institute, provides mindfulness education in schools and community mindfulness retreats[761]
Educational and vocational services	Academic and career support for individuals with behavioral health or substance use disorders	The Aunties and Uncles Program offers a nine-month Native Youth Internship program where youth develop leadership skills and engage with leadership in the community[762]

C. Illustrative CDEPs reimbursement potential

Below is a non-exhaustive review of four CDEPs recognized by the CRDP, illustrating the breadth of these programs and their potential eligibility for reimbursement.[763] For a complete list of the 36 CDEPs recognized by CRDP and the services offered, please refer to the California Reducing Health Disparities Project, Statewide Evaluation (Chapter 3.6; CDEP descriptions). Each program's eligibility for Medi-Cal reimbursement was determined by how its services aligned with established Medi-Cal reimbursement criteria.[764]

1. Experience Hope for Teens, Catholic Charities of East Bay[765]

Included as part of the CRDP Implementation Pilot Projects

i. Population of focus

Experience Hope for Teens is designed for African American youth (ages 11-14 years) and their families.[766]

ii. Program description[767]

Experience Hope for Teens program is a school-based intervention program designed for middle and high school African American students in Oakland and Richmond counties. The program offers psychotherapy (both individual and group), restorative practices, and consultation services to school professionals. The program's stated goals are to improve access to trauma-informed services, reduce students' trauma symptoms, and enhance schools' capacity for trauma-informed responses. This

[761] Culture is Health, Integral Community Solutions Institute
[762] Culture is Health, Aunties and Uncles Program, see section on Current news
[763] CDPH – see section on Implementation Pilot Project Contracts
[764] Non-Specialty Mental Health Services: Psychiatric and Psychological Services
[765] All information contained in the Experience Hope for Teens sections comes from publicly available sources. Please refer to each section for specific source details.
[766] Culture is Health, Experience Hope for Teens, see section on Groups Served
[767] Culture is Health, Experience Hope for Teens, see section on Approach to Programming

approach is stated to help interrupt the school-to-prison pipeline while promoting well-being, hope, and resilience among youth and families.[768]

iii. Program components potentially eligible for Medi-Cal reimbursement

The reimbursement potential for each service component of the Experience Hope for Teens program was based on its alignment with Medi-Cal's established criteria and guidelines.[769] For additional details on Medi-Cal reimbursable behavioral health services and Experience Hope for Teens service offerings, please refer to the DHCS website and the Experience Hope for Teens website.

Experience Hope for Teens[770]		
Service components of the model	**Service description**	**Potential for reimbursement[771]**
Psychotherapy	Individual counseling	May be eligible under Medi-Cal NSMHS psychotherapy services
	Group counseling	
Care management	Care management for families navigating the child welfare system	May be eligible under Medi-Cal NSMHS health behavioral assessment and intervention services and psychiatric collaborative care management services
Peer support	Group facilitation focusing on behavioral health and positive relationships	May be eligible under Medi-Cal Peer Support Services benefit
Psychoeducation	Educational workshops on behavioral health and wellness and restorative practices	May be eligible under Medi-Cal NSMHS dyadic psychoeducational services
Wraparound services	Crisis support, parenting classes, and therapy for families involved with the child welfare system	May be eligible under Medi-Cal NSMHS psychotherapy services

2. Aunties & Uncles Program, Sonoma County Indian Health Project, Inc[772]

[768] Culture is Health, Experience Hope for Teens, see section on Approach to Programming

[769] Non-Specialty Mental Health Services: Psychiatric and Psychological Services; Medi-Cal coverage for EPSDT

[770] Experience Hope for Teens

[771] Non-Specialty Mental Health Services: Psychiatric and Psychological Services; Medi-Cal Peer Support Services

[772] All information contained in the Aunties and Uncles Program sections comes from publicly available sources. Please refer to each section for specific source details.

Included as part of the CRDP Implementation Pilot Projects

i. Population of focus

Aunties and Uncles Program (AUP) is designed for Native American youth and young adults (ages 14-24 years) and their families.[773]

ii. Program description[774]

The Aunties and Uncles Program (AUP) is designed to reduce depression and suicide behaviors among Native American youth (ages 14-24 years). Through involving family members and organizing intergenerational cultural events, AUP aims to help youth build a supportive network and reduce behavioral health stigma in the community. The program uses "aunties and uncles" mentors (i.e., trained transition aged youth, tribal members, traditional medicine people, and elders), to deliver services including behavioral health education, cultural activities, and community resources. Further, AUP supports youth in accessing mental health services at the Sonoma County Indian Health Project, Inc., including individual psychotherapy, substance use counseling, and psychiatric treatment.

iii. Program components potentially eligible for Medi-Cal reimbursement

The reimbursement potential for each service component of the Aunties and Uncles Program was based on its alignment with Medi-Cal's established criteria and guidelines.[775] For additional details on Medi-Cal reimbursable behavioral health services and Aunties and Uncles Program offerings, please refer to the DHCS website and the Aunties and Uncles Program website.

Aunties & Uncles Program[776]		
Service components of the model	**Service description**	**Potential for reimbursement**[777]
Behavioral health outreach	Traditional and cultural events in schools and tribal communities	May not align with Medi-Cal NSMHS benefits
Peer support	Youth talking circle	May be eligible under Medi-Cal Peer Support Services benefit

[773] Culture is Health, Aunties and Uncles Program, see section on Approach to Programming
[774] Culture is Health, Aunties and Uncles Program, see section on Approach to Programming
[775] Non-Specialty Mental Health Services: Psychiatric and Psychological Services; Medi-Cal coverage for EPSDT
[776] Culture is Health, Aunties and Uncles Program, see section on Approach to Programming
[777] Non-Specialty Mental Health Services: Psychiatric and Psychological Services; Medi-Cal Peer Support Services

Psychoeducation	Suicide prevention education	May be eligible under Medi-Cal NSMHS dyadic psychoeducational services
	Traditional workshops	May not align with Medi-Cal NSMHS benefits
	Gathering of Native Americans (GONA) Workshops	May not align with Medi-Cal NSMHS benefits

3. Gender Health Center[778]

Included as part of the CRDP Implementation Pilot Projects

i. Population of focus

The Gender Health Center (GHC) is designed for Queer, Transgender, Black, Indigenous, and People of Color across all age groups.[779]

ii. Program description[780]

The GHC provides accessible and affirming healthcare services to transgender, nonbinary, and gender-nonconforming communities. The programs stated goals include creating a safe and supportive environment where individuals can access the care they need without fear of discrimination or bias. GHC aims to achieve these goals through integrating medical, behavioral health, and social services.

The program offers various services, including hormone replacement therapy, primary medical care, and psychotherapy. These services are designed to support individuals throughout their transition journey and beyond, addressing both physical and mental health needs. Additionally, GHC provides care management and advocacy to help individuals navigate the healthcare system and access necessary resources (e.g., assistance with insurance, legal documentation, referral to supportive services). The center also places a strong emphasis on community education, offering workshops and training sessions to increase awareness and understanding of transgender and gender-nonconforming issues.

iii. Program components potentially eligible for Medi-Cal reimbursement

The reimbursement potential for each service component of the Gender Health Center was based on its alignment with Medi-Cal's established criteria and

[778] All information contained in the Gender Health Center sections comes from publicly available sources. Please refer to each section for specific source details.
[779] Gender Health Center – Mission Statement
[780] Gender Health Center

guidelines.[781] For additional details on Medi-Cal reimbursable behavioral health services and Gender Health Center offerings, please refer to the DHCS and the Gender Health Center website.

Gender Health Center[782]		
Service components of the model	**Service description**	**Potential for reimbursement[783]**
Psychotherapy	Individual therapy	May be eligible under Medi-Cal NSMHS psychotherapy services
	Group therapy	
	Family therapy	
Care management	Healthcare navigation, enrollment assistance, access to affirming providers and hormones	May be eligible under Medi-Cal NSMHS health behavioral assessment and intervention services and psychiatric collaborative care management services
Letter Assessments	Letters from behavioral health professionals to document medical necessity for hormones or surgery	May not align with Medi-Cal NSMHS benefits
Advocacy	Support with grievances and appeals	May not align with Medi-Cal NSMHS benefits

4. Cultura y Bienestar, La Clinica de La Raza[784]

Included as part of the CRDP Implementation Pilot Projects

i. Population of focus

Cultura y Bienestar (CyB) is designed for the Latinx community, including children and youth, in Alameda County[785]

ii. Program description[786]

The CyB program provides prevention and early intervention services (e.g., outreach, education, consultation) to reduce stigma and enhance behavioral health awareness within Alameda County's Latinx community. Through fostering cultural connectedness

[781] Non-Specialty Mental Health Services: Psychiatric and Psychological Services; Medi-Cal coverage for EPSDT
[782] Gender Health Center - Services
[783] Non-Specialty Mental Health Services: Psychiatric and Psychological Services
[784] All information contained in the Cultura y Bienestar sections comes from publicly available sources. Please refer to each section for specific source details.
[785] The California Reducing Disparities Project Phase II, see Chapter 3.6
[786] The California Reducing Disparities Project Phase II, see Chapter 2

and emphasizing community values, CyB aims to connect Latinx individuals with mental health providers, addressing the under-utilization of behavioral health care services.[787]

The program offers various services that are delivered through trained promotores (i.e., health educators). These services include wellness education, assessment of family/individual needs, referrals to appropriate services, individual psychotherapy, and group interventions (e.g., support groups, healing events). Additionally, CyB offers specialized training and consultation on behavioral health topics for professionals, organizations, and community leaders. These sessions focus on culturally responsive approaches to working with the Latino community, including issues related to acculturation, parenting, trauma, substance abuse, domestic violence, and co-occurring conditions.

iii. Program components potentially eligible for Medi-Cal reimbursement

The reimbursement potential for each service component of the Cultura y Bienestar was based on its alignment with Medi-Cal's established criteria and guidelines.[788] For additional details on Medi-Cal reimbursable behavioral health services and Cultura y Bienestar offerings, please refer to the DHCS website and the Cultura y Bienestar website.

Cultura y Bienestar[789]		
Service components of the model	**Service description**	**Potential for reimbursement[790]**
Psychotherapy	Individual	May be eligible under Medi-Cal NSMHS psychotherapy services
Support groups	Peer support groups	May be eligible under Medi-Cal Peer Support Services benefit
	Traditional healing events	May not align with Medi-Cal NSMHS benefits
Consultation	Mental health technical assistance for community leaders and organizations	May not align with Medi-Cal NSMHS benefits
Psychoeducation	Workshops that include parenting strategies, self-care, child development, etc.	May be eligible under Medi-Cal NSMHS dyadic psychoeducational services

[787] The California Reducing Disparities Project Phase II, see section on executive summary
[788] Non-Specialty Mental Health Services: Psychiatric and Psychological Services; Medi-Cal coverage for EPSDT
[789] Cultura y Bienestar
[790] Non-Specialty Mental Health Services: Psychiatric and Psychological Services; Medi-Cal Peer Support Services

Chapter 11: Considerations for payors

Medi-Cal managed care plans (MCPs), Medi-Cal Fee-For-Service (FFS), county mental health plans (MHPs), and other health insurers (collectively referred to as "payors") can play a critical role in the adoption and sustainability of EBPs and CDEPs. By contracting with providers to expand use of these practices, payors can drive improvements in care, reduce costs, and ensure better behavioral health outcomes for their members.[791]

Investing in EBPs and CDEPs can lead to significant long-term cost savings by reducing the need for more intensive services. Early intervention through effective EBPs and CDEPs can reduce hospital admissions, emergency room visits, and other high-cost services.[792]

While many elements of EBPs and CDEPs may resemble traditional behavioral health services, there are several important considerations for payors seeking to formalize access to these practices.

A. Identifying and contracting with providers

Payors can actively support EBP and CDEP providers with technical assistance during the contracting process, as incorporating non-traditional providers in the delivery of EBPs and CDEPs can present several challenges, including:

- Some non-traditional providers may lack billing knowledge and capabilities.
- It can be difficult to distinguish between reimbursable and non-reimbursable services.

Additionally, Medi-Cal payors may encounter additional challenges:

- Non-traditional providers must meet minimum provider standards in the Medi-Cal State Plan, which may require additional verification.
- Some non-traditional providers may not fully understand Medi-Cal eligibility requirements and how to enroll as a provider.

If certain non-traditional providers are not eligible under the Medi-Cal State Plan, Medi-Cal payors could consider requesting a State Plan Amendment to resolve the issue.

[791] Information about outcomes for individual EBPs available through the SAMHSA Evidence-Based Practices Resource Center and California Evidence-Based Clearinghouse

[792] Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment, National Library of Medicine

B. Identifying whether Medi-Cal payors can reimburse the EBP or CDEP through an existing Medi-Cal policy

There are several policies through which Medi-Cal payors can reimburse services provided as part of EBPs and CDEPs. These include:[793]

i. Non-specialty mental health services (NSMHS)[794]

ii. Specialty mental health services (SMHS)[795]

iii. Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) Benefit[796]

iv. Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration[797]

v. Family First Prevention Services Act (FFPSA)[798]

An EBP or CDEP may be reimbursable under one or more of these policies. However, whether each policy applies will depend on how the EBP or CDEP is delivered (e.g., whether a Medi-Cal beneficiary is eligible for NSMHS or SMHS).

Identifying the applicable policy is a critical step given each policy covers a different set of services.

i. NSMHS coverage

Generally, Medi-Cal MCPs and Medi-Cal FFS delivery systems are required to provide or arrange for the provision of NSMHS for the following populations: [799]

- Individuals aged 21 or older with mild to moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental disorders, as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Individuals under 21, to the extent otherwise eligible for services through EPSDT,[800] regardless of level of distress or impairment or the presence of a diagnosis; and
- Individuals of any age with potential mental health disorders not yet diagnosed.

[793] Additional funding for EBPs could come from Mental Health Services Act (MHSA) funds through Prevention and Early Intervention (PEI) programs. See this DHCS resource for more information.
[794] Non-Specialty Mental Health Services
[795] Medi-Cal Specialty Mental Health Services
[796] Early and Periodic Screening, Diagnostic and Treatment, Centers for Medicare and Medicaid Services
[797] Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative
[798] California's Five-Year State Prevention Plan, California Department of Social Services
[799] Non-Specialty Mental Health Services (NSMHS), DHCS
[800] Medi-Cal Coverage for EPSDT

NSMHS are delivered via managed care and fee-for-service delivery systems and include:[801]

- Mental health evaluation and treatment, including individual, group and family psychotherapy, and dyadic behavioral health services.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies and supplements.
- School-based services and NSMHS

    The Local Educational Agency Medi-Cal Billing Option Program (LEA BOP) services are available for NSMHS when those services are provided in a school-based setting to students under 22 years of age by a practitioner at a Local Educational Agency (LEA) enrolled with LEA BOP, which covers screenings and assessments and services authorized in a care plan, such as an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP). More information about LEA BOP, including covered services and qualifying practitioners, may be found on the LEA BOP website and the LEA BOP Provider Manual. LEA BOP is considered a sustainable source of funding for screenings, assessments, and services pursuant to a care plan such as an IEP or IFSP.

    The CYBHI Fee Schedule program services are available as outlined through the NSMHS. The program sets the reimbursement rate for a certain set of outpatient, school-linked mental health and substance use disordered services rendered to children and youth who are under 26 years old, enrolled in public TK-12 schools or institutions of higher education (e.g., California Community Colleges), and covered by Medi-Cal managed care plans, Medi-Cal Fee-for-Service, commercial health insurance, and disability insurers. The CYBHI Fee Schedule program creates a sustainable reimbursement pathway for Local Educational Agencies (LEAs) and public institutions of higher education (IHEs) to receive funding for outpatient behavioral health services rendered that are not part of an IEP or IFSP care plan.

Note: A neurocognitive disorder (for example, dementia) or a substance-related and addictive disorder (for example, stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to

[801] Non-Specialty Mental Health Services, DHCS, p. 1

receive NSMHS.[802] However, Medi-Cal MCPs must provide or arrange NSMHS for individuals with these conditions if they have a mental health disorder (or might have one that has not been diagnosed) and meet the criteria for NSMHS as described above.[803]

NSMHS can be provided by licensed clinical social workers (LCSWs), licensed professional clinical counselors (LPCCs), licensed marriage and family therapists (LMFTs), licensed psychologists, psychiatric physician assistants (PAs), psychiatric nurse practitioners (NPs), and psychiatrists as consistent with their training and licensing requirements. Associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers and psychology assistants can also provide psychotherapy services under the supervision of a licensed clinician.

For additional detail on NSMHS (e.g., authorization, place of service, referral, and other billing requirements; specific services included), refer to Non-Specialty Mental Health Services: Psychiatric and Psychological Services (Nov. 2022).

ii. SMHS coverage

County MHPs are required to provide or arrange for the provision of medically necessary SMHS for members in their counties who meet access criteria for SMHS as described in Behavioral Health Information Notice 21-073.[804]

Medi-Cal MCPs and Medi-Cal FFS delivery systems are required to provide or arrange for the provision of SMHS for the following populations:[805]

Individuals aged 21 and older must meet both of the following criteria:[806]

1. The individual has one or both of the following:
    a) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
    b) A reasonable probability of significant deterioration in an important area of life functioning.
2. The individual's condition in criterion 1 is due to either of the following:

[802] Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements, DHCS, pg. 3
[803] Ibid.
[804] BHIN 21-073 available at https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf
[805] Non-Specialty Mental Health Services: Psychiatric and Psychological Services (Nov. 2022).
[806] As defined by Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Coverage Requirements

a) A diagnosed mental health disorder, based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

b) A suspected mental disorder that has not yet been diagnosed.

1. Individuals under 21 years of age must meet either of the following criteria:[807]

- The individual has a condition putting them at high risk for a mental health disorder due to experiencing trauma, as shown by at least one of the following:

a) Scoring in the high-risk range on a trauma screening tool approved by Medi-Cal

b) Involvement in the child welfare system

c) Involvement in the juvenile justice system

d) Experiencing homelessness

2. The individual meets both requirements a) and b):

a) The individual has at least one of these conditions:

- A significant impairment
- A reasonable probability of significant deterioration in an important area of life functioning
- A reasonable probability of not progressing developmentally as appropriate
- A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

b) The individual's condition in requirement A above is due to at least one of the following:

- A diagnosed mental health disorder, according to the criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
- A suspected mental health disorder that has not yet been diagnosed.

[807] As defined by Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Coverage Requirements

- Significant trauma placing the recipient at risk of a future mental health condition, based on the assessment of a licensed mental health professional

Note: Neurocognitive disorders (for example, dementia) and substance-related and addictive disorders (for example, stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive SMHS.[808]

SMHS can include:

- Rehabilitative mental health services
- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatrist and psychologist services
- Psychiatric nursing facility services

Providers that are eligible for reimbursement under SMHS include those with MDs/DOs,[809] general pharmacists, advanced practice pharmacists, clinical nurse specialists, nurse practitioners, registered nurses, licensed clinical social workers, licensed vocational nurses, occupational therapists, professional clinical counselors, marriage and family therapists, mental health rehabilitation specialists, clinical psychologists, physician assistants, certified peer specialists, and psychiatric technicians, among others.[810]

An SMHS provider may address a co-occurring substance use concern as part of the mental health care they are providing to the member. However, the primary focus of the service must be on addressing the member's mental health (e.g., symptoms, condition, diagnosis, and/or risk factors), which can include co-occurring SUD. Providers must only offer services that fall within their professional scope of practice and expertise.[811]

Similarly, a DMC/DMC-ODS provider may address a co-occurring mental health concern as part of the SUD services they are providing if the circumstances are similar.

[808] Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements, DHCS, pg. 3
[809] Doctor of Medicine; Doctor of Osteopathic Medicine
[810] SMHS Billing Manual, p. 44
[811] CalAIM Behavioral Health Initiative Frequently Asked Questions

For information about SMHS, refer to Behavioral Health Information Notices and the SMHS Billing Manual.

iii. Coverage under the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) Benefit

The EBPs and CDEPs included in this document are primarily intended to serve children and youth. As a result, many of the EBPs and CDEPs in this document may be covered under the Medicaid EPSDT benefit[812].

Under EPSDT, Medi-Cal covers all medically necessary services for individuals under 21, including those to "correct or ameliorate" physical and mental health conditions or illnesses. This includes, but is not limited to, physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; and treatment for vision, hearing, and dental diseases and disorders.[813]

In the context of mental health and substance use disorder (SUD) services, CMS focuses on rehabilitative services, which can include:[814]

- Community-based crisis services, such as mobile crisis teams and intensive outpatient care
- Individualized mental health and substance use treatment services, including in non-traditional settings such as a school, workplaces, or homes
- Medication management
- Counseling and therapy to address psychological barriers that may prevent the development of skills needed for independent living
- Rehabilitative equipment, such as daily living aids

Medi-Cal members under 21 can receive EPSDT services if they are medically necessary and covered by Medicaid, even if these services are not listed in California's Medicaid State Plan (Medi-Cal).[815]

Many, if not all, of the EBPs and CDEPs described in this document could likely qualify as EPSDT services. As a result, the Medi-Cal delivery system may have substantial

[812] Early and Periodic Screening, Diagnostic and Treatment, Centers for Medicare and Medicaid Services
[813] Medi-Cal coverage for EPSDT
[814] EPSDT coverage guide; Section 1905(a)(13) of the Social Security Act; 42 C.F.R. § 440.130(d).
[815] EPSDT coverage guide

flexibility to expand coverage for these practices without needing to formally include them in the Medi-Cal State Plan.[816]

iv. Coverage under the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration

This Section 1115 Demonstration (formerly known as the CalBH-CBC Demonstration) utilizes the Centers for Medicare & Medicaid Services' (CMS') 2018 guidance and related federal funding to improve care for Medi-Cal members with significant behavioral health needs. DHCS's central goal of the BH-CONNECT Demonstration is to develop a robust continuum of community-based behavioral health care services for Medi-Cal members living with significant behavioral health needs.[817] The demonstration clarifies that coverage for three specific EBPs —Multisystemic Therapy (MST), Parent-Child Interaction Therapy (PCIT), and Functional Family Therapy (FFT)— is required under the EPSDT benefit.[818]

v. Coverage under the Family First Prevention Services Act (FFPSA)

This 2018 amendment to the Title IV-E foster care program and Title IV-B programs aims to strengthen family support services to help children remain at home and reduce reliance on unnecessary congregate care placements. The FFPSA achieves this by increasing prevention service options, increasing oversight and requirements for placements, and enhancing standards for congregate care settings.[819] CDSS's Five-Year State Prevention Plan under Title IV-E and the FFPSA incorporates ten EBPs described in this document: Healthy Families America (HFA), Nurse Family Partnership (NFP), Parents as Teachers (PAT), Multisystemic Therapy (MST), Homebuilders, Brief Strategic Family Therapy, Parent-Child Interaction Therapy (PCIT), Functional Family Therapy (FFT), Family Check-Up (FCU), and Motivational Interviewing.[820] For EBPs that are not reimbursable under Medi-Cal policies, Title IV-E prevention services funding may serve as a "payer of last resort."[821]

vi. Expanding coverage

In some cases, the EBPs described in this document are already reimbursable for eligible patients under a Medi-Cal policy. Where this is not the case, CalHHS acknowledges the potential for EBPs and CDEPs to improve outcomes for Medi-Cal

[816] CMS notes that it would generally expect a state to include in its State Plan the services and providers with their qualifications, as well as a reimbursement methodology for each service it provides. However, CMS also notes it is available to provide technical assistance to states that are covering a service for children that has not otherwise been identified in their State Plan. EPSDT coverage guide (page 11-12).
[817] Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative
[818] BH-CONNECT Application (Oct. 2023)
[819] Family First Prevention Services Act, CDSS
[820] California's Five-Year State Prevention Plan, California Department of Social Services
[821] https://www.cdss.ca.gov/Portals/9/CCR/FFPSA/CA-FFPSA-FiveYear-Prevention-Planv2.pdf

members. As a result, CalHHS encourages Medi-Cal payors to voluntarily expand coverage of these practices to the extent permissible under existing policies and / or notify the sponsoring CalHHS department if a State Plan Amendment is required.

C. No Wrong Door among Medi-Cal payors for mental health services and co-occurring conditions

A consideration for behavioral health care delivery in the Medi-Cal context involves the division of responsibility among Medi-Cal MCPs and Medi-Cal FFS for NSMHS, County MHPs for SMHS, and DMC / DMC-OSD for SUD services. Depending on an individual's circumstances, an individual can move between the NSMHS and SMHS systems or receive care from both simultaneously.[822] For example, care that begins in NSMHS could evolve into SMHS following additional diagnoses.

When this occurs, Medi-Cal requires a "No Wrong Door" policy to ensure that individuals receive clinically appropriate and covered treatment regardless of the setting.[823] To ensure seamless care, Medi-Cal entities should collaborate with providers to coordinate benefits and facilitate appropriate reimbursement.

The below principles provide general guidance on how Medi-Cal FFS, Medi-Cal MCPs, County MHPs, and DMC / DMC-ODS providers may coordinate benefits in compliance with the "No Wrong Door" policy:[824]

- Individuals should receive services based on individual clinical needs and established therapeutic relationships;
- Medi-Cal MCPs and County MHPs must provide services before a diagnosis is made, during the assessment, or before it is decided whether the individual meets the criteria for NSMHS or SMHS;
- Medi-Cal MCPs must cover NSMHS services, even if those services are not listed in the individual's treatment plan;
- Both Medi-Cal MCPs and County MHPs must cover mental health and SUD services, even if the mental health condition and SUD are co-occurring;
- Individuals receiving NSMHS who meet both NSMHS and SMHS criteria may continue receiving NSMHS unless and until their clinician recommends SMHS

[822] Non-Specialty Mental Health Services (NSMHS), DHCS

[823] Pursuant to APL 22-005 for NSMHS and BHIN 22-011 for SMHS, both Medi-Cal MCPs and MHPs are required to implement the No Wrong Door policy. The No Wrong Door policy states that consistent with W&I Code section 14184.402(f), clinically appropriate and covered NSMHS and SMHS are reimbursable Medi-Cal services by both Medi-Cal MCPs and County MHPs when:

1. Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met;
2. The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
3. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

Additionally, Medi-Cal MCPs are also required to reimburse NSMHS services that are not included in an individual treatment plan.

[824] Non-Specialty Mental Health Services (NSMHS), DHCS

exclusively, and the beneficiary has been transferred to a county MHP provider who agrees to take over their care; and

- Individuals may concurrently receive NSMHS via a Medi-Cal MCP or FFS provider and SMHS via a County MHP provider, as long as services are coordinated and not duplicated. These decisions should be made with the beneficiary using a patient-centered, shared decision-making process.

Chapter 12: Illustrative member scenarios

A. Substance use disorder (SUD) scenario

Note: Principal healthcare services are numbered; blue text represents EBP / CDEP. See additional detail on each service in the table that follows the description

Description: A 15-year-old has been struggling with substance use disorder (SUD) for the past four months. Both of his parents are non-English speaking.

A bilingual case manager assigned to the 15-year-old has been assisting his family in accessing resources and support **(1)**. Four months ago, the 15-year-old was diagnosed with an unspecified anxiety disorder and cannabis SUD **(2)** by his primary care physician (PCP). The PCP documented the 15-year-old's diagnoses and shared them with his case manager. The PCP is continuing to monitor the 15-year-old and will assess whether medication is needed if his unspecified anxiety disorder and/or SUD worsens.

The case manager referred the 15-year-old and his parents to a licensed therapist who provides an outpatient treatment, Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA) **(3)**. As part of CIFFTA, the 15-year-old has attended Adolescent Therapy once every other week and Family Therapy on the alternating weeks (50-minute sessions each) for the past three months and is currently still undergoing treatment.

The case manager also referred the 15-year-old and his parents to a community-based organization that provides Familias Unidas **(4)**. Through that program, his parents have been attending parent group sessions over the past month at the CBO, though on an inconsistent basis (every two weeks instead of every week as recommended). The 15-year-old and his parents also have their first family session in the coming week.

The 15-year-old receives Medi-Cal coverage through a managed care plan (MCP).

Table 1. Illustrative beneficiary scenario for SUD: summary of services received (non-EBPs / CDEPs shaded in gray)[825]

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
1. Case management	Case manager	• Assessment and evaluation • Coordination of treatment plan • Referral services • Monitoring	N	MCP	N/A	N/A
2. Anxiety and SUD diagnosis and management	PCP	• Screening • Development of treatment plan prescription • Referral services and care coordination • Monitoring	N	MCP	N/A	N/A
3. Culturally Informed and Flexible Family-Based Treatment for	Licensed psychologist	• Adolescent Therapy • Family Therapy	Y	MCP[826]	• Adolescent Therapy: CPT code 90837[827] • Family Therapy: CPT code 90847[828]	• The 15-year-old meets the criteria for NSMHS[829] psychotherapy for recipients under age 21 as he has a diagnosis of a mental health disorder • For Adolescent Therapy:

825 Non-Specialty Mental Health Services (NSMHS), Analysis by Manatt Health from Jan 2022 to Feb 2023, The California Evidence-Based Clearing House, CIFFTA, The California Evidence-Based Clearing House, Familias Unidas

826 If the 15-year-old meets the criteria specified under Medi-Cal Specialty Mental Health Services (SMHS), services will be delivered via County MHPs

827 Non-Specialty Mental Health Services (NSMHS)

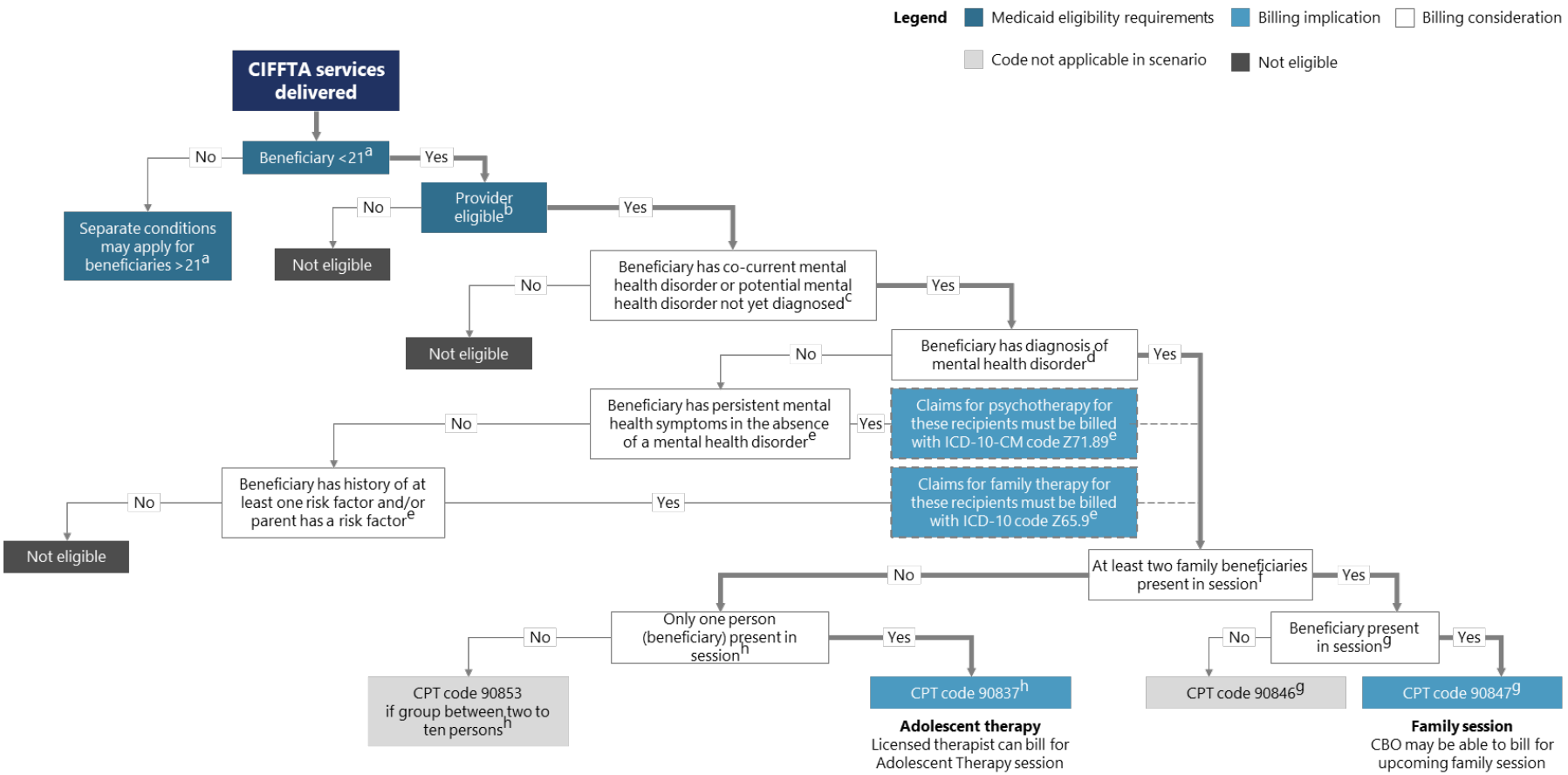
828 Non-Specialty Mental Health Services (NSMHS)

829 Non-Specialty Mental Health Services (NSMHS)

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
Adolescents (CIFFTA) *See Figure 2 for additional detail*						○ Service provided may be considered individual psychotherapy ○ Adolescent Therapy sessions for the 15-year-old are 50 minutes long, so may be eligible to bill with CPT code for 60 minutes • For Family Therapy: ○ Service provided may be considered family psychotherapy (with patient present)
4. Familias Unidas	Licensed Marriage and Family Therapist (LMFT) at a community-based organization	• Multiparent group sessions • Family sessions	Y	MCP	• Multiparent group sessions: CPT code 90849[830] • Family sessions: CPT code 90847[831]	• The 15-year-old meets the criteria for NSMHS[832] psychotherapy for recipients under age 21 as he has a diagnosis of a mental health disorder • For Multiparent group sessions:[28] ○ Service provided may be considered multiple-family group psychotherapy For Family sessions: [28] ○ Service provided may be considered family psychotherapy (with patient present)

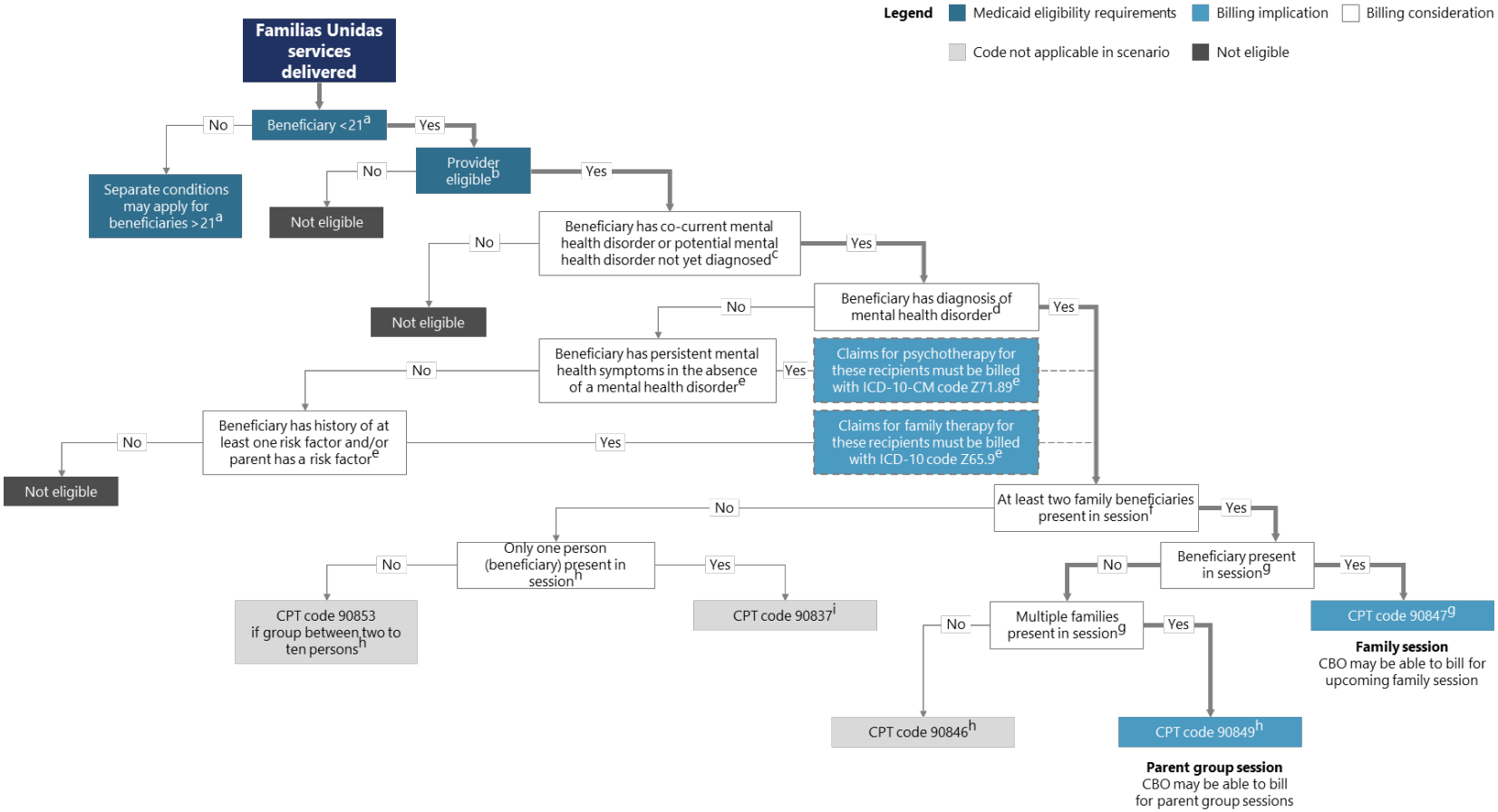
830 Non-Specialty Mental Health Services (NSMHS), page 27
831 Non-Specialty Mental Health Services (NSMHS), page 27
832 Non-Specialty Mental Health Services (NSMHS)

Figure 2. Potential billing guidance for licensed psychologist providing CIFFTA[833]



[833] Non-Specialty Mental Health Services (NSMHS) – (a) page 1, (b) page 4, (c) page 2, (d) page 24, (e) page 25, (f) page 26, (g) page 27, (h) page 28

Figure 3. Potential billing guidance for LMFT providing Familias Unidas[834]



[834] Non-Specialty Mental Health Services (NSMHS) – (a) page 1, (b) page 4, (c) page 2, (d) page 24, (e) page 25, (f) page 26, (g) page 27, (h) page 28

B. Foster Care scenario

Note: Principal healthcare services are numbered; blue text represents EBP/CDEP. See additional detail on each service in the table that follows the description

Description: The family of a child aged between birth and 2 years old is at risk for involvement in the child welfare system. The child has no history of medical or developmental concerns.

A Child Welfare Services (CWS) worker is assigned to assist in strengthening the family and providing case management **(1)**. The CWS worker, with the support of the family's nurse practitioner (NP), referred the family to a nearby Healthy Families America (HFA) site. HFA staff contacted the family to learn about their current needs and has since sent an HFA staff beneficiary for weekly 1-hour home visits over the past two months to help promote the caregiver-child relationship and secure attachment **(2)**. The HFA staff also provides the family with referrals as needed to relevant community resources; the HFA staff recommended a visit to the PCP for potential screenings.

During the recent PCP visit, the child was screened for Adverse Child Experiences (ACEs) and scored a 4, indicating that the child is "high-risk" for toxic stress **(3)**.[835] In addition to referring the caregiver for psychotherapy **(4)**, the PCP also suggested Parents Anonymous® **(5)**. Two weeks ago, the caregiver started attending weekly 2-hour online support groups facilitated by a Parent Group Leader and a Group Facilitator who is a Certified Medi-Cal Peer Support Specialist.

The child and family receive Medi-Cal coverage through a managed care plan (MCP).

[835] ACE Screening Clinical Workflows, ACEs and Toxic Stress Risk Assessment Algorithm, and ACE-Associated Health Conditions: For Pediatrics and Adults

Table 2. Illustrative beneficiary scenario for foster care: summary of services received (non-EBPs / CDEPs shaded in gray)[836]

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
1. Child Welfare Services (CWS)	Child Welfare Services (CWS) worker	• Assessment and evaluation • Coordination of care • Referral services • Monitoring	N	MCP	N/A	N/A

2. Healthy Families America (HFA)	HFA staff beneficiary	• Home visitation
		• Referral to community resources
			Y	MCP	• Home visitation: CPT code 98960[837]	• Child meets the medical necessity criteria for Community Health Worker Services (CHW) as the child has a positive Adverse Childhood Experiences (ACEs) screening
						• The child has a written recommendation from a licensed practitioner (NP) for CHW services
						• For home visitation:
						  ○ Service may be considered as psychoeducation delivered by a CHW worker
						• For referral to community resources:
						  ○ Service may not be billable under HCPCS code G9008 as the provider is not clinical staff

836 Medi-Cal Coverage of CHW Services, Medi-Cal Peer Support Services Specialist Program, BHIN 22-026, Analysis by Manatt Health from Jan 2022 to Feb 2023, The California Evidence-Based Clearinghouse, HFA, The California Evidence-Based Clearinghouse, Parents Anonymous

837 Medi-Cal Coverage of CHW Services

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
3. Adverse Childhood Experiences (ACEs) Screening	Primary care provider (PCP)	• Screening • Development of treatment plan prescription • Referral services and care coordination • Monitoring	N	MCP	N/A	N/A
4. Psychotherapy	Psychologist	• Psychotherapy	N	MCP	N/A	N/A
5. Parents Anonymous®	Certified Medi-Cal Peer Support Specialist	• Online Parents Anonymous® groups	Y	MCP	• Online Parents Anonymous® groups: HCPCS code H0038[838,839]	• For online Parents Anonymous® groups: ○ Service may be considered as Peer Support services as it is delivered by a Certified Medi-Cal Peer Support Specialist

838 Medi-Cal Peer Support Services Specialist Program; BHIN 22-026

839

Figure 4. Potential billing guidance for HFA staff beneficiary providing HFA[840]

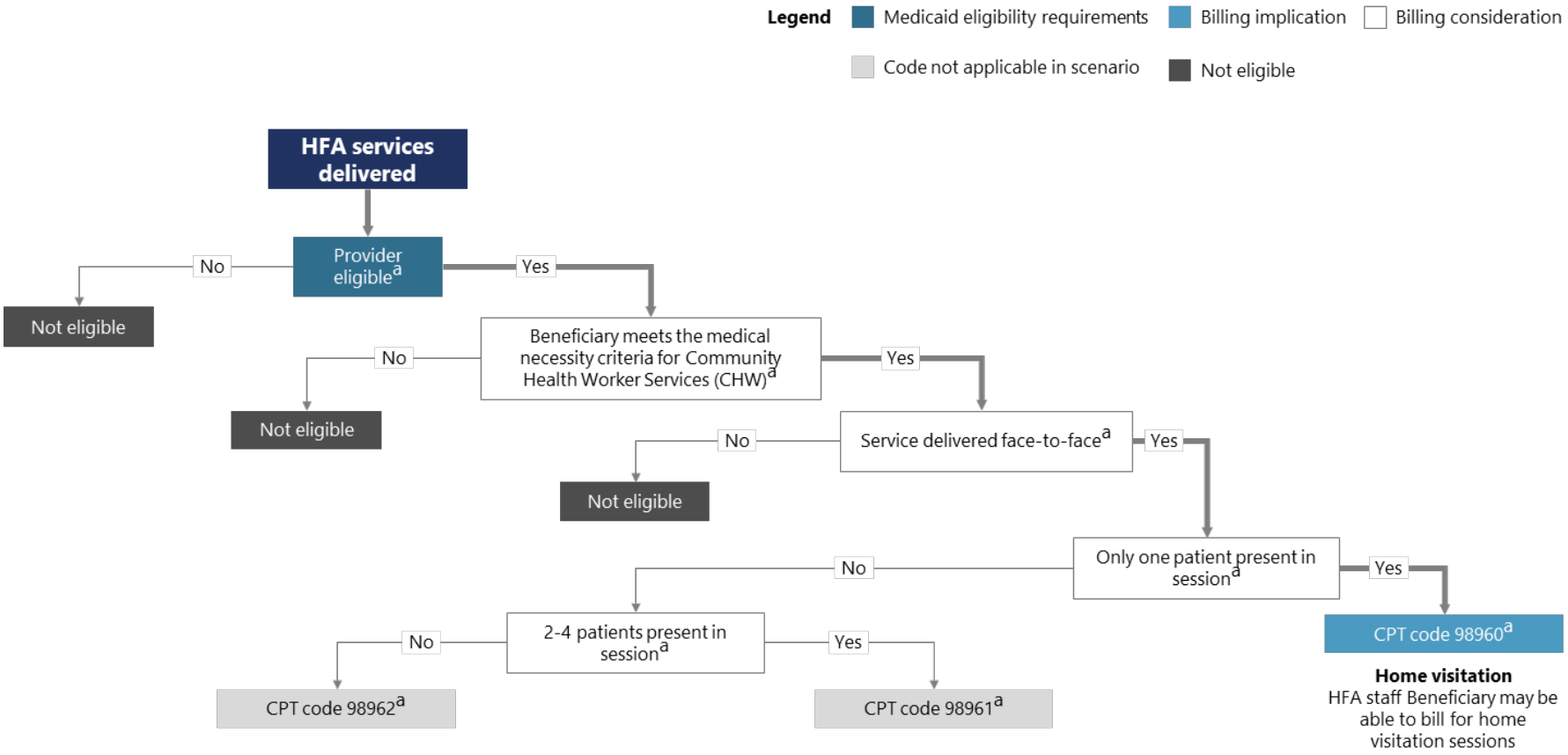
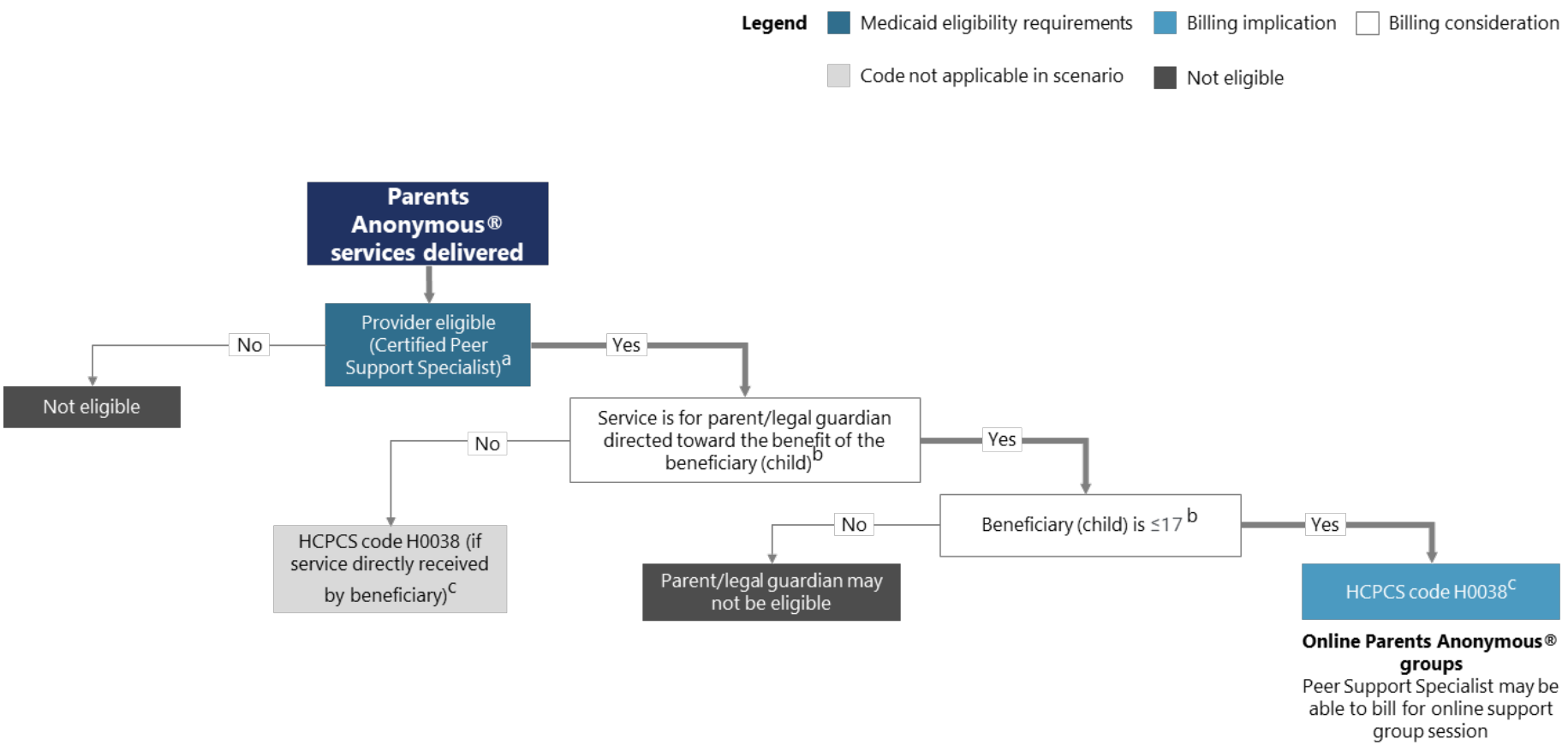


Figure 5. Potential billing guidance for a Peer Support Specialist providing Parents Anonymous® [841]

[840] (a) Medi-Cal Coverage of CHW Services

[841] BHIN 22-026 – (a) page 3, (b) page 2, (c) page 4


Legend
Medicaid eligibility requirements
Billing implication
Billing consideration
Code not applicable in scenario
Not eligible
Parents Anonymous® services delivered
Provider eligible (Certified Peer Support Specialist)a
No
Not eligible
Yes
Service is for parent/legal guardian directed toward the benefit of the beneficiary (child)b
No
HCPCS code H0038 (if service directly received by beneficiary)c
Yes
Beneficiary (child) is ≤17 b
No
Parent/legal guardian may not be eligible
Yes
HCPCS code H0038c
Online Parents Anonymous® groups
Peer Support Specialist may be able to bill for online support group session

C. Suicidal Ideations (SI) scenario

Note: Principal healthcare services are numbered; blue text represents EBP / CDEP. See additional detail on each service in the table that follows the description

Description: An 18-year-old has diagnosed post-traumatic stress disorder (PTSD) and depression and regularly sees a psychiatrist for evaluation and medication **(1)**.

During the past month, a friend called a crisis hotline for the 18-year-old after discovering that the 18-year-old developed a suicide plan. A Youth Mobile Crisis Response team was dispatched to respond to and assess the adolescent **(2)**. The team deescalated the behavioral health crisis and stabilized the adolescent. No imminent risk of danger was noted at the time. The mobile crisis team alerted the adolescent's primary care provider (PCP) and psychiatrist of the crisis and connected her to a youth peer respite.

A PCP visit is scheduled immediately following the crisis, and the adolescent is diagnosed with Suicidal Ideation **(3)**. The PCP provided a referral to new therapist for weekly psychotherapy sessions that the adolescent will start attending soon **(4)**. Members of the mobile crisis team have also followed-up with the adolescent to check on status and provide support as needed.

The 18-year-old has been staying at a peer respite **(5)** for the past 13 days while maintaining regular telehealth appointments with the psychiatrist for new medication. At the peer respite, the 18-year-old attends support group sessions for suicidality, practices mindfulness exercises, and occasionally participates in arts and crafts.

The adolescent receives Medi-Cal coverage through a managed care plan (MCP).

Table 3. Illustrative beneficiary scenario: summary of services received (non-EBPs / CDEPs shaded in gray)[842]

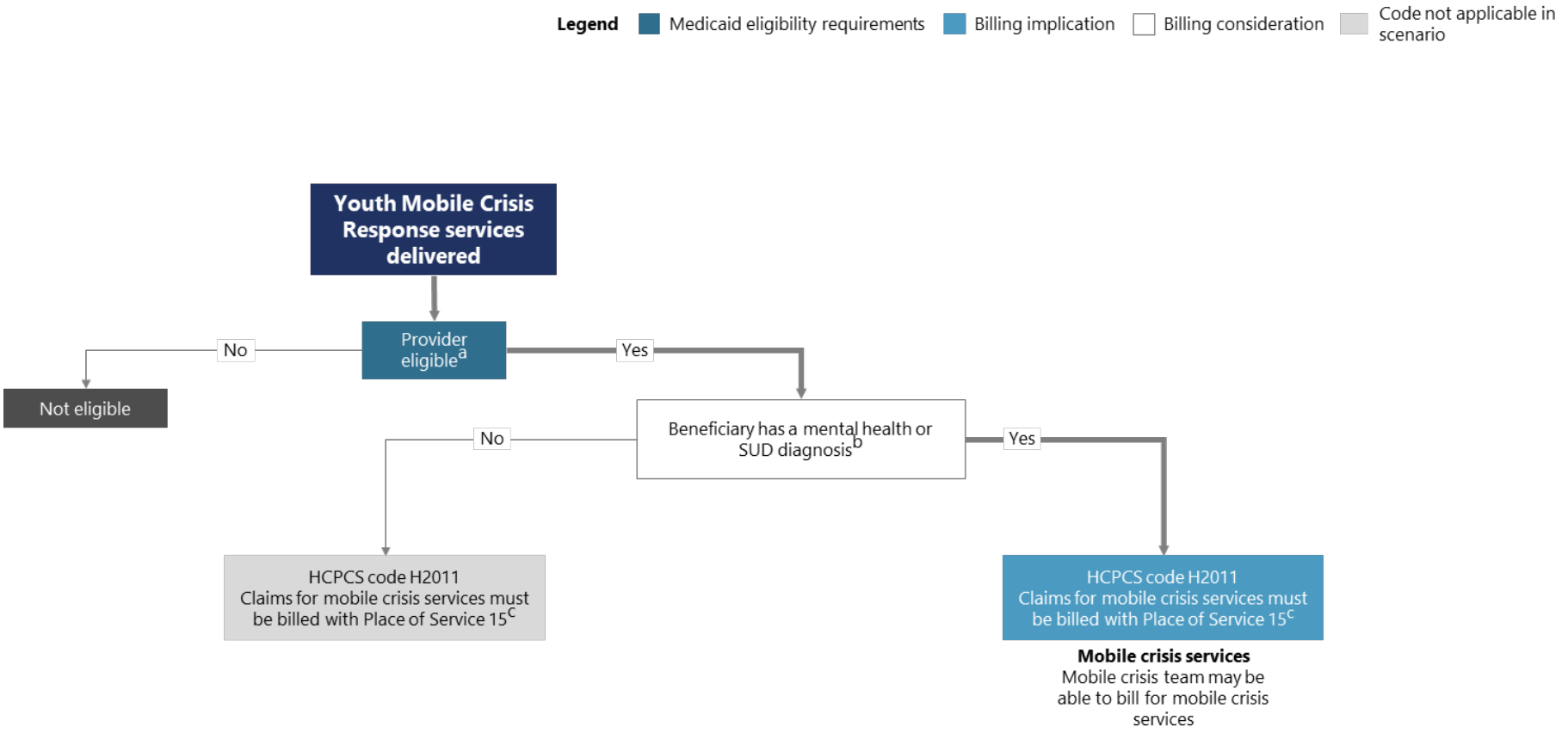
Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
1. PTSD/ depression diagnosis, regular evaluation, and medication management	Psychiatrist	• Medication management • Referral services and care coordination • Monitoring	N	MCP	N/A	N/A
2. Youth Mobile Crisis Response	Mobile crisis team	• Mobile crisis response • Referral to resources • Follow-up check-in	Y	MCP	• All mobile crisis services: HCPCS code H2011 (with Place of Service 15)[843]	• Adolescent is an eligible Medi-Cal beneficiary experiencing a behavioral health crisis • For mobile crisis response, referral to resources, and follow-up check-ins: ○ Services are all considered components of mobile crisis services
3. Physical health treatment, Suicidal Ideation screening,	Primary care provider (PCP)	• Screening • Development of treatment plan prescription • Referral services and care coordination	N	MCP	N/A	N/A

842 BHIN 23-023https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D84845A9-9DA6-434D-8B97-00CD24F101E7/nonspecmental.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO, Analysis by Manatt Health from Jan 2022 to Feb 2023, LAPPA – Peer Respite

843 BHIN 23-023

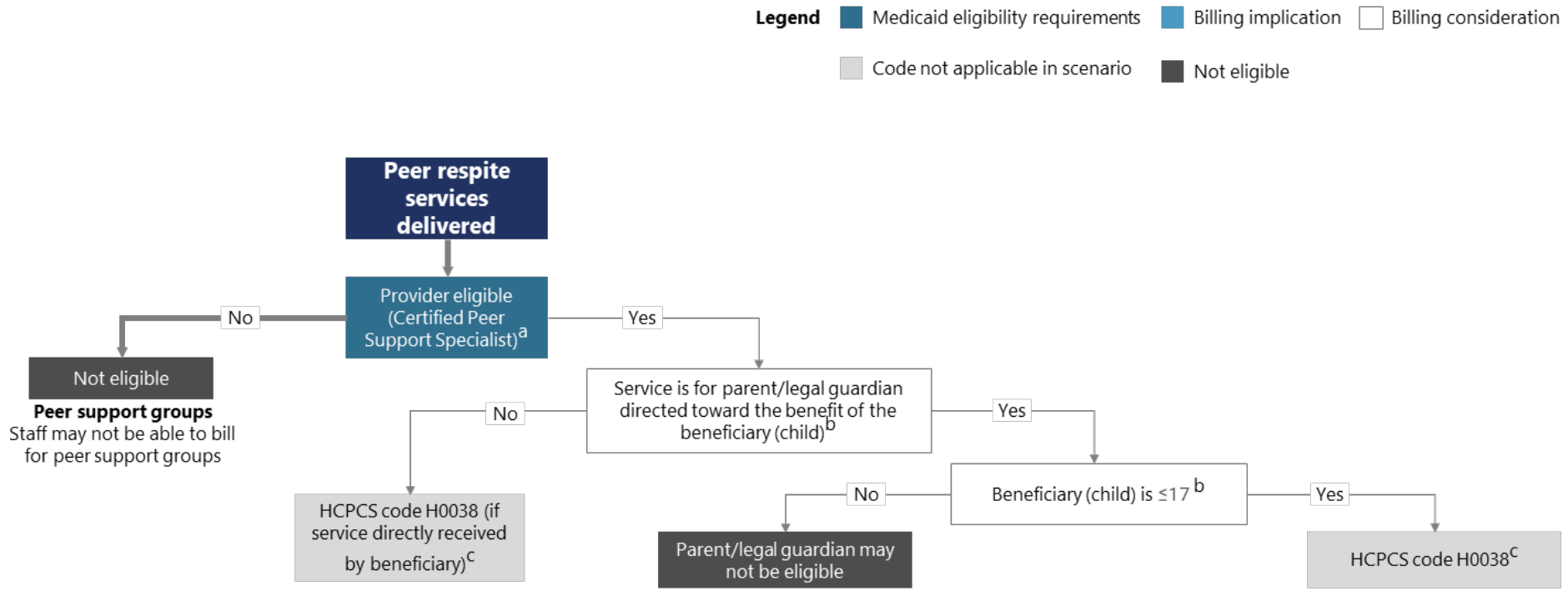
Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
behavioral health referral		• Monitoring				
4. Psychotherapy	Licensed therapist	• Psychotherapy	N	MCP	N/A	N/A
5. Peer respite	Staff with lived experiences	• Peer support groups • Mindfulness exercises • Arts and crafts	Y	MCP	N/A	• For peer support groups: ○ Services are delivered by a non-Medi-Cal Peer Support Specialist and are not reimbursable under Medi-Cal • For mindfulness exercises and arts and crafts: ○ Services are not currently reimbursed under Medi-Cal as they are not health care services

Figure 6. Potential billing guidance for mobile crisis team providing youth mobile crisis services[844]



[844] BHIN 23-023 – (a) page 2, (b) page 5, (c) page 25

Figure 7. Potential billing guidance for staff providing peer respite services[845]



[845] BHIN 22-026 – (a) page 3, (b) page 2, (c) page 4

D. Serious Mental Illness (SMI) scenario

Note: Principal healthcare services are numbered; blue text represents EBP/CDEP. See additional detail on each service in the table that follows the description

Description: A teen aged 14-16-years old had previous engagement with the juvenile justice system. During Juvenile Detention, a psychiatrist diagnosed the teen with a SMI and has since continued to evaluate their condition and manage their medication **(1)**. In addition, the psychiatrist referred the teen to other wraparound services for the teen's SMI.

The teen also participated in the Transition to Independence (TIP) Model program while in Juvenile Detention and has continued to participate in the TIP Model after leaving detention and returning to school **(2)**. Through the program, the teen receives coaching from a Transition Facilitator (TF) and Peer Support Specialist twice a week at school to set goals for future planning and work towards self-sufficiency. In addition, the teen occasionally attends monthly group dinner meetings organized by the Peer Support Specialist on education and career topics.

After recent discussions with teen's care team, the assigned case manager **(3)** recommended the teen and their family see a licensed therapist for Multisystemic Therapy (MST). During the initial session at the family's home, the therapist and family, including the teen, identified strengths and weaknesses of the family and their interactions with environmental systems such as peers and school. The therapist recommended the family attend 1-hour MST sessions twice a week **(4)**.

The teen and their family receive Medi-Cal coverage through a managed care plan (MCP).

Table 5. Illustrative beneficiary scenario: summary of services received (non-EBPs / CDEPs shaded in gray)[846]

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
1. PTSD/ depression diagnosis, regular evaluation, and medication management	Psychiatrist	• Medication management • Referral services and care coordination • Monitoring	N	MCP	N/A	N/A

2. Transition to Independence (TIP) Model	Transition Facilitator and Peer Support Specialist at school	• Coaching sessions
		• Group dinner meetings
			Y	MCP	• Coaching sessions: HCPCS code H0038[847]	• For coaching sessions:
						  ○ Service may be considered as Peer Support services as it is delivered by a Certified Medi-Cal Peer Support Specialist
						• For group dinner meetings:
						  ○ Service not billable through Medi-Cal as it is not a health care service

3. Case management	Case manager	• Assessment and evaluation • Coordination of treatment plan • Referral services • Monitoring	N	MCP	N/A	N/A

846 Non-Specialty Mental Health Services (NSMHS), Medi-Cal Peer Support Services Specialist Program, BHIN 22-026, Analysis by Manatt Health from Jan 2022 to Feb 2023, The California Evidence-Based Clearinghouse, TIP, The California Evidence-Based Clearinghouse, MST

847 Medi-Cal Peer Support Services Specialist Program; BHIN 22-026

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
4. Multisystemic Therapy (MST)	Licensed Marriage and Family Therapist (LMFT) at an outpatient clinic	• Therapy	Y	MCP	• Therapy: CPT code 90837[848]	• The teen meets the criteria for SMHS[849] psychotherapy for recipients under age 21 as they have previous juvenile justice involvement and a diagnosis of a mental health disorder • For therapy sessions: ○ Service provided may be considered as psychotherapy ○ Therapy sessions for the teen and family are 60 minutes long, so may be eligible to bill with CPT code for 60 minutes

848 Non-Specialty Mental Health Services (NSMHS), DHCS

849 BHIN 21-073

Figure 8. Potential billing guidance for Transition Facilitator/Peer Support Specialist providing TIP model services[850]

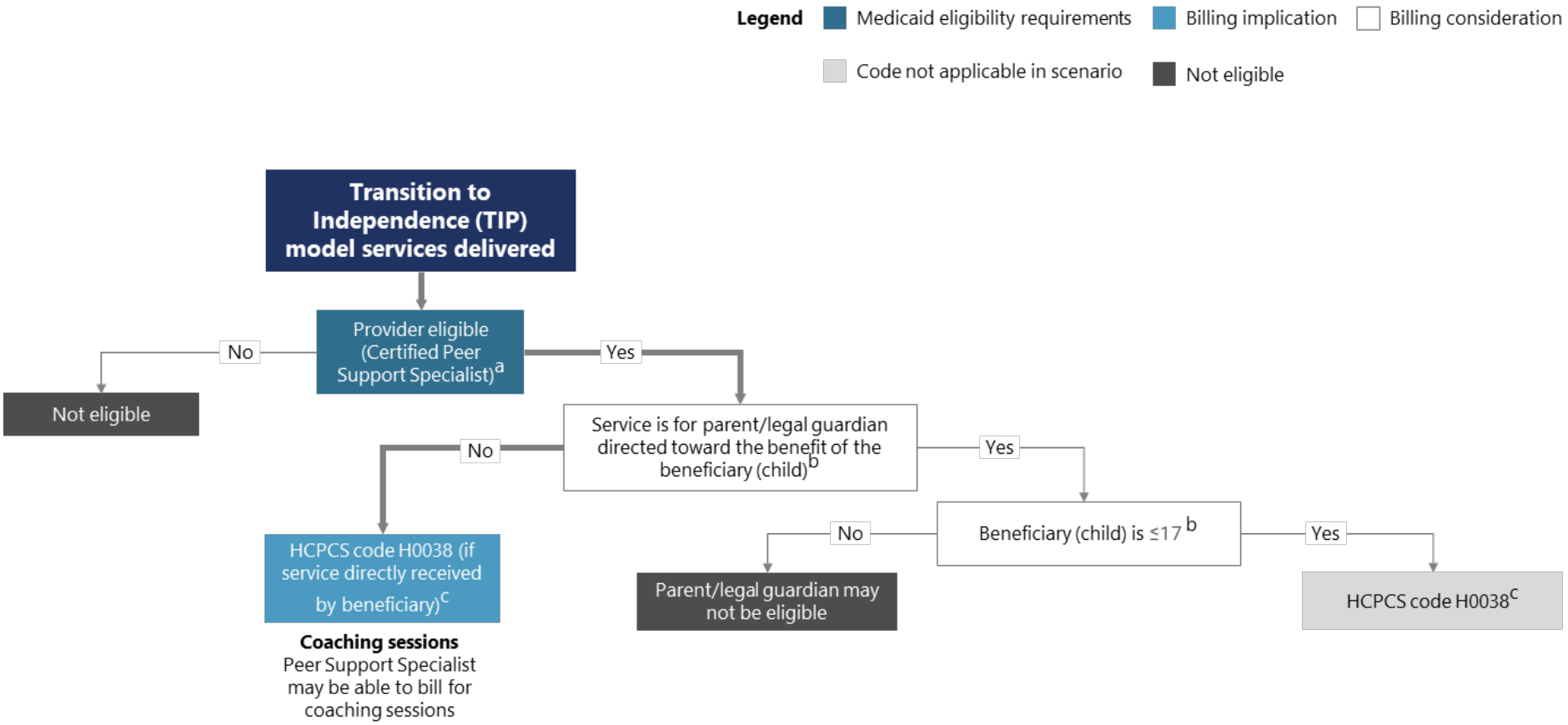
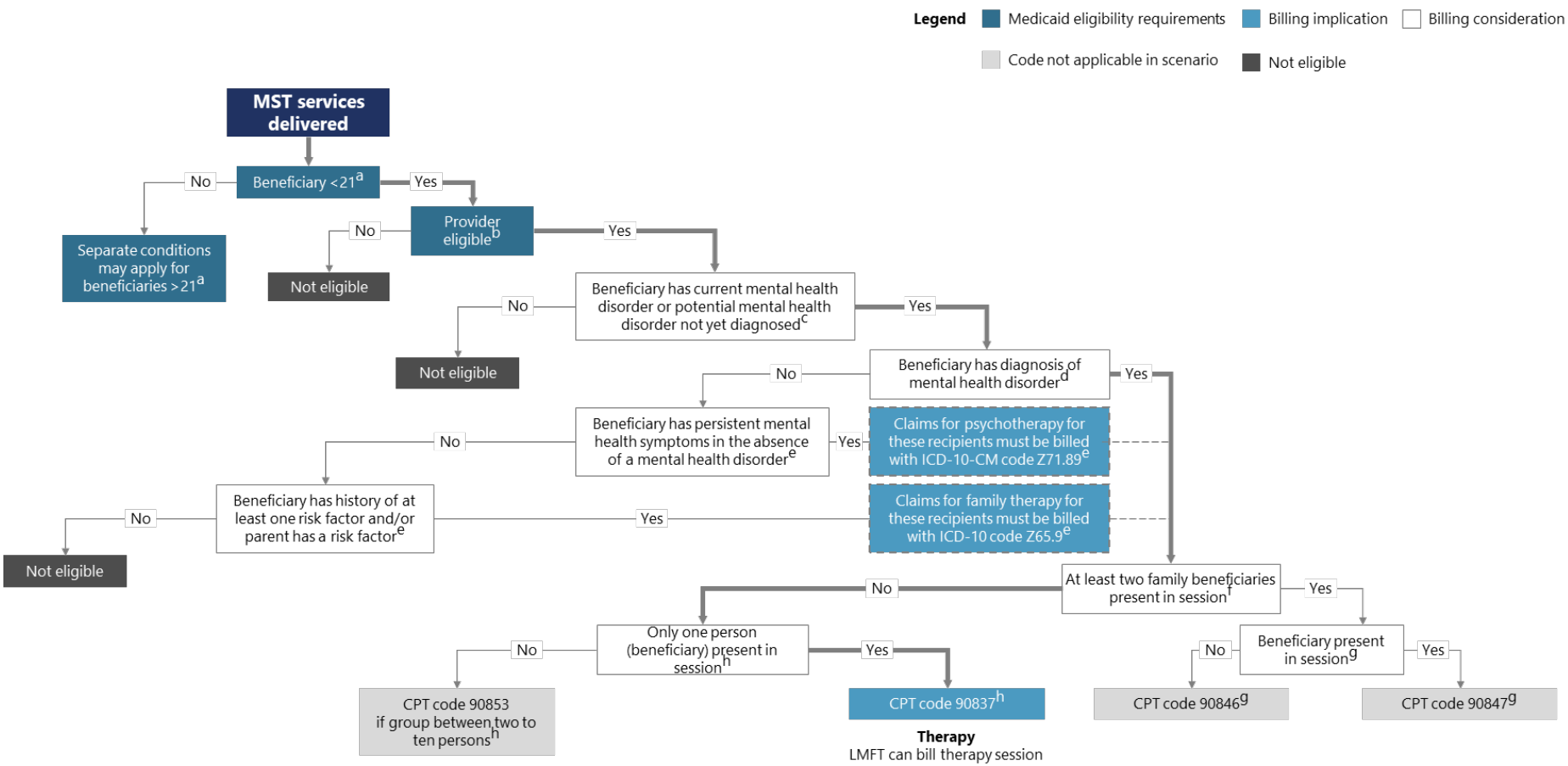


Figure 9. Potential billing guidance for LMFT providing MST[851]

850 BHIN 23-023 – (a) page 2, (b) page 5, (c) page 25

851 Non-Specialty Mental Health Services (NSMHS) – (a) page 1, (b) page 4, (c) page 2, (d) page 24, (e) page 25, (f) page 26, (g) page 27, (h) page 28


Legend
Medicaid eligibility requirements
Billing implication
Billing consideration
Code not applicable in scenario
Not eligible
MST services delivered
Beneficiary <21[a]
No
Yes
Separate conditions may apply for beneficiaries >21[a]
Provider eligible[b]
No
Yes
Not eligible
Beneficiary has current mental health disorder or potential mental health disorder not yet diagnosed[c]
No
Yes
Not eligible
Beneficiary has diagnosis of mental health disorder[d]
No
Yes
Beneficiary has persistent mental health symptoms in the absence of a mental health disorder[e]
No
Yes
Claims for psychotherapy for these recipients must be billed with ICD-10-CM code Z71.89[e]
Beneficiary has history of at least one risk factor and/or parent has a risk factor[e]
No
Yes
Claims for family therapy for these recipients must be billed with ICD-10 code Z65.9[e]
Not eligible
At least two family beneficiaries present in session[f]
No
Yes
Only one person (beneficiary) present in session[h]
No
Yes
CPT code 90853 if group between two to ten persons[h]
CPT code 90837[h]
Therapy
LMFT can bill therapy session
Beneficiary present in session[g]
No
Yes
CPT code 90846[g]
CPT code 90847[g]

E. Intellectual and Developmental Disabilities (IDD) scenario

Note: Principal healthcare services are numbered; blue text represents EBP / CDEP. See additional detail on each service in the table that follows the description

Description: A single parent has a young child (ages 4-6 years) who was diagnosed at an early age with an Intellectual and Developmental Disability (IDD). A Regional Center[852] **(1)** helps oversee care coordination for the child and ensures that the child has access to care in compliance with the Lanterman Act.[853]

A few months ago, the child's preschool teacher noticed potential signs of anxiety in the child. After a discussion with the other members of child's Individualized Education Plan (IEP) team, the team contacted the parent and case manager from the Regional Center and recommended the child get screened **(2)**. An official diagnosis for social anxiety disorder was then confirmed by the child's psychiatrist **(3)**. Based on the current severity of symptoms, the psychiatrist referred the parent and child attend Parent and Child Interaction Therapy (PCIT) as a treatment; if the symptoms for anxiety worsen, the psychiatrist may prescribe medication after PCIT is completed.

Over the past 10 weeks, the parent and child attended weekly 1-hour long PCIT sessions with a therapist in an outpatient clinic **(4)**. The parent and child still have 4 sessions remaining.

The parent has also been attending 2-hour long group sessions (four participants total) based on Level 3 of the Positive Parenting Program (Triple P) facilitated by the school psychologist **(5)**, who is also a beneficiary of the child's IEP team. The sessions are tailored to parents of children with co-occurring IDD and a mental disorder. There are five sessions total, with each session targeting a specific problem behavior or issue; the parent recently finished attending the fourth session.

The child and parent receive Medi-Cal coverage through a managed care plan (MCP).

852 Regional Centers, DDS
853 Lanterman Act and Related Laws, DDS

Table 6. Illustrative beneficiary scenario: summary of services received (non-EBPs / CDEPs shaded in gray)[854]

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
1. Care coordination / case management	Regional Center	• Assessments • Determination of eligibility for services • Case management	N	MCP	N/A	N/A
2. Special education services	Individualized Education Plan (IEP) team (e.g., teacher, psychologist, speech/occupational therapist)	• IEP • Specialized instruction • Assistive technology • Referral to resources	N	MCP	N/A	N/A
3. Anxiety diagnosis, regular evaluation, and medication management	Psychiatrist	• Medication management • Referral services and care coordination • Monitoring	N	MCP	N/A	N/A

[854] Non-Specialty Mental Health Services (NSMHS), Medi-Cal Coverage of CHW Services, Analysis by Manatt Health from Jan 2022 to Feb 2023, The California Evidence-Based Clearing House, PCIT, The California Evidence-Based Clearinghouse, Triple P

Principal service	Provider/practitioner	Service sub-components	Delivered as part of an EBP? (detail follows if Y)	Potential Medi-Cal payor(s) if service is covered	Potential billing code for EBPs	Explanation
4. Parent Child Interaction Therapy (PCIT)	Licensed Marriage and Family Therapist (LMFT) at an outpatient clinic	• Therapy session	Y	MCP	• Therapy session: CPT code 90847[855]	• The child meets the criteria for NSMHS[856] psychotherapy for recipients under age 21 as the child has a diagnosis of a mental health disorder • For Family Therapy: ○ Service provided may be considered family psychotherapy (with patient present)
5. Positive Parenting Program (Triple P)	School psychologist	• Small discussion group	Y	MCP	• Small discussion group: CPT code 98961[857]	• Child meets the medical necessity criteria for Community Health Worker Services (CHW) as the child has a diagnosis of a mental health disorder • For small discussion groups: ○ Service may be considered as group education delivered by a qualified, non-physician health care professional using a standard curriculum

855 Non-Specialty Mental Health Services (NSMHS), DHCS
856 Non-Specialty Mental Health Services (NSMHS), DHCS
857 Medi-Cal Coverage of CHW Services

Figure 10. Potential billing guidance for LMFT providing PCIT[858]

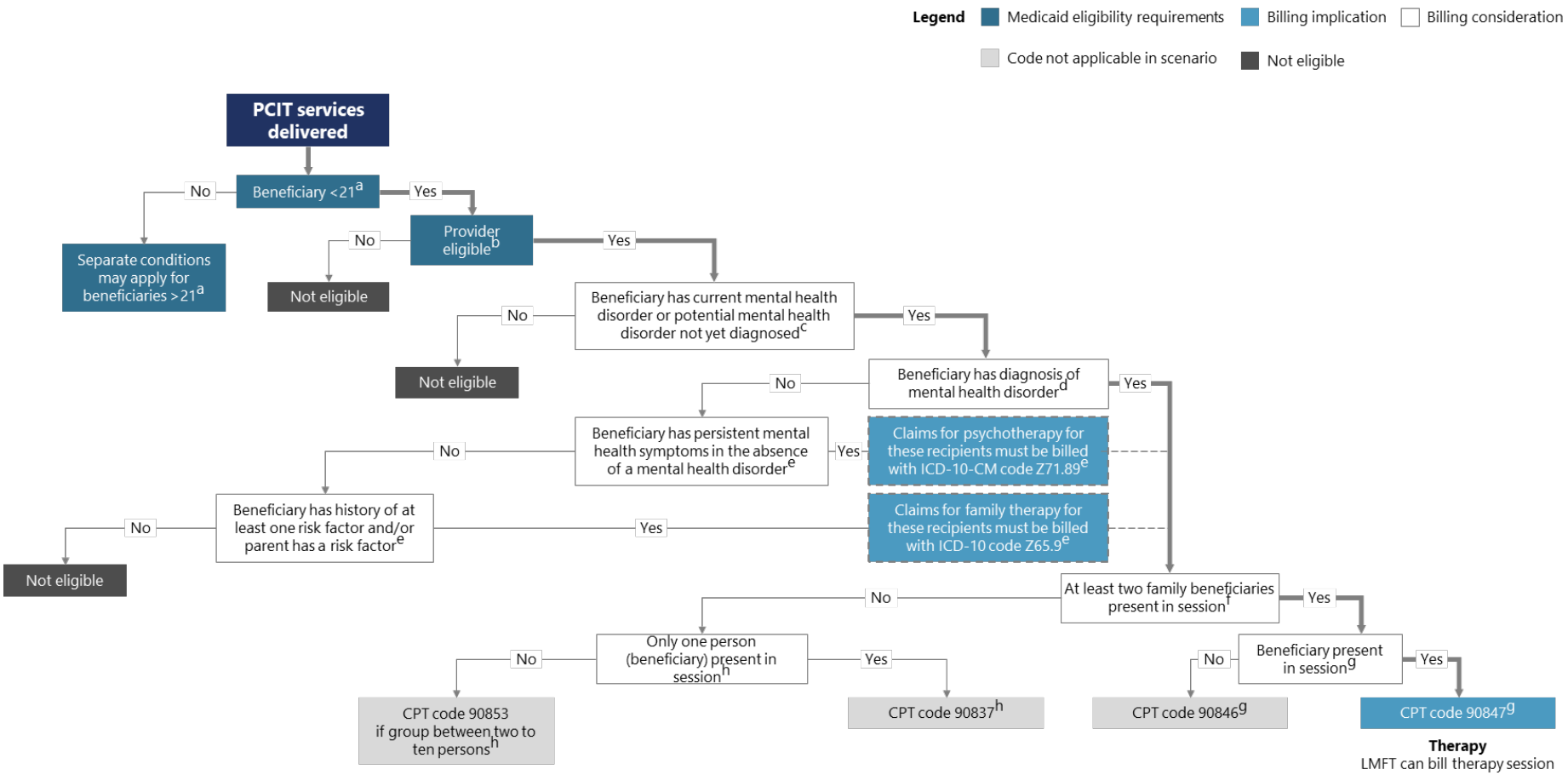
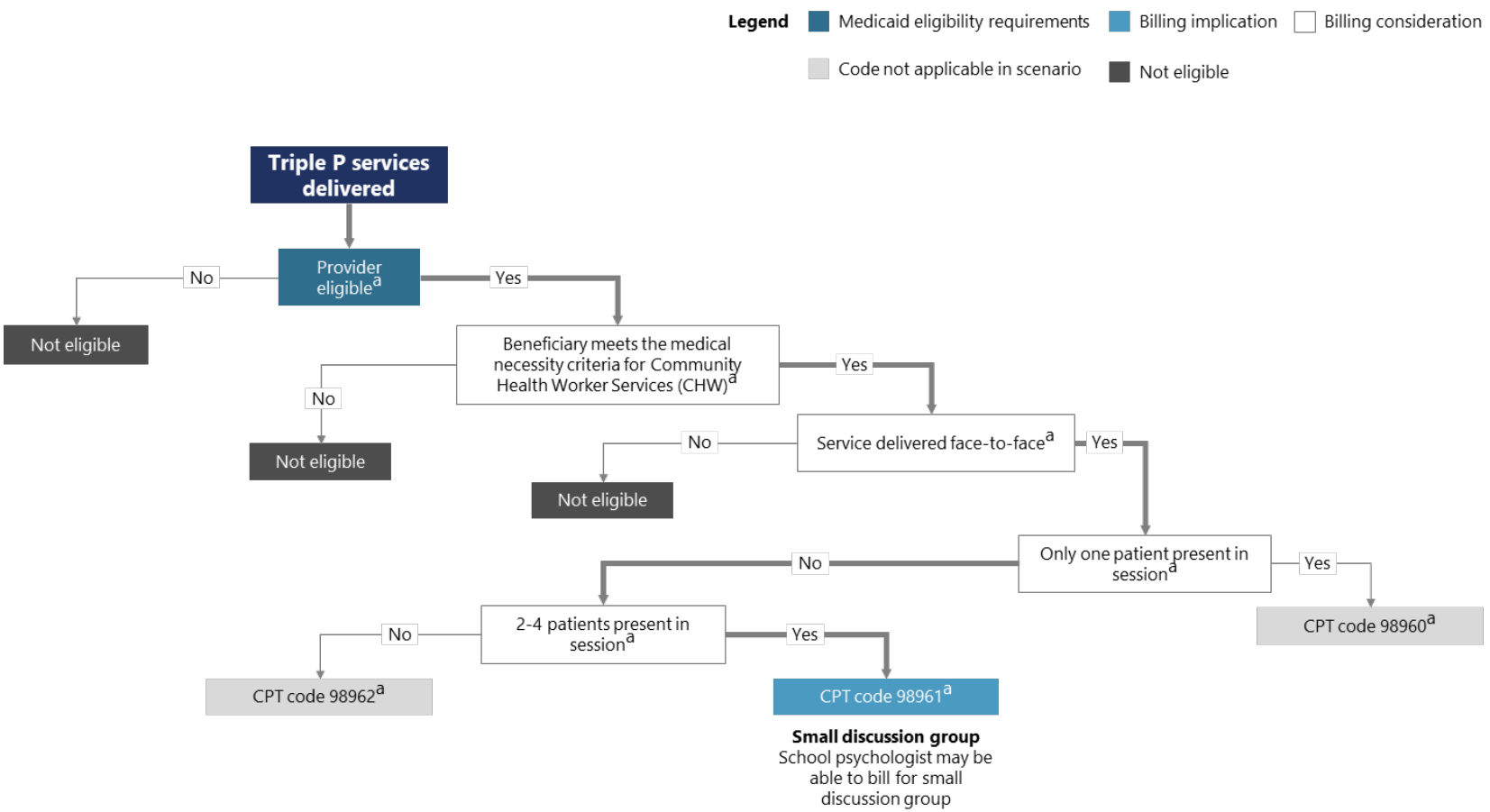


Figure 11. Potential billing guidance for school psychologist providing Triple P[859]

858 Non-Specialty Mental Health Services (NSMHS) – (a) page 1, (b) page 4, (c) page 2, (d) page 24, (e) page 25, (f) page 26, (g) page 27, (h) page 28

859 Medi-Cal Coverage of CHW Services


Legend
Medicaid eligibility requirements
Billing implication
Billing consideration
Code not applicable in scenario
Not eligible
Triple P services delivered
Provider eligible[a]
No
Yes
Not eligible
Beneficiary meets the medical necessity criteria for Community Health Worker Services (CHW)[a]
Yes
No
Not eligible
Service delivered face-to-face[a]
No
Yes
Not eligible
Only one patient present in session[a]
No
Yes
CPT code 98960[a]
2-4 patients present in session[a]
No
Yes
CPT code 98962[a]
CPT code 98961[a]
Small discussion group
School psychologist may be able to bill for small discussion group

Appendix: Rules for use of specific CPT/HCPCS codes

A. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

SABIRT services include screening for alcohol and drug use, assessment, brief interventions, and referral to treatment.

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)			
CPT/HCPCS code[860]	**Description**	**Medi-Cal Reimbursement Information[861]**	**Eligible Providers[862]**
G0442	Annual alcohol misuse screening	• Medi-Cal reimburses alcohol and drug use screening, assessment, brief interventions and referral to treatment for recipients aged 11 and older, including pregnant women, in primary care settings • Billing frequency is once per year per provider	Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), and psychiatrist
H0049	Drug use screening		
H0050	Alcohol and drug services, brief intervention		

860 Analysis by Manatt Health from Jan 2022 to Feb 2023
861 Evaluation and Management (E&M)
862 Non-Specialty Mental Health Services (NSMHS), DHCS

B. Case Management Medical Team Conference

Case Management Medical Team Conference services include case management by a medical team that discusses a treatment plan for a patient who requires attention from more than one medical specialty.

Case Management Medical Team Conference			
CPT/HCPCS code[863]	**Description**	**Medi-Cal Reimbursement Information[864]**	**Eligible Providers[865]**
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family; 30 minutes or more, participation by nonphysician health care professional	• Medi-Cal reimburses case management services for conferences with persons immediately involved in the case or recovery of the patient. • Billing frequency is once per day per provider	Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Clinical Counselors (LPCC), Psychologists
99368	Medical team conference with interdisciplinary team of health care professionals when patient and/or family is not present; 30 minutes or more, participation by nonphysician health care professional		

863 Analysis by Manatt Health from Jan 2022 to Feb 2023
864 Non-Specialty Mental Health Services (NSMHS), DHCS
865 Non-Specialty Mental Health Services (NSMHS), DHCS

C. Central Nervous System (CNS) Assessments/Tests

CNS services include developmental testing (assessment of fine and/or gross motor/language, cognitive level, social and memory, or executive functions where interpretation is included), psychological testing and evaluation, neuropsychological testing and devaluation (assessment of intellectual abilities, attention, learning, memory, visual-spatial skills, visual-motor integration, language, motor coordination, and executive functioning), and psychological or neuropsychological test administration and scoring.

Central Nervous System Assessments/Tests			
CPT/HCPCS code[866]	**Description**	**Medi-Cal Reimbursement Information**[867]	**Eligible Providers**[868]
Developmental Testing with Interpretation[869]			
96112	Developmental test administration including assessment of fine and gross motor, language, cognitive level, social, and memory or executive functions by standardized developmental instruments with interpretation and report, initial hour	• Medi-Cal reimburses developmental testing when a child has signs concerning for developmental delay or loss of previously acquired developmental skills or when a developmental screening test is abnormal • Claims must include an itemization of the tests performed • CPT codes 96112 and 96113 can be used once per year for any provider	Clinical Nurse Specialist (CNS), Medical Doctor/Doctor of Osteopathy (MD/DO), Nurse Practitioner (NP), Occupational Therapist (OT), Physician Assistant (PA), and psychologists
96113	Developmental test administration; each additional 30 minutes after the first hour of service		
Psychological Testing and Evaluation[870]			
96130	Psychological testing and evaluation; first hour (31 minutes minimum)	• Medi-Cal reimburses psychological testing when a current medical or mental health evaluation has been conducted and a	Clinical Nurse Specialist (CNS), Medical

[866] Analysis by Manatt Health from Jan 2022 to Feb 2023
[867] Non-Specialty Mental Health Services (NSMHS), DHCS
[868] Non-Specialty Mental Health Services (NSMHS), DHCS; Specialty Mental Health Services Medi-Cal Billing Manual
[869] Non-Specialty Mental Health Services (NSMHS), DHCS
[870] Non-Specialty Mental Health Services (NSMHS), DHCS

96131	Psychological testing and evaluation; each additional hour after the first hour of service	specific diagnostic or treatment questions still exists which cannot be answered by a psychiatric diagnostic interview and history-taking • Claims must include an itemization of the tests performed • CPT code 96130 can be used once per year for any provider. CPT code 96131 can be used twice per year for any provider	Doctor/Doctor of Osteopathy (MD/DO), Nurse Practitioner (NP), Physician Assistant (PA), and psychologists
Neuropsychological Testing and Evaluation[871]			
96132	Neuropsychological testing evaluation services; first hour	• See NSMHS for a full list of criteria when considering if neuropsychological testing is considered medically necessary • Claims must include an itemization of the tests performed • CPT code 96132 can be used once per year for any provider. CPT code 96133 can be used twice per year for any provider	Clinical Nurse Specialist (CNS), Medical Doctor/Doctor of Osteopathy (MD/DO), Nurse Practitioner (NP), Physician Assistant (PA), and psychologists
96133	Neuropsychological testing evaluation services; each additional hour after the first hour of service		
Psychological or Neuropsychological Test Administration and Scoring[872]			
96136	Psychological or neuropsychological test administration and scoring, by physician or other qualified health care professional, two or more tests; first 30 minutes	• Medi-Cal reimburses psychological testing when a current medical or mental health evaluation has been conducted and a specific diagnostic or treatment questions still exists which cannot be answered by a psychiatric diagnostic interview and history-taking • See NSMHS for a full list of criteria when considering if neuropsychological testing is considered medically necessary • Claims must include an itemization of the tests performed	Clinical Nurse Specialist (CNS), Medical Doctor/Doctor of Osteopathy (MD/DO), Nurse Practitioner (NP), Physician Assistant (PA), and psychologists
96137	Psychological or neuropsychological test administration and scoring, by physician or other qualified health care professional, two or more tests; each additional 30 minutes		

871 Non-Specialty Mental Health Services (NSMHS), DHCS
872 Non-Specialty Mental Health Services (NSMHS), DHCS

96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes	• CPT codes 96136, 96138, 96146 can be used once per year for any provider. CPT codes 96137 and 96139 can be used nine times per year for any provider	
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes		
96146	Psychological or neuropsychological test administration, via electronic platform, with automatic result, only		

D. Community Health Worker (CHW) Services

CHW services are preventive health services to prevent disease, disability, and other health conditions. CHW services can address various issues including but not limited to the control and prevention of chronic conditions or infectious diseases, mental health conditions and substance use disorders, need for preventive services, perinatal health conditions, sexual and reproductive health; environmental and climate-sensitive health issues, child health and development, oral health, aging, injury, domestic violence, and violence prevention.

Community Health Worker (CHW) Services			
CPT/HCPCS code[873]	**Description**	**Medi-Cal Reimbursement Information[874]**	**Eligible Providers[875]**
98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.	• Pursuant to 42 CFR Section 440.130(C), Medi-Cal covers community health worker (CHW) services as preventive services and with the written recommendation of an eligible provider • CHW services are considered medically necessary for members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers meeting their health or health-related social needs, and/or benefit from preventive services. The recommending provider shall determine whether a member meets the medical necessity criteria for CHW services based on the presence of one or more of the following: ○ Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental	Physician or other licensed practitioner of the healing arts within their scope of practice under state law
98961	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2–4 patients		

873 Analysis by Manatt Health from Jan 2022 to Feb 2023
874 Medi-Cal Coverage of CHW Services
875 Medi-Cal Coverage of CHW Services

98962	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5–8 patients.	disorder or substance use disorder that has not yet been diagnosed o Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, etc., that indicate risk but do not yet warrant diagnosis of a chronic condition) o Positive Adverse Childhood Events (ACEs) screening o Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse o Results of a social drivers of health screening indicating unmet health-related social needs, such as housing or food insecurity o One or more visits to a hospital emergency department within the previous six months o One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization o One or more stays at a detox facility within the previous year o Two or more missed medical appointments within the previous six months o Member expressed need for support in health system navigation or resource coordination services o Need for recommended preventive services • CHW violence preventive services are available to a Medi-Cal member who meets any of the following circumstances: o The member has been violently injured as a result of community violence	

		○ A licensed health care provider has determined that the member is at significant risk of experiencing violent injury as a result of community violence ○ The member has experienced chronic exposure to community violence	

E. Dyadic Psychoeducational Services

Dyadic psychoeducational services are planned, structured interventions that present information to prevent the development or worsening of behavioral health conditions and achieve optimal mental health and long-term resilience.

Psychoeducational Services			
CPT/HCPCS code[876]	**Description**	**Medi-Cal Reimbursement Information**[877]	**Eligible Providers**[878]
H2027	Psychoeducational service, 15 minutes	• Medi-Cal reimburses Dyadic Psychoeducational Services (using HCPCS code H2027) for recipients aged 0 to 20 years, for psychoeducational services provided to the child and/or caregiver(s) • H2027 is reimbursable for the initial and periodic psychoeducational services, per 15 minutes	Medical Doctor, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), and Psychiatric Nurse Practitioner (NP)

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877 Non-Specialty Mental Health Services (NSMHS), DHCS
878 Non-Specialty Mental Health Services (NSMHS), DHCS

F. Enhanced Care Management (ECM) and Community Supports

ECM is a statewide Medi-Cal benefit that takes a whole-person, interdisciplinary approach to addressing clinical and non-clinical needs of members with the most complex medical and social needs. Community Supports are services that address members' health-related social needs, wellbeing, and cost of care (e.g., support to secure and maintain housing, access to medically tailored meals, other community-based services).

<table>
<tr><th colspan="4">Enhanced Care Management (ECM) and Community Supports</th></tr>
<tr><th>CPT/HCPCS code[879]</th><th>Description</th><th>Medi-Cal Reimbursement Information[880]</th><th>Eligible Providers[881]</th></tr>
<tr><td>G9008</td><td>Enhanced care management in-person by clinical staff</td><td rowspan="3">• Medi-Cal reimburses members who are enrolled in a Medi-Cal Managed Care Plan (MCP) and meet at least one of the ECM Populations of Focus:
○ Adults, unaccompanied youth and children, and families experiencing homelessness
○ Adults, youth, and children who are at risk for avoidable hospital or emergency department care
○ Adults, youth, and children with serious mental health and/or substance use disorder needs
○ Adults living in the community and at risk for long-term care institutionalization</td><td rowspan="3">Community-based ECM Providers that enter into contracts with MCPs; see ECM Policy Guide for list of example ECM Providers</td></tr>
<tr><td>G9012</td><td>Enhanced care management in-person provided by non-clinical staff</td></tr>
<tr><td>T1016</td><td>Case management, per 15 minutes</td></tr>
</table>

879 Analysis by Manatt Health from Jan 2022 to Feb 2023
880 ECM and Community Supports HCPCS Coding Guidance
881 ECM Policy Guide

		○ Adult nursing facility residents transitioning to the community ○ Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s) ○ Children and youth involved in child welfare (foster care) ○ Adults and youth who are transitioning from incarceration ○ Pregnant and postpartum individuals; birth equity population of focus (starting in 2024) • ECM and Community Supports services are defined by a combination of a HCPCS code and a modifier; see ECM and Community Supports HCPCS Coding Guidance for more details on modifiers	

G. Health Behavior Assessment and Intervention Services

Health behavior assessments and interventions are used to identify and address psychological, behavioral, emotional, cognitive, and interpersonal factors relevant for the prevention, treatment, or management of physical health problems. Health behavior assessments include services such as health-focused clinical interviews, behavioral observations, and clinical decision making. Health behavior interventions are provided individually, to a group, or to a family, and include services such as promotion of functional improvement, minimization of psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions.

Health Behavior Assessment and Intervention Services			
CPT/HCPCS code[882]	**Description**	**Medi-Cal Reimbursement Information[883]**	**Eligible Providers[884]**
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)	• Medi-Cal reimburses health behavior assessment and intervention services when used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems • Codes are not reimbursable on the same day to the same provider as evaluation and management service codes (including CPT codes 99406 and 99407) or CPT codes 90785 thru 90899 • CPT codes 96156, 96158, 96164, 96167, 96170, and 96171 can be used once per day for any provider. CPT code 96159 can be	Medical Doctor, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), and Psychiatric Nurse Practitioner (NP)
96158	Health and behavior intervention, individual, face-to-face; initial 30 minutes		
96159	Health and behavior intervention, individual, face-to-face; each additional 15 minutes		
96164	Health and behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes		

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883 Non-Specialty Mental Health Services (NSMHS), DHCS
884 Non-Specialty Mental Health Services (NSMHS), DHCS

96165	Health and behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	used four times per year for any provider. CPT codes 96165 and 96168 can be used six times per day for any provider	
96167	Health and behavior intervention, family with patient present, face-to-face; initial 30 minutes		
96168	Health and behavior intervention, family with patient present, face-to-face; each additional 15 minutes		
96170	Health and behavior intervention, family without patient present, face-to-face; initial 30 minutes		
96171	Health and behavior intervention, family without patient present, face-to-face; each additional 15 minutes		

H. Interactive Complexity

Interactive Complexity is an add-on code for psychiatric services that pertains to communication challenges during a psychiatric procedure.

Interactive Complexity			
CPT/HCPCS code[885]	**Description**	**Medi-Cal Reimbursement Information[886]**	**Eligible Providers[887]**

90785	Interactive complexity	May be billed with CPT codes for:
		• Psychiatric diagnostic evaluation (90791, 90792)
		• Psychotherapy (90832, 90834, 90837)
		• Psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99201 through 99216, 99221 through 99223, 99227 through 99240, 99242 through 99250, 99252 through 99255, 99304 through 99327, 99329 through 99333, 99336, 99341, 99342, 99344 through 99350)
		• Group psychotherapy (90853) when any of the following are present:
		  ○ Communication difficulties among participants that complicate care delivery, related to issues such as: high anxiety, high reactivity, repeated questions or disagreement
		  ○ Caregiver emotions or behaviors that interfere with implementing the treatment plan
			Clinical Nurse Specialist (CNS), Medical Doctor/Doctor of Osteopathy (MD/DO), Licensed Psychiatric Technician (LPT), Licensed Vocational Nurse (LVN), Mental Health Rehabilitation Specialist (MHRS), Pharmacist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), psychiatrist, and other

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886 Non-Specialty Mental Health Services (NSMHS), DHCS
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		○ Evidence or disclosure of a sentinel event and mandated report to a third party (for example, abuse or neglect with report to state agency) ○ The mental health provider overcomes communication barriers by using any of the following methods: play equipment or other physical devices, interpreter, or translator for a recipient who: ▪ Is not fluent in the same language as the mental health provider, or ▪ Has not developed or has lost the expressive or receptive communication skills needed to use or understand typical language	

I. Mobile Crisis

Mobile crisis services provide rapid response, individual assessment and community-based stabilization to individuals who are experiencing a behavioral health crisis. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member a behavioral health crisis (e.g., member's home, school, workplace, on the street).

Mobile Crisis			
CPT/HCPCS Code (Place of Service Code)[888]	**Description**	**Medi-Cal Reimbursement Information**[889]	**Eligible Providers**[890]
H2011 (15)	Mobile Crisis, per encounter	• Medi-Cal reimburses mobile crisis services prior to and after determination of a mental health or SUD diagnosis, or a determination that the member meets access criteria for SMHS, DMC and/or DMC- ODS services • Medi-Cal behavioral health delivery systems shall submit one claim per mobile crisis services encounter, which must include the four minimum components of a Medi-Cal reimbursable encounter (see BHIN 23-023 for more detail) • Reimbursement for the encounter is considered all inclusive • A Member may receive more than one mobile crisis service encounter on the same day	Mobile crisis team (must meet standards outline in BHIN 23-023)

888 Analysis by Manatt Health from Jan 2022 to Feb 2023
889 BHIN 23-023
890 Specialty Mental Health Services Medi-Cal Billing Manual

J. Peer Support Services

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Peer Support Services can be delivered and claimed as a standalone service or provided in conjunction with other SMHS, DMC, or DMC-ODS services, including inpatient and residential services.

Peer Support Services			
CPT/HCPCS code[891]	**Description**	**Medi-Cal Reimbursement Information**[892]	**Eligible Providers**[893]
H0025	Behavioral health prevention education services	• SMHS, DMC-ODS, and DMC claims must include taxonomy code 175T00000X (Peer Specialist) for reimbursement • All claims are billed in 15-minute increments • Peer Support Services are billed using a combination of procedure codes and modifiers; see BHIN 22-026 for more details on modifiers	Peer Support Specialists
H0038	Peer support		

891 Analysis by Manatt Health from Jan 2022 to Feb 2023

892 Medi-Cal Peer Support Services Specialist Program; BHIN 22-026

893 BHIN 22-026

K. Psychiatric Diagnostic Evaluation

A psychiatric diagnostic evaluation is used to assess and diagnose an individual's mental health. The evaluation consists of an integrated biopsychosocial assessment (and medical assessment if evaluation includes medical services) that includes the elicitation of a complete medical history (to include past, family, and social), psychiatric history, a complete mental status exam (and other physical examination elements as needed for an evaluation with medical services), establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan.

Psychiatric Diagnostic Evaluation			
CPT/HCPCS code[894]	**Description**	**Medi-Cal Reimbursement Information[895]**	**Eligible Providers[896]**
90791	Psychiatric diagnostic evaluation without medical services	• Medi-Cal reimburses psychiatric diagnostic evaluations for recipients ages 0 -20 years and their caregivers • Psychiatric diagnostic evaluations must be consistent with the scope of license and competency of the mental health provider and must be documented in the medical record with the following items included: ○ Presenting problem/changes in functioning/history of presenting concern ○ Mental health and substance use history ○ Medical history and current medications ○ Social and cultural factors ○ Risk and safety factors ○ Case conceptualization and diagnostic summary	Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), and psychiatrist
90792	Psychiatric diagnostic evaluation with medical services		

894 Analysis by Manatt Health from Jan 2022 to Feb 2023
895 Non-Specialty Mental Health Services (NSMHS), DHCS
896 Non-Specialty Mental Health Services (NSMHS), DHCS; Specialty Mental Health Services Medi-Cal Billing Manual

L. Psychotherapy

Psychotherapy services encompass a range of treatments that aim to assist individuals in identifying and changing troubling emotions, thoughts, and behaviors.

Psychotherapy			
CPT/HCPCS code[897]	**Description**	**Medi-Cal Reimbursement Information**[898]	**Eligible Providers**[899]
Family Therapy			Clinical Nurse Specialist, Medical Doctor/Doctor of Osteopathy, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), Psychiatric Nurse Practitioner (NP), and psychiatrist
90846	Family psychotherapy without patient present; *50 minutes*	• Family therapy requires at least two family members and primarily focuses on family dynamics as they relate to the patient's mental status and behavior(s). However, all family members do not need to be present for each service; for instance, parents or caregivers can qualify for family therapy without their infant present, if necessary. Both children and adult Members are eligible to receive family therapy mental health services deemed medically necessary. • In accordance with APL 22-029, DHCS allows Members under age 21 to receive a maximum of five family therapy sessions before a mental health diagnosis is required.[900] Regardless of the five-visit limitation, participants in the Medi-Cal delivery system must provide family therapy for Members under age 21 with risk factors for mental health disorders or parents/caregivers with related risk factors, including: ○ Separation from a parent/caregiver due to incarceration, immigration, or death ○ Foster care placement	
90847	Family psychotherapy with patient present; *50 minutes*		
90849	Multiple-family group psychotherapy		

897 Analysis by Manatt Health from Jan 2022 to Feb 2023
898 Non-Specialty Mental Health Services (NSMHS), DHCS
899 Non-Specialty Mental Health Services (NSMHS), DHCS; Specialty Mental Health Services Medi-Cal Billing Manual
900 All Plan Letter 22-029

		○ Food insecurity ○ Housing instability ○ Exposure to domestic violence or trauma maltreatment ○ Severe/persistent bullying ○ Discrimination • Any diagnostic criteria used should be age appropriate, e.g., for young children, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) should be utilized to help practitioners more accurately identify diagnosis in young children who do not have language skills or exhibit the same symptoms as older children and adults	
Group Therapy			
90853	Group psychotherapy	• Group therapy requires at least two but not more than ten persons at the session. There is no restriction on the number of Medi-Cal-eligible persons who must be included in the group's composition • Group therapy sessions less than one and one-half hours are not reimbursable	
Individual Therapy			
90832	Psychotherapy with patient; *30 minutes*	• Individual therapy sessions with the same provider are restricted to a maximum duration of one and a half hours per day	
90834	Psychotherapy with patient; *45 minutes*		
90837	Psychotherapy with patient; 60 *minutes*		
90839	Psychotherapy for crisis; *first 60 minutes*		
90840	Psychotherapy for crisis each additional 30 minutes		

M. Screening Services

Screening services are used to detect potential mental health disorders.

Screening Services			
CPT/HCPCS code[901]	**Description**	**Medi-Cal Reimbursement Information[902]**	**Eligible Providers[903]**
Adverse Childhood Experience (ACE) Screening			
G9920	ACE screening-lower risk, patient score of 0-3	• Medi-Cal reimburses ACE screening in all inpatient and outpatient settings in which billing occurs • Billing frequency limits are as follows: ○ For members under age 21, one screening per year, per provider ○ For members aged 21 through 64 years, one screening per adult lifetime per provider – screenings completed while the recipient is under age 21 do not count toward the one screening allowed in their adult lifetime	Medical Doctor, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), and Psychiatric Nurse Practitioner (NP) Note: Providers must also have taken a certified Core Training and self-attested to their completion of the training
G9919	ACE screening-higher risk, patient score of 4 or greater		
Brief Emotional/Behavioral Assessment			

901 Analysis by Manatt Health from Jan 2022 to Feb 2023
902 Non-Specialty Mental Health Services (NSMHS), DHCS; Evaluation and Management (E&M)
903 Non-Specialty Mental Health Services (NSMHS), DHCS

96127	Social-emotional-brief emotional/behavioral assessments	• Providers must document in the medical record the name of the instrument, the score, and that the results were discussed with the member/family and were incorporated into the plan of care as appropriate • Billing frequency is limited to twice per day, per provider	Medical Doctor, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), and Psychiatric Nurse Practitioner (NP)
	Depression Screening		
G8431	Screening for depression documented as positive: follow-up plan is required	• HCPCS codes G8431 and G8510 may not be billed for the same date of service, for the same recipient, by the same provider • For pregnant or postpartum members: ○ Combined total claims using HCPCS codes G8431 and/or G8510 may not exceed two per year, per member, by any provider of prenatal or postpartum care ○ Providers must include a pregnancy or postpartum diagnosis code on all claims	Medical Doctor, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), and Psychiatric Nurse Practitioner (NP)
G8510	Screening for depression documented as negative		
	Developmental Screening		
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument	• CPT code 96110 is not reimbursable if billed within one month of code 99460 or 99462 (normal newborn care services) by the same provider for the same recipient	Medical Doctor, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric

			Physician Assistant (PA), and Psychiatric Nurse Practitioner (NP)

N. Smoking and Tobacco Cessation Counseling

Smoking and tobacco cessation counseling is used to help an individual stop smoking or using tobacco.

Case Management Medical Team Conference			
CPT/HCPCS code[904]	**Description**	**Medi-Cal Reimbursement Information[905]**	**Eligible Providers[906]**
99406	Smoking and tobacco use cessation counseling visit; intermediate, more than 3 minutes up to 10 minutes	• Medi-Cal reimburses tobacco cessation counseling for members age 0 -20 years and their caregivers • Billing frequency is limited to one counseling session per day	Medical Doctor, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), licensed psychologists, Psychiatric Physician Assistant (PA), and Psychiatric Nurse Practitioner (NP)
99407	Smoking and tobacco use cessation counseling visit; intensive, more than 10 minutes		

[904] Analysis by Manatt Health from Jan 2022 to Feb 2023
[905] Non-Specialty Mental Health Services (NSMHS), DHCS; Evaluation and Management (E&M)
[906] Non-Specialty Mental Health Services (NSMHS), DHCS