Medi-Cal Children's Health Advisory Panel (MCHAP) Meeting

November 5, 2026
10 a.m. - 2 p.m.

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Hybrid Meeting Tips

- Use either a computer or phone for audio connection.
- Mute your line when not speaking.
- Members are required to turn on their cameras during the meeting.
- Registered attendees will be able to make oral comments during the public comment period.
- For questions or comments, email MCHAP@dhcs.ca.gov.

Welcome, Roll Call, Today's Agenda

Nancy Netherland, Chair

DHCS

Membership Renewal

Michelle Baass, Director

DHCS

Election of 2027 Chairperson

Michelle Baass, Director

Director’s Update

Michelle Baass, Director

Unsatisfactory Immigration Status (UIS) Members: Transition from Managed Care to Fee-for-Service (FFS)

What the Transition to FFS Means for UIS Members (1 of 2)

Most Medi-Cal members get their benefits through a Medi-Cal health plan, which coordinates with local providers to help members access care and covers Enhanced Care Management (ECM) and Community Supports, like housing and transportation assistance. When they move to FFS, these members risk losing provider continuity and ECM/Community Supports. Other services, like pharmacy benefits, specialty mental health services, and substance use disorder treatment, remain unaffected.

Note: all numbers on this slide are preliminary.

Who is Impacted

1.93M Medi-Cal members must transition to FFS.

1.21M Had a service in the past year

AGE

12% <18 | 81% 19–64 | 9% 65+

LANGUAGE

73% Spanish -speaking

TOP 6 COUNTIES · 80% of high care disruption risk

County	UIS Members
Los Angeles	59,561
Orange	12,843
San Diego	10,111
Riverside	5,114
San Bernardino	5,964
Santa Clara	2,779

~40% have seen a primary care provider (PCP) in the past year

What the Transition to FFS Means for UIS Members (2 of 2)

What Services Continue

- **Pregnancy & prenatal:** Only 5.6% of care sits with not-ready providers.
- **Dialysis (really transportation):** Facilities are largely enrolled — the risk is getting there, not the treatment.
- **Nursing facilities:** Only 3.9% of nursing facility care is at risk.
- **Pharmacy benefit:** The pharmacy benefit already runs FFS; the prescriber is what needs protecting.
- **Community health centers:** 98% of centers are ready
- **Specialty mental health and substance use disorder:** Services covered through the county behavioral health plans are not impacted.

Where Members Lose Care Continuity

- **Transportation:** 86% of rides provided today are through brokers who can't enroll; this puts access to critical care at risk.
- **Home health:** Providers accounting for 82% of care are enrolled but not actively billing FFS.
- **Autism & Behavioral Health Treatment:** Of 1,286 providers, only 3 bill FFS.
- **Behavioral Health (BH) :** ~50% impacted; mild-to-moderate only; county specialty continues.
- **Homeless & Street Medicine:** 89,906 members are especially hard to reach – 35% have continuity risk.

**Note: all numbers on this slide are preliminary.*

How We're Supporting This Population

Three coordinated tracks are underway to protect continuity of care for members transitioning to FFS.

Managed Care Plan (MCP) Engagement

- **Direct plans** to help members transition their care: Identify urgent- and active-risk members and share FFS provider rosters.
- **Collect data** to improve member stratification and provide context to DHCS teams engaging members, enabling a smoother transition.
- **Share data** to support authorizations and ensure care continues.

Provider Engagement

- **Reaching out** to confirm providers continue caring for members in FFS.
- **Identifying providers** that can take more members in FFS.
- **Helping providers** understand FFS and enroll.
- **Collaborating** with community clinics and Federally Qualified Health Centers (FQHC) and Community Health Worker organizations.

Member Engagement and Support

- **Care Navigation** helps members find a provider and understand how to access care.
- **Nurse Advice Line** routes members with urgent clinical needs to the most appropriate care option.
- **Care Coordination and Care Management** facilitates provider coordination for members with complex needs. Provides 1:1 member support through assessment, care plan management, and care coordination.
- **Direct Member Communication** mail, text, email members notices, reminders and tools.

Ordering, Referring, and Prescribing (ORP) Provider Enrollment

ORP Background

- Federal Medicaid rules require all providers who order, refer, or prescribe to be enrolled in Medicaid with an individual (Type 1) National Provider Indicator (NPI) ***and*** for that NPI to be on the claim.
- DHCS launched a **multi-year, enterprise-wide effort** to implement and enforce these requirements across all delivery systems.
- Enforcement aligns with federal compliance requirements, improves data accuracy, strengthens payment controls, reduces improper payments, and protects program integrity.
- To minimize impacts, DHCS has conducted targeted outreach and education, secured additional resources to support timely application processing, and developed an implementation approach guided by data-driven go/no-go criteria.

ORP Enforcement Timeline and Provider Action

- ORP claim edits will be implemented from **February 2027 through June 2028.**
  - Medical CA-MMIS FFS **ordering claim edits** begin February 2027.
  - Pharmacy Medi-Cal Rx **prescribing claim edits** begin March 2027.
  - Medical CA-MMIS FFS **referring claim edits** begin April 2027.
  - Behavioral Health Short-Doyle **ordering claim edits** begin October 2027.
- Any changes to timelines will be communicated through provider manuals, bulletins, frequently asked questions (FAQ), the DHCS website, and DHCS subscription lists.
- DHCS strongly encourages **providers who are not enrolled**, and who order, refer, or prescribe, to **submit their Medi-Cal enrollment application today.**
  - For enrollment support, review the ORP Enrollment slide deck or utilize the Provider Inquiry Form.

Work and Community Engagement Requirements

Medical Frailty Exclusion for Work and Community Engagement Requirements

Beginning January 1, 2027, federal law requires certain adults ages 19 to 64 in the Medi-Cal expansion group to meet work and community engagement requirements as a condition of eligibility.

- Individuals in this group must demonstrate that they:
  1. Meet a specified exclusion and are not subject to work and community engagement requirements;
  2. Meet an exception for work and community engagement requirements; or
  3. Meet a qualifying activity for work and community engagement requirements.
- Individuals who meet the criteria for **medical frailty** are considered "specified excluded" and not subject to work and community engagement requirements . Timely identification and verification of these individuals will ensure they are not unnecessarily required to report on whether they meet work and community engagement requirements.
- The following slides outline DHCS' approach for developing a framework to identify and exclude individuals based on medical frailty.

Specified Excluded vs. Applicable Individuals (1 of 2)

Specified Excluded Individuals

(not subject to work and community engagement requirements; evaluated in month of application)

- Medically frail individuals.
- Participants in a drug addiction or alcohol treatment and rehabilitation program.
- Parents, guardians, caretaker relatives, or family caregivers of a dependent child under age 14, or of a disabled individual.
- Veterans with a disability rated as total under 38 U.S.C. § 1155.
- Members of a household receiving Supplemental Nutrition Assistance Program (SNAP) and not exempt from SNAP work requirements.
- Individuals compliant with Temporary Assistance for Needy Families (TANF) work reporting requirements.
- American Indians and Alaska Natives.
- Former foster care youth under age 26 (i.e., individuals eligible under the former foster care youth (FFCY) eligibility group).
- Inmates of a public institution.
- Pregnant individuals or those entitled to postpartum Medi-Cal coverage.

Specified Excluded vs. Applicable Individuals (2 of 2)

Applicable Individuals

(subject to work and community engagement requirements)

Exceptions *[evaluated in lookback month(s)]*	**Qualifying Activities** *[evaluated in lookback month(s)]*
Mandatory Exceptions: » Under age 19. » Entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B. » Described in a mandatory eligibility group (e.g., parents/caretaker relatives within certain incomes, individuals receiving Supplemental Security Income). » Incarcerated at some point in the three-month period prior to the relevant month. » Specified excluded individuals (if relevant during the lookback month). **Optional Short-Term Hardships Exceptions:** » Receiving inpatient or institutional care*. » Travel outside one's community for medical care for themselves or a dependent.* » Living in a county with a federal emergency or disaster declaration. » Living in a county with high local unemployment. **Individual must request exception.*	» Work (at least 80 hours). » Community service (at least 80 hours). » Participation in a work program (at least 80 hours). » Educational enrollment (at least half time). » Any combination of the above listed activities (for a total of at least 80 hours). » Income of at least $580/month (or for seasonal workers, an average $580/month income over a six-month period).

Federal Framework for Medical Frailty

June 2026 Interim Final Rule (IFR)

Defines medically frail as "an individual whose physical, mental, or other behavioral health condition **significantly impairs [their] ability to comply with the community engagement requirement**" and who:

- Is blind or disabled;
- With a substance use disorder, excluding stable recovery;
- With a disabling mental disorder;
- With a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
- With a serious or complex medical condition.

September 2026 Operational Framework

- Clarifies that states must develop a list of health conditions to identify medically frail individuals. The list must be defensible and consistent with the definition of "medically frail."
- Confirms that states must verify medical frailty *ex parte** using reliable information available to the state (e.g., claims, encounter, and other available health data) to the maximum extent possible.
- Describes an example approach that places diagnosis and health care service codes into tiers to identify and verify individuals as medically frail.

**Using available electronic or other information first, without requesting information from the individual.*

California's Approach to Identifying and Verifying Medical Frailty

California is developing a multi-pronged approach to identifying and verifying medical frailty that prioritizes existing eligibility and health data while minimizing administrative burden on members, eligibility workers, and providers.

1. **Use a medical frailty screener at application and renewal** for individuals whose status cannot be established through available claims, encounter, or other administrative data. *(see next slide for more on the permissibility of self-attestation.)*
2. **Check existing eligibility and program data** to identify individuals who may qualify as medically frail based on blindness/disability or enrollment in Medi-Cal programs with eligibility criteria that align with medical frailty.
3. **Develop and apply a medical frailty code set to available health data** to establish medical frailty status when existing eligibility and program data are unable to do so.
4. **Conduct individualized review** when medical frailty cannot be established via program or health care data. This may include using a provider form, medical or treatment records, and/or MCP care management information.

Medical Frailty: Additional Considerations



Self-Attestation

- In 2027, California will verify medical frailty based on self-attestation or data/documentation and maintain that status for 12 months before reverification.
- In 2028 and beyond, California will:
  - Verify medical frailty status based on self-attestation once per enrollment period and maintain that status for six months before reverification.
  - Verify medical frailty based on data/documentation and maintain that status for 12 months before reverification.



Ongoing Litigation

- California and 25 other states challenged key provisions of the federal Centers for Medicare & Medicaid Services (CMS) Interim Final Rule (IFR).
- On October 29, the court ruled that:
  - The portion of the IFR that defines medically frail to include "impairs the individual's ability to work" is declared unlawful and vacated.
  - Instead, states must implement the statutory definition of medical frailty.
  - CMS may not penalize states for any errors or delays in implementing for a period of six months.

Good Faith Waivers

The Interim Final Rule outlines how states may seek approval for a good faith waiver to temporarily delay implementation for up to six months at a time through December 31, 2028.

Note: CMS has not provided guidance or submission instructions for the good faith waiver.

CMS will consider the following when reviewing waiver requests:

- **Progress the state has made** toward implementing work reporting requirements.
- **Key barriers or challenges,** including funding, design, development, procurement, or system readiness.
- The state's **implementation plan,** including timeline and milestones.
- Any **exigent circumstances** (e.g., administrative or external emergencies) affecting implementation.
- *The rule anticipates that ten states will submit waiver requests and that CMS will only approve two.*

DHCS submitted its Good Faith Waiver application October 28!



Questions?

Birthing Care Pathway Report Update

Anastasia Coutinho, MD, Medical Consultant, Quality and Population Health Management

DHCS

Agenda

- Birthing Care Pathway Overview
- Progress Since March 2025
- Highlights of Policy Implementation
- Transforming Maternal Health (TMaH) Model
- Looking Ahead



Birthing Care Pathway Overview



A comprehensive policy and care model roadmap supporting Medi-Cal members from conception through 12 months postpartum.

- Addresses the **physical, behavioral health, and health-related social needs** of pregnant and postpartum members.
- Focuses on improving **access to care,** strengthening **care coordination**, providing **whole-person care**, and modernizing how Medi-Cal **pays for maternity care**.
- Goals are to **reduce maternal morbidity and mortality** and **address racial and ethnic disparities** in maternal health outcomes.

What We Heard from Medi-Cal Members

The Birthing Care Pathway was shaped by the lived experiences of Medi-Cal members.



Respectful Care

Members want to feel heard and described positive experiences with doulas and midwives.



Care Navigation

Members often had to coordinate care themselves and were unaware of available benefits and services.



Behavioral Health

Members had trouble finding perinatal mental health providers; key moments to build trust were often missed.

The Birthing Care Pathway Policy Roadmap

Policy Areas DHCS Has Implemented/Is Implementing

- Provider Access and Medi-Cal Managed Care Plan (MCP) Oversight and Monitoring
- Behavioral Health and Trauma-Informed Care
- Risk Stratification and Assessment
- Medi-Cal Maternity Care Payment Redesign
- Care Management and Social Drivers of Health
- Perinatal Care for Justice-Involved Individuals
- Data and Quality
- State Agency Partnerships

Strategic Opportunities for Further Exploration

- Provider Access and MCP Oversight and Monitoring
- Behavioral Health
- Maternal Care Models and Access
- Provider Resources
- Data and Quality
- State Agency Partnerships

Additional details on each focus area and policy solution are in the Birthing Care Pathway Report.

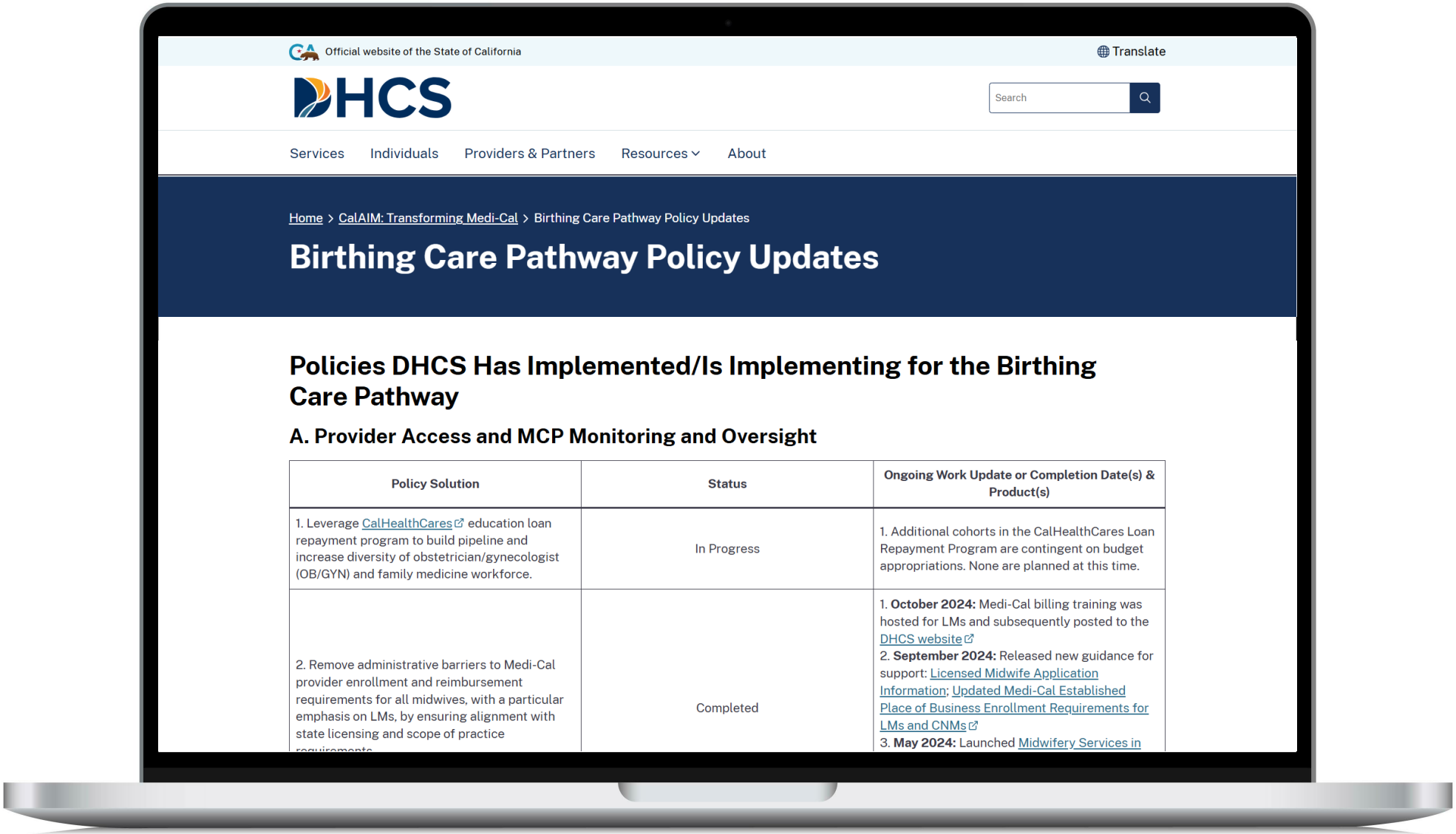
Progress Since March 2025

Since our last MCHAP update, the Birthing Care Pathway has moved from planning to implementation.

Status	September 2026	March 2025
Completed	**33**	10
In Progress	**9**	23
Not Started	**0**	9

A minimum of 4 additional policies will be completed by December 2026.

Birthing Care Pathway Policy Updates



Expanding Provider Access and Choice

Focus Area A: Provider Access and MCP Monitoring and Oversight

Providers

Doulas

- Issued a Standing Recommendation for doula services (November 2023)
- Launched the statewide doula directory and published the Doula Implementation Stakeholder Workgroup Report (July 2025)

Midwives

- Removed administrative barriers to Medi-Cal enrollment for licensed midwives and launched the Midwifery Services in Medi-Cal webpage (2024)

Member Access

Breast pumps

- Removed the treatment authorization request (TAR) to streamline access to high-quality breast pumps (July 2025)

Member awareness

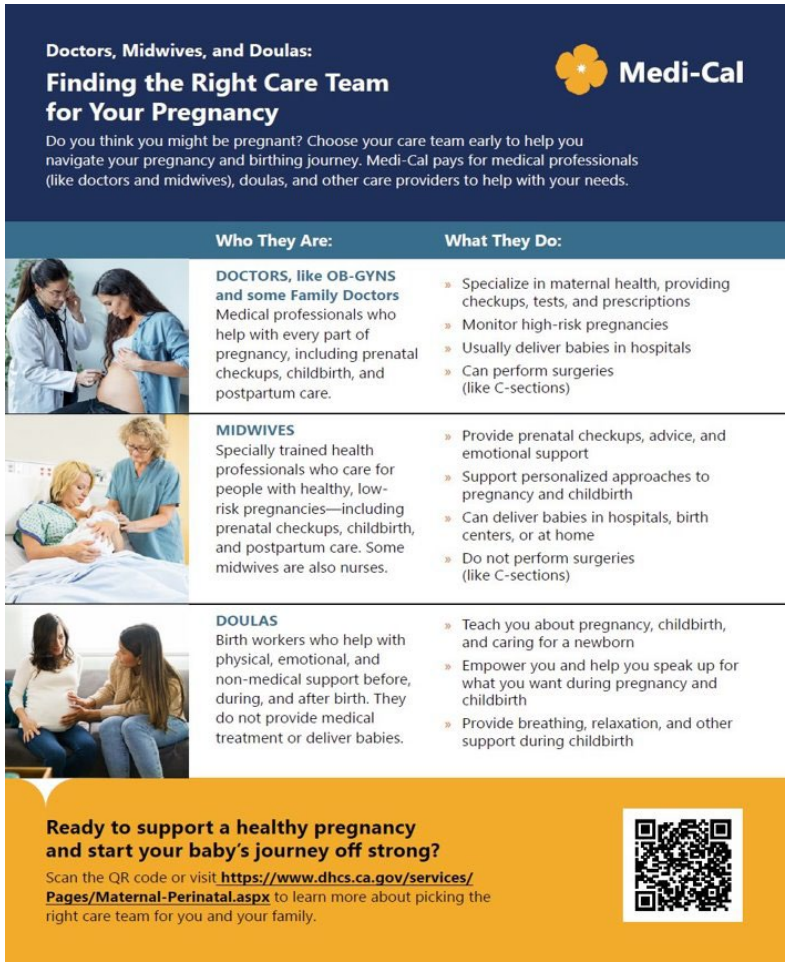
- Updated MyMedi-Cal, published perinatal infographics, and refreshed member-facing webpages (2024-2025)

Unified Policy

- Consolidated perinatal policies into a single Maternity All Plan Letter (APL) (APL 26-005, May 2026)

Member Fact Sheets

Doctors, Midwives, and Doulas: Finding the Right Care Team for Your Pregnancy



Doctors, Midwives, and Doulas:

Finding the Right Care Team for Your Pregnancy

Medi-Cal

Do you think you might be pregnant? Choose your care team early to help you navigate your pregnancy and birthing journey. Medi-Cal pays for medical professionals (like doctors and midwives), doulas, and other care providers to help with your needs.

Who They Are:	What They Do:
DOCTORS, like OB-GYNS and some Family Doctors Medical professionals who help with every part of pregnancy, including prenatal checkups, childbirth, and postpartum care.	» Specialize in maternal health, providing checkups, tests, and prescriptions » Monitor high-risk pregnancies » Usually deliver babies in hospitals » Can perform surgeries (like C-sections)
MIDWIVES Specially trained health professionals who care for people with healthy, low-risk pregnancies—including prenatal checkups, childbirth, and postpartum care. Some midwives are also nurses.	» Provide prenatal checkups, advice, and emotional support » Support personalized approaches to pregnancy and childbirth » Can deliver babies in hospitals, birth centers, or at home » Do not perform surgeries (like C-sections)
DOULAS Birth workers who help with physical, emotional, and non-medical support before, during, and after birth. They do not provide medical treatment or deliver babies.	» Teach you about pregnancy, childbirth, and caring for a newborn » Empower you and help you speak up for what you want during pregnancy and childbirth » Provide breathing, relaxation, and other support during childbirth

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **https://www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to learn more about picking the right care team for you and your family.

Services for Pregnant People and New Parents



Services for Pregnant People and New Parents

Medi-Cal

If you have Medi-Cal and are pregnant or just had a baby, you have access to free health care and services to keep you and your baby healthy and safe.

Medi-Cal Programs and Services

Health Care
Medi-Cal covers health care for you and your baby—from pregnancy until at least one year postpartum. That includes labor and delivery, doctor visits, hospital stays, emergency care, medical supplies, medications, family planning, dental, vision, and more.

Care Coordination
Get help managing your health care before and after your baby is born, including follow up doctor's visits, rides to the doctor, and specialty care referrals.

Mental Health & Addiction
Talk to a therapist and get help for common issues like postpartum depression or anxiety, mental health needs, or alcohol and drug treatment.

Classes for Health, Childbirth, & Parenting
Learn how to stay healthy during pregnancy, make a birth plan, and take care of your new baby.

Breastfeeding & Nutrition
Get help with breastfeeding coaching, free breast pumps, nutrition counseling, and vitamins.

Community Supports
If you qualify, you can get help with housing, healthy food, and other needs along with your health care.

American Indian Maternal Support Services
American Indian mothers in select counties can get health care, education, emotional support, and home visits before and after having a baby.

Other Programs and Services

Paid Family Leave
Get up to eight weeks of paid leave for each parent to care for your family within a 12-month period.

Women, Infants, and Children
Get healthy foods, breastfeeding help, and checkups for you and your baby.

CalFresh
For members who want to add to their budget to put healthy and nutritious food on the table.

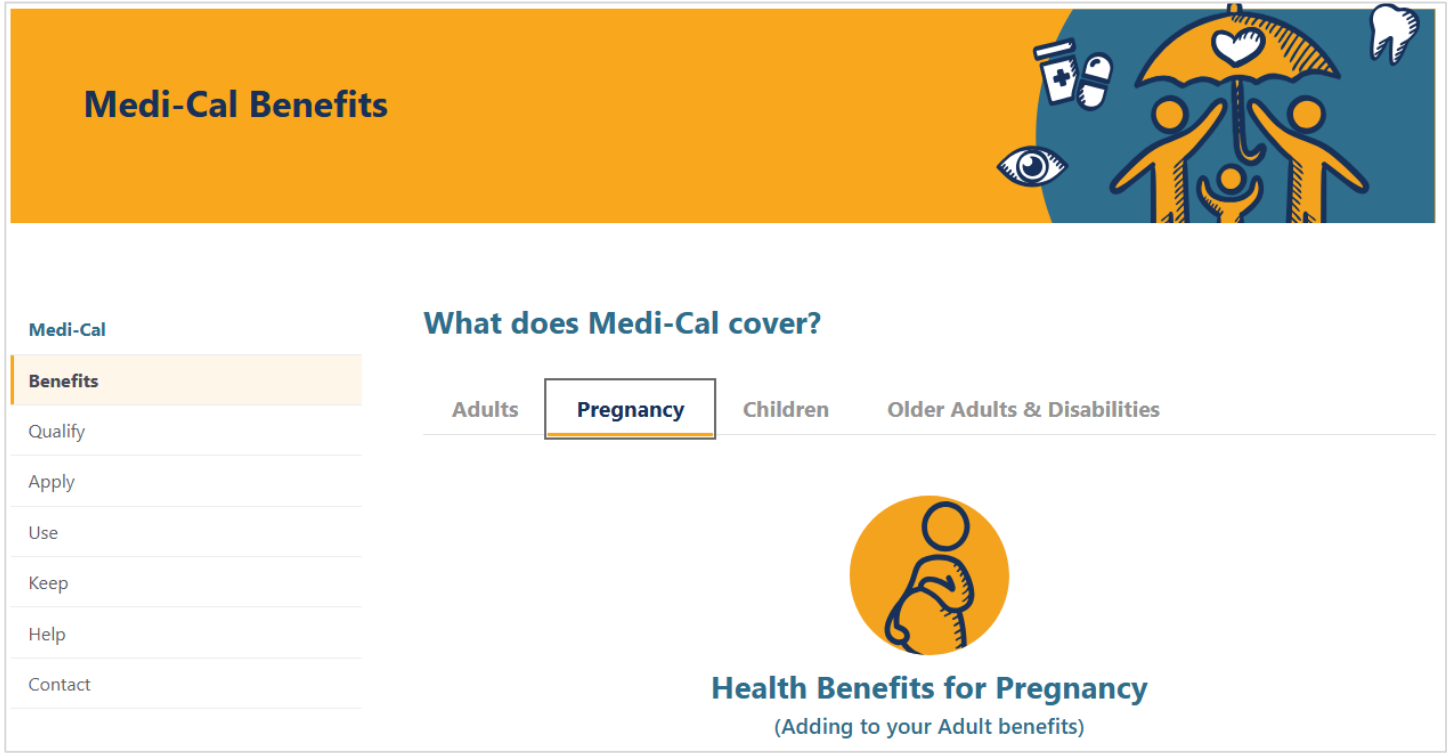
Black Infant Health
Black pregnant and postpartum people can get both one-on-one and group help.

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to explore these free services and find the right support for you and your family.

MyMedi-Cal

DHCS published an updated MyMedi-Cal – a guide for members on how to use their Medi-Cal benefits – with information about perinatal benefits and providers.



Omnibus Maternity All Plan Letter



- Medi-Cal maternity guidance had historically been documented across more than 30 DHCS policy letters, as well as multiple provider manuals, policy guides, and other DHCS resources.
- The omnibus maternity APL (26-005), released on March 25, 2026, consolidates these many policies and serves as the “one-stop shop” for MCPs on the maternity services that MCPs must provide to pregnant and postpartum Medi-Cal members, in addition to opportunities for MCPs to enhance the quality of maternal health care services.
- The omnibus maternity APL encompasses 35 unique APLs.

APL's Table of Contents

The omnibus maternity APL is divided into 13 sections that cover the spectrum of prenatal to postpartum care.

1. Risk Assessments for Pregnant and Postpartum Members
2. Maternity Services
3. Non-Invasive Prenatal and Newborn Screenings
4. Access to Maternal Providers
5. Behavioral Health During Prenatal and Postpartum Periods
6. Lactation Services
8. Doula Services
9. Community Health Worker Services
10. Group Perinatal Care
11. Community Supports
12. Population Health Management (PHM)
13. Family Planning Services and Reproductive Health
14. Abortion Services

Identifying Risk/Supporting Behavioral Health

Focus Area B: Behavioral Health and Trauma-Informed Care

- Updated and disseminated Substance Use Disorder (SUD) Perinatal Practice Guidelines (August 2024; refreshed November 2025)
- Amended MCP and behavioral health contracts to strengthen access to qualified perinatal behavioral health providers (effective 2026-2027)
- Reinforced no maximum stay policy for residential SUD treatment
- Advancing trauma-informed care reframing for members affected by Adverse childhood experiences (ACEs), intimate partner violence (IPV), and racism (in progress, established December 2026)

Focus Area C: Risk Stratification and Assessment

- Released Risk Stratification, Segmentation, and Tiering (RSST) Birthing algorithm to MCPs to identify high-risk members across medical, behavioral, and social domains, designed to reduce bias in older methodologies (February 2026)
- Integrating IPV screening into Medi-Cal risk assessments (in progress, established December 2026)

Summary of MCP Contract Changes



Emphasize the importance of Non-Specialty Mental Health Services (**NSMHS**) and/or **SUD** services for pregnant and postpartum members and require MCPs to ensure their **members are aware** these services are available during the prenatal and postpartum periods.



Highlight the need for **timely access** to behavioral health services during the prenatal and postpartum periods from any network provider **without prior authorization**; out-of-network providers are available if the MCP does not have a behavioral health network provider with perinatal expertise.



Reinforce **coordination requirements and responsibilities** for pregnant and postpartum members in the **Enhanced Care Management (ECM)** Population of Focus for Individuals with serious mental health and/or SUD needs and **across MCPs and Behavioral Health Delivery Systems (BHDS) plans** for those receiving SMHS and/or SUD care.

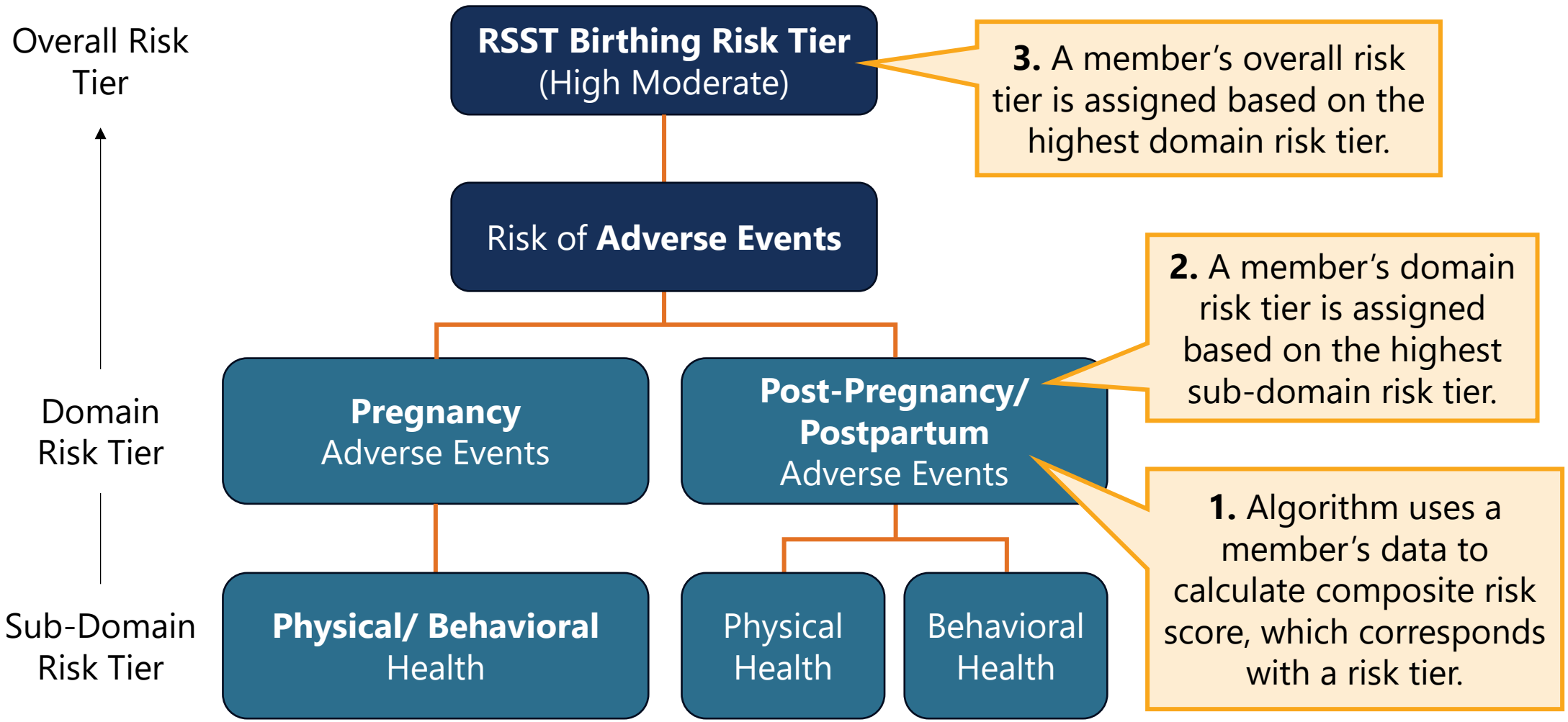


Prioritize NSMHS and/or SUD care and access for pregnant and postpartum members in MCPs' **continuous quality improvement programs**.



Encourage use of Alliance for Innovation on Maternal Health (AIM) **Patient Safety Bundles** on mental health and SUD care during pregnancy and postpartum, where appropriate.

RSST Birthing



Modernizing Payment and Care Coordination

Focus Area D: Medi-Cal Maternity Care Payment Redesign

- Increased rates for maternity providers and enhanced supplemental payments for labor and delivery (January 2025)
- Published Licensed Midwife and Alternative Birthing Center billing guidance (August 2026)
- Expanded maternity measures in the Quality Incentive Pool for public hospitals (January 2024)

Focus Area E: Care Management and Social Drivers of Health

- Published Transitional Care Services guidance for pregnant and postpartum members (January 2026)
- Expanded ECM referral pathways from social services and behavioral health providers (January 2026)
- Transitional Rent went live as a Community Support for eligible members (January 2026)
- Encouraged MCP partnerships with IPV and housing community-based organizations (CBO) as ECM/Community Supports providers (2025-2026)

Transitional Care Services (TCS) for Pregnant and Postpartum Members

**Requirements align with Comprehensive Perinatal Services Program (CPSP) requirements and American College of Obstetricians and Gynecologists (ACOG), and U.S. Preventive Services Task Force (USPSTF) guidelines*

High-Risk TCS (Not Pregnant or Postpartum)

- Applies to all members listed under PHM Policy Guide definition; and who are **not** pregnant or postpartum (including, but not limited to, members with long-term services and supports (LTSS) needs, in or entering ECM or Complex Care Management (CCM), and children with special health care needs)

Lower-Risk TCS (Not Pregnant or Postpartum)

- Lower-risk members in transitions are defined as those not included in **any of the three categories (in orange, blue, and green)**

High-Intensity Pregnancy and Postpartum TCS

- Any pregnant or postpartum member who meets any one of the criteria outlined on next slide

Moderate-Intensity Pregnancy and Postpartum TCS

- Any pregnant or postpartum member who does **not** meet any one of the criteria outlined on next slide

Defining High vs. Moderate Intensity TCS for Pregnant and Postpartum Members



TCS intensity is based on medical, behavioral health, and social risk criteria.

Note: There is *no* lower-risk TCS category for this population.

High-intensity TCS

Provide high-intensity pregnancy and postpartum TCS to any member who meets any of the following:

- Have an admission that is not for their delivery at any point during pregnancy or in the 12 months postpartum
- Is identified as high-risk through RSST
- Meets high-risk criteria for TCS in another program (e.g., LTSS, receiving ECM)
- Has any single DHCS-specified medical, behavioral health, or social risk factor*
- Is referred as high-risk by a provider, care team, or discharging facility based on clinical judgment

Moderate-Intensity TCS

- Members who do not meet any of the criteria above should receive moderate-intensity pregnancy and postpartum TCS.

**DHCS-specified criteria were selected to allow MCPs to use existing claims data and information that plans already have to support implementation.*

Connecting Systems, Data, and Partners

Focus Area F: Perinatal Care for Justice-Involved Individuals

- Ensured pre-release Medi-Cal enrollment for pregnant and postpartum individuals (2023-2024)
- Expanding 90-day pre-release services statewide (remaining counties live in fall 2026)

Focus Area G: Data and Quality

- Launched Medi-Cal Connect to share integrated health and social data (August 2025)
- Developing key performance indicators (KPI) to track Birthing Care Pathway adherence (live December 2026)

Focus Area H: State Agency Partnerships

- Published the statewide Maternal Health Strategic Plan with the California Department of Public Health (CDPH), Office of the California Surgeon General (OSG), and California Maternal Quality Care Collaborative (CMQCC) (September 2025)
- Released the Paid Family Leave/State Disability Insurance (SDI) provider resource guide with Employment Development Department (EDD) and Legal Aid at Work (January 2025)
- Published Home Visiting Best Practices Letter (September 2026)

Current Pregnancy-Related Measures

Outcome Measurement	Definition of Measurement
Timeliness of Prenatal Care*	Percent of a prenatal care visit in the first trimester or within 42 days of enrollment in the organization
Postpartum Care*	Percent with a postpartum visit on or between 7 and 84 days after delivery
Prenatal Depression Screening and Referral*	Percent in which persons were screened for clinical depression using a standardized instrument during the period
Postpartum Depression Screening and Referral*	Percent in which persons received follow-up care within 30 days of a positive depression screen finding
Prenatal Immunizations	Percent of those who received influenza *and* Tdap vaccinations
Low-Risk Cesareans	Percent of cesareans in Nulliparous, Term, Singleton, Vertex (NSTV) liveborn deliveries

*Accountable MCAS Metrics as of MY2026

Proposed KPI Measures

Outcome Measurement	Definition for Measurement
Doula Utilization	Percent of pregnant and postpartum members with **any** doula claim/encounter
Midwifery Utilization - Any	Percent of pregnant members with **any** prenatal midwifery claims/encounters
Midwifery Utilization – L&D	Percent of pregnant members with a midwifery claim/encounter for **labor & delivery (L&D)**
Access to Lactation Durable Medical Equipment (DME)	Percent of pregnant or postpartum members with an electric breast pump claim
Pregnant and Postpartum Transitional Care Services	PPC-Pst (7-84 days) (Healthcare Effectiveness Data and Information Set (HEDIS) with 7/42-day sub-rate (in Medi-Cal Connect)
Low-Risk Cesareans	Percent of live NSTV births with a cesarean
WIC Utilization	Percent of those eligible for services, but **not** enrolled

Transforming Maternal Health (TMaH) Model

TMaH Model

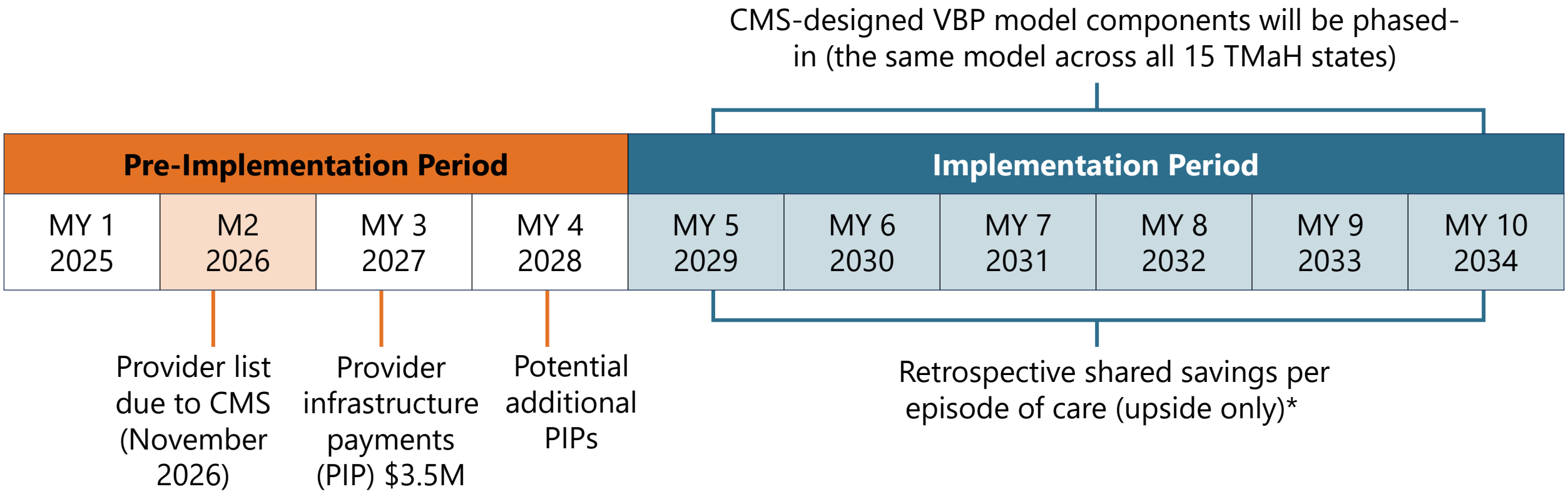
- In **January 2025**, CMS selected California as one of **15 states** to implement the TMaH Model
- A **10-year delivery and payment model** testing whether evidence-informed interventions, sustained by a **value-based payment (VBP) model**, can improve maternal outcomes and reduce Medicaid/Children's Health Insurance Program (CHIP) costs
- Implemented in **five Central Valley counties**: Fresno, Kern, Kings, Madera, and Tulare
- **$17 million in federal funding**, plus targeted technical assistance



How it connects to the Birthing Care Pathway

- TMaH focuses on a sub-state region, while the Birthing Care Pathway is statewide
- Lessons learned and evidence-based practices from the TMaH region can be **scaled statewide** through the Birthing Care Pathway

TMaH Model Year (MY) Timeline*



*Approximate timing (still to be finalized by CMS)

Investing in Provider Readiness and Member-Centered Care



Building provider capacity and readiness for the TMaH value-based payment model

- $3.5 million in (PIPs will be available to participating providers starting in 2027, with additional funding in 2028 pending CMS approval
- MCPs will disburse PIPs to providers and monitor for compliance; a DHCS contractor will provide technical assistance
- CMS will share additional guidance on PIPs in October 2026



CMS-Approved PIP Uses:

- Patient safety initiatives and maternal care assessments
- Quality measure reporting for value-based payment
- Data integration/Electronic Health Record (EHR) upgrades
- Team-based care
- Enhanced access to care (e.g., telehealth, evening/weekend hours)
- Connections to CBOs to address upstream drivers of health

Postpartum Pathway Concept Paper

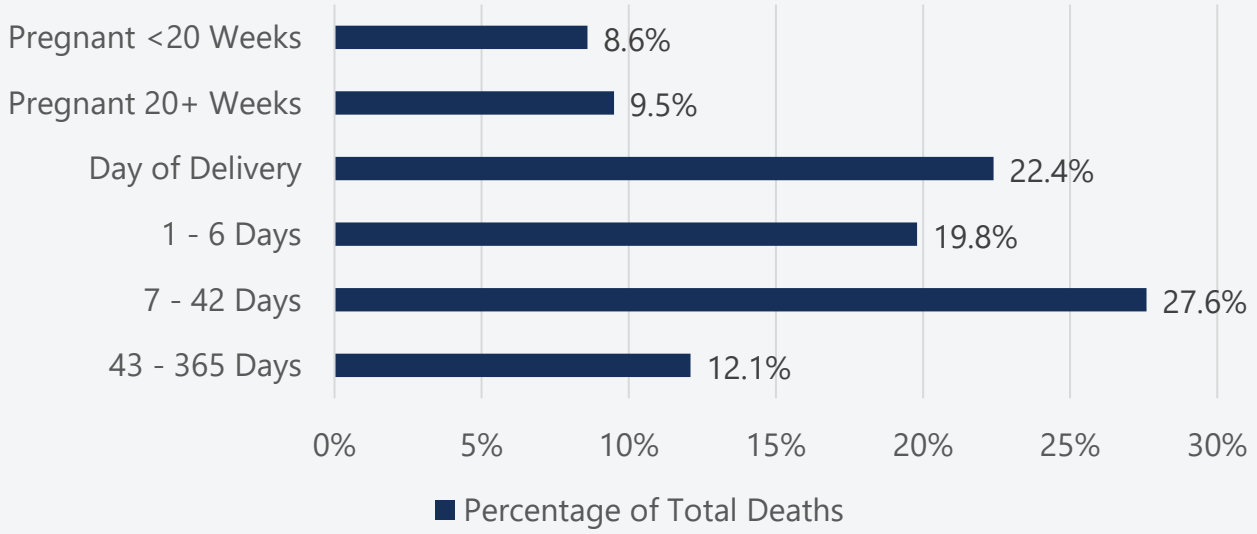
Postpartum Pathway Concept Paper

- Published on July 31, 2025, the postpartum pathway concept paper presents a proposed, measurable clinical model that supports whole-person care by addressing both medical and social drivers of health.
- Developed with CDPH, OSG, the Purchaser Business Group on Health, and the CMQCC

Why focus on the postpartum period:

- More than half of California's perinatal deaths occur within 12 months postpartum
- Every five days, a Californian dies from a pregnancy-related complication

Figure A: Pregnancy Related Deaths by Timing of Death, California, 2020–2022



Data Source: CDPH Pregnancy Related Mortality

Pregnancy Related Deaths by Timing to Death, California, 2020-2022

CDPH Pregnancy-Related Mortality | Date Downloaded: May 2025

Prepared by the California Department of Health Care Services

Postpartum Pathway Goals



1. Reduce morbidity and mortality among postpartum individuals



2. Address racial and ethnic disparities in maternal health outcomes among Black, American Indian/Alaska Native, and Pacific Islander individuals



3. Reduce stress, trauma, and mood disorders, including depression and anxiety, with timely access to treatment



4. Reduce isolation among vulnerable and historically marginalized communities



5. Improve chronic condition and interconception care to support healthier future pregnancies

Looking Ahead

What's Next

Near-Term Priorities (2026)

- Complete 7 of 9 remaining policy solutions to finish all possible
- Finalize in-progress items, including IPV screening integration and trauma-informed care reframing (estimated in December 2026)

Sustaining Implementation

- Support MCPs in implementing high-yield policies, including through a potential learning collaborative (2027-2028)

Looking Ahead

- Continue stakeholder and community engagement
- Prepare for the TMaH VBP transition beginning in 2028
- Explore strategic opportunities for the next generation of policy



Questions?

Break

California Children's Services (CCS) Eligibility Changes

Susan Philip, Deputy Director, Health Care Delivery Systems
Jake Johnson, Chief, Integrated Systems of Care

DHCS

Today's Roadmap

1

The Basics

- CCS populations, key terms, and what is changing

2

H.R. 1 and Young Adults

- Work requirements, six-month renewals, and coverage pathways for ages 19-20

3

Unsatisfactory immigration status (UIS) to Fee-for-Service (FFS)

- What changes for children and families on January 1, 2027

4

What Families Need to Hear

- Key messages, resources, and discussion

Part 1: The Basics

CCS Overview, key terms, and what is changing

CCS Overview: Key Coverage and Delivery System Concepts (1/2)

CCS Overview:

- CCS covers children/youth, ages 0–20, with CCS-eligible conditions
- Members must meet medical, residential, and financial rules
- Care delivered by CCS-paneled providers

CCS County Types

- **Classic counties:** The County CCS Program manages CCS care
- **Whole Child Model counties:** The MCP manages CCS care
- **Independent/Dependent Counties:** Counties authorize services/DHCS authorize services

	Independent CCS	Dependent CCS
Whole Child Model (33)	**17 Counties:** Butte, Humboldt, Marin, Mendocino, Merced, Monterey, Napa, Orange, Placer, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Solano, Sonoma, Yolo	**16 Counties:** Colusa, Del Norte, Glenn, Lake, Lassen, Mariposa, Modoc, Nevada, Plumas, San Benito, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yuba
Classic CCS (25)	**15 Counties:** Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare, Ventura	**10 Counties:** Alpine, Amador, Calaveras, El Dorado, Imperial, Inyo, Kings, Madera, Mono, Tuolumne

CCS Overview: Key Coverage and Delivery System Concepts (2/2)

Medi-Cal and CCS Coverage:

- **Full-scope Medi-Cal** Members are covered for all Medi-Cal benefits included in the State Plan Amendment
- **Restricted-scope Medi-Cal** Members are only covered for emergency, pregnancy-related, and certain long-term care
- **Medi-Cal CCS** Members are enrolled in full-scope Medi-Cal and CCS; Medi-Cal covers CCS care.
- **CCS-Only** Members are enrolled in CCS, but not in full-scope Medi-Cal; county and Medi-Cal/state split the funding depending on whether the member is also enrolled in restricted-scope Medi-Cal; or if they are not enrolled in Medi-Cal at all (i.e., exceed income thresholds)

Delivery System Terms:

- **FFS** Medi-Cal members see any Medi-Cal provider; no health plan or assigned primary care provider
- **Managed care:** The MCP covers Medi-Cal services as well as care management services.

Immigration Status and Why Coverage Ends

Immigration status

- **Satisfactory immigration status (SIS)** citizens and **qualified non-citizens (QNC)**
  - QNC youth under 21 keep SIS (Children's Health Insurance Program Reauthorization Act (CHIPRA) 214) and stay in their MCP
- **UIS**
  - Undocumented: subject to the adult enrollment freeze (ages 19+, since 1/1/26)
  - Documented (e.g., Permanently Residing Under Color of Law (PRUCOL), 5-year bar): not subject to the freeze

Why coverage ends

- **Procedural reason:** a missed step (renewal not returned, work hours not met). No path to CCS-Only.
- **Eligibility reason:** all steps done, but no longer eligible (e.g., over income). May be assessed for CCS-Only.
- **Grace period (3 months)** protects existing full-scope coverage for undocumented members under the freeze
- **Reconsideration period (90 days)** to finish a missed renewal

Federal and State Changes at a Glance

Change	Source	Effective	Who is primarily affected
Undocumented adult enrollment freeze	State budget	January 1, 2026 (Already in effect)	Undocumented persons ages 19+ (for CCS: ages 19–20)
QNC definition	H.R. 1 §71109	October 1, 2026	Specified lawfully present immigrants age 21 and older. No effect on CCS eligibility
Six-month renewals	H.R. 1 §71107	January 1, 2027	Affordable Care Act (ACA) New Adult Group, ages 19–64
Work/community engagement	H.R. 1 §71119	January 1, 2027	ACA New Adult Group, ages 19–64
Retroactive coverage limits	H.R. 1	January 1, 2027	1 month for New Adult Group; 2 months for all other members
UIS managed care to FFS transition	SMDL #25-003	January 1, 2027	All UIS members in managed care will transition to Medi-Cal FFS
UIS monthly premiums	State budget	July 1, 2027	Specified UIS members; amount pending

What H.R. 1 Means for CCS

Change	What it means for CCS
QNC Definition	No impact on CCS children. QNC youth under age21 keep SIS, full-scope Medi-Cal, and their plan.
Six-Month Renewals	Children ages 0–18 are not affected. They stay on 12-month renewals.
Work Requirements	» DHCS screens for exceptions first. » CCS members under age 19 are not in the New Adult Group. » Parents or caretakers of a child age 13 or younger are excused.

Most CCS members are ages 0-18 and are not affected by these provisions.

Part 2: H.R. 1 and Young Adults Ages 19-20

Work requirements, six-month renewals, and coverage pathways

New Work and Community Engagement Requirements



- New condition of Medi-Cal eligibility for the New Adult Group, starting January 1, 2027
- Members must show work, volunteering, school, or other community engagement, or qualify for an exception
- CMS interim final rule sets the operating framework (final effective July 31)



- **Who is in the New Adult Group?**
  - Ages 19–64
  - Not pregnant
  - Not on Medicare Part A or B
  - Not eligible for another mandatory Medi-Cal group
  - Income under 138% of the federal poverty level

For CCS, the group to watch is young adults ages 19-20.

Mandatory Exceptions

Who Is Excused

- Children under age 19
- Medical frailty
- Parents, guardians, or caretakers of a child age 13 or younger
- Foster youth and former foster youth under age 26
- Pregnant and postpartum individuals
- People eligible for another mandatory group (e.g., non-Modified Adjusted Gross Income (MAGI))

Most important for CCS

- Under age 19 covers most CCS members
- Medical frailty is the main path for ages 19-20
- Parents of a child age 13 or younger; guidance on caregivers of CCS members ages 14-21 is still pending

DHCS' Approach to Medical Frailty

Not meeting work requirements is a procedural loss. However, in light of recent court vacating CMS IFR rule on Medical Frailty, DHCS anticipates that CCS Members will qualify under Medical Frailty.

A federal court vacated CMS's requirement in the Interim Final Rule that a qualifying condition must also "significantly impair" a person's ability to work.

- States must apply the statutory medical-frailty definition. Individuals may qualify based on a condition within one of the statutory categories, **without** a separate work-impairment test.
- DHCS is revising its identification and verification approach to align with the court ruling and forthcoming federal guidance.
- For 2027, medical frailty may be established through available program or health data, documentation, or self-attestation, as permitted under federal rules.

Six-Month Renewals: Timing Matters



The way back exists, but it starts with Medi-Cal.

- Affects only CCS members ages 19-20 in the New Adult Group
- Children ages 0-18 stay on 12-month renewals
- **Renewal finished within the 90-day cure period**; coverage comes back with no gap
- **After 90 days**, no CCS-Only bridge; the member must restore Medi-Cal first
- **Undocumented members who reapply** will only be able to enroll in restricted-scope Medi-Cal, then a CCS-only assessment

CCS Coverage Pathways for Ages 19-20

Adult Enrollment Freeze

- **Newly applying (undocumented):** restricted-scope Medi-Cal, then a CCS-Only assessment
- **Existing full-scope member who loses coverage**
  - Restores within the three-month grace period: keeps Medi-Cal CCS
  - Reapplies after the grace period: may only enroll into restricted-scope, then a CCS-only assessment
  - Does not reapply: no CCS-Only bridge

H.R.1: Work Requirements and Six-Month Renewals

- Losing Medi-Cal for a procedural reason (including unmet work requirements) closes the CCS-Only door
- Member must restore or reapply for Medi-Cal to get Medi-Cal CCS back
- Losing Medi-Cal for an eligibility reason (e.g., over income) may lead to CCS-Only

Pathways at a Glance: Ages 19–20

Situation	Medi-Cal Steps Completed?	CCS Coverage	Funding	Next Step
Full-scope Medi-Cal (currently enrolled)	Yes	Medi-Cal CCS	State*	Coverage continues
Over income (eligibility reason)	Yes	Potentially CCS-Only	50% State | 50% County	CCS-Only assessment
Restricted-scope Medi-Cal (new undocumented, or reapplied after grace period)	Yes	Restricted-scope + potentially CCS-Only	Emergency care: Medi-Cal State | Federal; Other CCS care: 50% State | 50% County	CCS-Only assessment
QNC, age 20 or younger	Yes	Medi-Cal CCS	State | Federal	Coverage continues
Any immigration status	No (procedural)	No Medi-Cal CCS; no CCS-Only	N/A	Reapply for Medi-Cal

** State draws federal funding only for federally eligible services (e.g., emergency services).*

Case Example: How Coverage Works for a 20-Year-Old with Hemophilia

Enrolled in restricted-scope Medi-Cal and eligible for CCS-Only

Emergency care

Covered by restricted-scope Medi-Cal

- Emergency department visit for a severe bleed
- Hospital stay or emergency surgery
- Must meet emergency coverage criteria

Ongoing CCS care

Covered by CCS-Only (if authorized)

- Routine hematology visits
- Clotting-factor therapy
- Lab monitoring
- Case management

Part 3: UIS to FFS on January 1, 2027

What changes for children and families

Who are the Affected Medi-Cal Members?

Not Affected Populations

- U.S. citizens
- Other immigrants:
  - Lawful Permanent Residents (green card holders) who have been in the U.S. for five years or longer.
  - Cuban and Haitian entrants
  - Compact of Free Association (COFA) Migrants (Micronesia, Marshall Islands, and Palau)
  - When they are lawfully present (CHIPRA): People under age 21; Pregnant people (including 12 months postpartum)
- Members enrolled in Program of All-Inclusive Care for the Elderly (PACE)

Affected Populations

- Medi-Cal members with UIS
- All undocumented immigrants, including children and pregnant people
- Lawful Permanent Residents (green card holders) who have been in the U.S. for less than five years.
- PRUCOL non-citizens living in the U.S. with the knowledge and permission of immigrations authorities (such as those with pending asylum or stay of deportation) while they wait for a final status.
- QNC who lose federal full-scope eligibility due to H.R. 1.

Who Is Transitioning to FFS

7,139

CCS members with UIS transitioning statewide

5,676

in Classic counties

1,463

in Whole Child Model counties

~4%

of total CCS enrollment (175,957, August 2026)

Members will keep their Medi-Cal and CCS. They will no longer be in a MCP. Instead, they will get their Medi-Cal services directly through Medi-Cal, which is called FFS.

What Changes on January 1, 2027

Area	What Happens
Coverage	Members with UIS leave their MCP but stay in Medi-Cal and CCS
Providers	Care must come from providers enrolled in Medi-Cal FFS
Complex Needs	Children with complex needs beyond CCS condition are handled case by case
Reviews and Renewals	CCS annual medical review and Medi-Cal renewal dates do not change
Member Notices	DHCS will mail a notice by December 1 (19 languages); monthly texts beginning on October 9; health plan notice by December 1
Age 21 and Older	CCS is not being extended past age 21

Who Coordinates Care After January 1

Classic counties

- County CCS Program continues to manage CCS care
- CCS services were already delivered through FFS, so CCS care does not change
- The change is in non-CCS benefits and care management that was delivered under the managed care delivery system

Whole Child Model counties

- CCS care management moves from the managed care plan to the County CCS Program
- MCPs sends each member's transition-of-care plan to the county by November 9
- CCS services continue through CCS-paneled FFS providers

Statewide: DHCS is contracting a care-coordination vendor, with CCS children as a priority.

Provider Access in FFS

- CCS paneling standards do not change, so the network's clinical quality does not change
- The concern is having enough providers: MCP network providers, who may not have enrolled in Medi-Cal FFS before, must now do so if they wish to treat UIS members
- CCS-paneled physicians receive the 39.7% augmentation in FFS

Care Management: What Stops, What Continues

Ends December 31, 2026

*(Services **ONLY** available under Managed Care Delivery System)*

- ECM
- CCM
- TCS
- California Integrated Care Management
- Community Supports

Continues in Medi-Cal FFS Delivery System

- CCS
- Community health worker (CHW) services
- Targeted case management (behavioral health)
- CPSP
- Doula and dyadic services

MCPs must help members connect with FFS providers and CHWs before January 1.

Staying Enrolled and Aging Out

Notices and staying enrolled

- DHCS will mail Member notices by December 1, in 19 languages
- MCPs will also send a CCS notice by December 1
- Members renewing must respond to both CCS and Medi-Cal requests. They are separate programs, so answering one does not take care of the other.

Turning 21

- CCS is not being extended beyond age 20
- Most members with UIS who age out keep full-scope Medi-Cal if they keep renewing every 6 months.

Part 4: What Families Need to Hear

Key messages, resources, and discussion

Key Messages for Families and Partners

1. CCS children ages 0-18 are not affected by H.R. 1
2. Members with UIS will lose their MCP but will keep Medi-Cal and CCS if they maintain renewal
3. ***Renew on time and answer every Medi-Cal request; it is the best protection to keep your coverage.***
4. Members should watch for the notice by December 1
5. Providers: enroll in Medi-Cal FFS now

Resources

- CCS Numbered Letter (NL) 03-0926: CCS Members with UIS (being revised)
- APL 26-016: APL for the UIS CCS transition
- UIS–FFS Policy Guide (v3 released October 14, 2026)
- All County Welfare Directors Letter (ACWDL) 26-14: Six-month renewals for the New Adult Group
- CCS Information Notice (IN) 25-05: CHW services in CCS
- DHCS Medi-Cal Changes (for families)
- Immigration Status and Changes to Medi-Cal Eligibility

Questions: CCSProgram@dhcs.ca.gov.

Discussion

1. What are you hearing from families?
2. Where do you expect access gaps in FFS: specialty care, private duty nursing, or mental health?
3. How can MCHAP members help spread the message about renewing on time?



Questions?

Behavioral Health Measures for Children and Youth (Part 2)

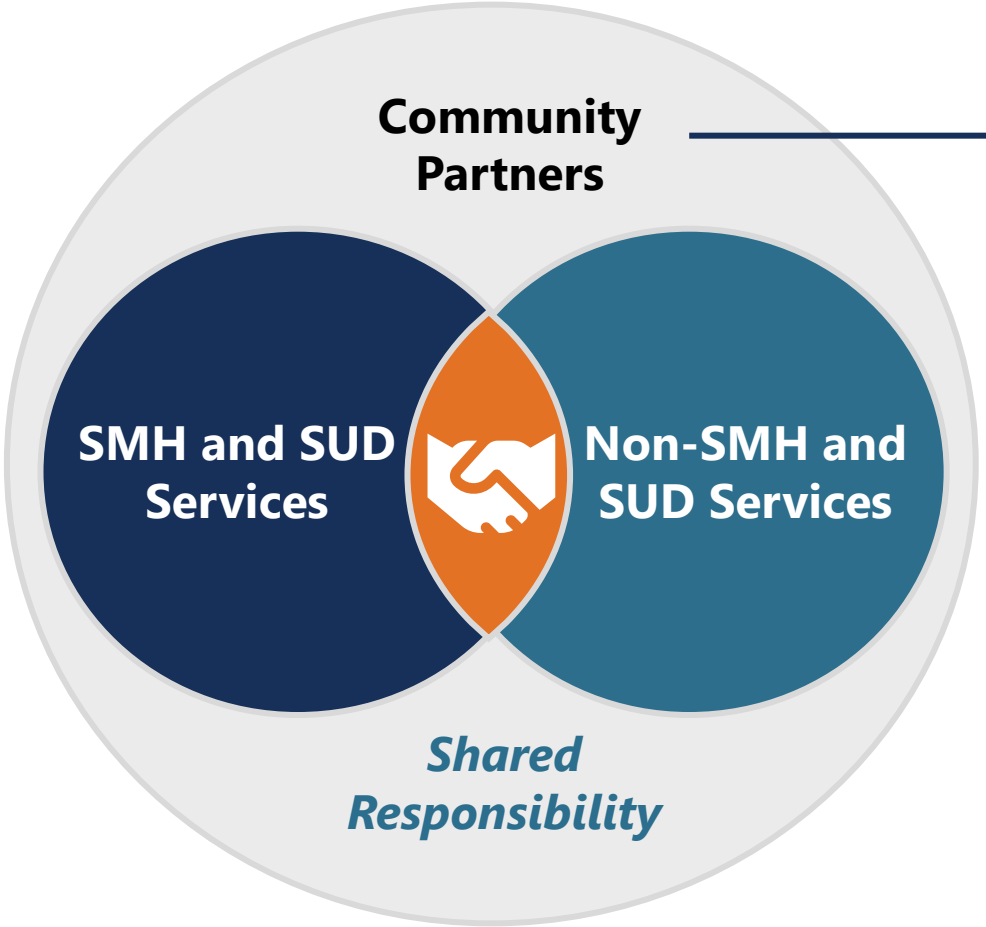
Anna Naify, PsyD, Acting Assistant Deputy Director, Behavioral Health

DHCS

Population Behavioral Health: A Full Delivery System Effort

The behavioral health delivery system is designed to meet the diverse treatment needs of Californians through **varying levels of care and shared responsibility among delivery system partners.**

The population behavioral health framework establishes common goals and standards to improve quality and equity across the continuum of care.



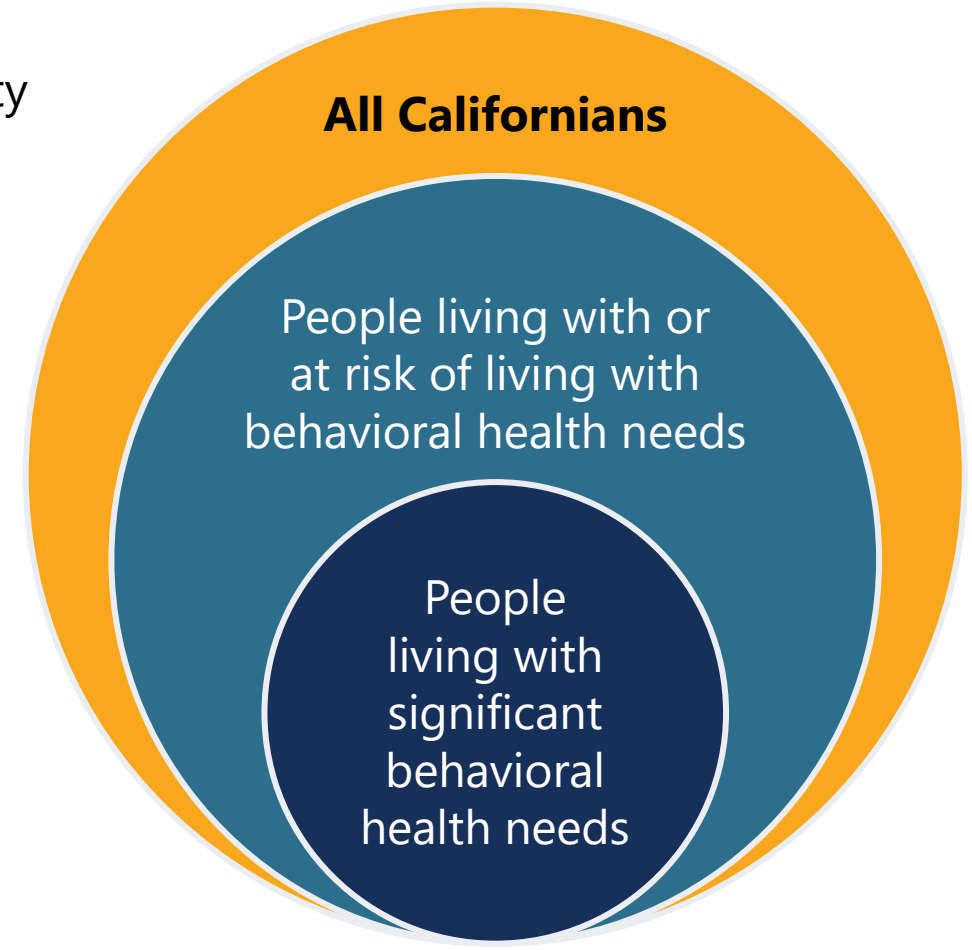
Inclusive of the following service delivery systems:

- Public Health
- Schools
- Child Welfare
- Legal System
- Commercial Insurance Plans
- CBOs
- Housing Partners

Population Behavioral Health: The Need to Reach Everyone

The population health approach to behavioral health aims to meet the needs of all eligible Californians, improve community well-being, and advance health equity. This approach:

- Considers the **entire population** who may benefit from services, not only those already seeking or receiving care
- Delivers **whole-person care interventions**
- **Coordinates** across service delivery systems
- **Uses data** to:
  - Identify populations for targeted outreach and interventions
  - Monitor effectiveness and drive continuous quality improvement
  - Identify and track racial and ethnic disparities in outcomes



14 Statewide Behavioral Health Goals

Health equity is built into every goal.



Goals for Reduction

- Suicides
- Overdoses
- Untreated behavioral health conditions
- Institutionalization
- Homelessness
- Justice involvement
- Removal of children from home



Goals for Improvement

- Care experience
- Access to care
- Prevention and treatment of co-occurring physical health conditions
- Quality of life
- Social connection
- Engagement in school
- Engagement in work

Additional information on the statewide behavioral health goals is available in the BHSA Policy Manual.

Measures in Two Phases

SUNSET

Phase 1: June 2025-June 2026
Population-Level Behavioral Health Measures

- One-time measures for each goal to support county behavioral health and MCP planning
- Selected from publicly available measures
- Used for planning only

CURRENT

Phase 2: July 2026 and beyond
Performance Measures

- Ongoing measures to assess performance on each goal, finalized in July 2026
- Designed and calculated by DHCS
- Used for planning, population health, and accountability

Process for Developing Performance Measures

DHCS applied a consistent, evidence-based approach for developing the Behavioral Health Transformation (BHT) performance measure set.

1

- Developed a Theory of Change for each goal to identify the county behavioral health and managed care interventions that would advance each goal.
- **See:** **BHT Theories of Change**

2

Selected two types of measures for each goal:

- Goal Measures: Measures that track overall performance on the goal.
- Intervention Measures: Measures of county behavioral health and managed care interventions identified in the Theory of Change
- **See:** **Measures List**

3

- Developed novel DHCS measures where an existing measure did not exist to measure the process or outcome of interest.
- **See:** **Specifications Manual**

Robust Stakeholder Engagement and Input



Expert Advisement

The **Quality and Equity Advisory Committee (QEAC)** advised DHCS throughout measure development and included county and MCP leaders, advocacy groups, quality measurement and health equity experts, and people with lived experience. DHCS:

- Convened public QEAC meetings (materials available here)
- Facilitated subcommittee meetings
- Gathered input through surveys



Public Input

- In addition to receiving feedback through public meetings, DHCS facilitated and reviewed two rounds **public comments** on the measures.



Inter-Agency Collaboration

- DHCS consulted with **11 sister state departments** and agencies to develop the Theories of Change and measures.

About the Performance Measure Set



- DHCS selected **34 measures** to begin calculating in 2026.
- The measures include a mix of Goal and Intervention Measures for each of the statewide behavioral health goals, as well as three cross-goal equity measures.
- 15 are existing measures from national measures stewards and surveys, and 19 are novel DHCS measures.
- DHCS will reevaluate and improve the BHT measure set **every three years**, informed by stakeholder feedback.
- DHCS has identified additional measures to add to the measure set in 2029, many focused on BHSA services that DHCS is beginning to collect data for this year.

Select Measures of Behavioral Health Interventions for Children and Youth



DHCS developed a wide range of measures under each of the BHT goals. ***All*** **measures can be stratified by age to assess for performance for children and youth.**

Several measures are especially relevant for children and youth, including:

- Coordinated Specialty Care for First Episode Psychosis
- Behavioral Health Services for Children and Youth in Foster Care
- Behavioral Health Services for Parents, Guardians, and Pregnant People with Significant Behavioral Health Needs
- High-Fidelity Wraparound (HFW), ECM, or Intensive Care Coordination (ICC) for Children and Youth in Foster Care
- Well-Child Visits for Children and Youth with Significant Behavioral Health Needs
- One or More Behavioral Health Services for People with Significant Mental Health Needs
- Initiation of SUD Treatment (IET-I)
- One or More Behavioral Health Services for People with Significant Mental Health Needs and Co-Occurring SUD
- Three or More Behavioral Health Services for People with Significant Mental Health Needs
- Depression Screening and Follow-Up for Adolescents (DSF-E)

BHT Performance Measure Rate Releases

June 30, 2026

Rates shared with Behavioral Health Plans (BHP) and MCPs

Aug 4, 2026

First public report

Fall 2026

Measures added to Behavioral Health Public County Profile

Annual public releases via Public County Profile

2029

Remaining measures calculated

The inaugural set of BHT Performance Measures rates are available now on the DHCS website.

How to Use the BHT Performance Measures

How Performance Measures Will Be Used



Transparency



Planning



Population Health



Accountability

How Performance Measures Will Be Used for Transparency and Planning

Transparency and Planning

Population Health

Accountability

Transparency

» DHCS will publish calculated measure rates, stratified by county/MCP and key demographics, for **public access each year**. This report is currently a standalone report, but future rates will be released through the County Profile going forward.

Planning

DHCS, counties, MCPs, and other stakeholders will use these measures to inform planning for addressing the goals.

» **Counties:** Use measures for BHSA collaborative planning in their Integrated Plans (IP)/Annual Updates

» **MCPs:** Use measures to develop their PHM Strategy Deliverables

How Performance Measures Will Be Used for Population Health

Transparency and Planning

Population Health

Accountability



DHCS will provide monthly rate updates and **associated person-level data** to counties and MCPs in Medi-Cal Connect, a statewide data analytics solution and tool for PHM.



This data will support counties' and MCPs' population health activities, **such as outreach and engagement, interventions, and other services**, that would improve outcomes and performance on the measures.

How Performance Measures Will Be Used for Accountability

Transparency and Planning

Population Health

Accountability

BHSA Accountability

» DHCS will use measures to evaluate the impact of each county's BHSA funding approach. DHCS **will not** require IP revisions or issue BHSA Correction Action Plans based on BHT measures performance alone before 2029.

Medi-Cal Accountability

» DHCS will use measures to monitor BHP and MCP performance on delivery of Medi-Cal services.

Using the Measure Improve Performance

Counties and MCPs can start using data, Theories of Change, and PHM to improve measure performance using the following approach:



Step 1: Analyze

- Analyze the data, examining the performance compared to the state, other counties, and by demographic categories assessing for disparities



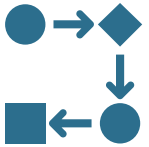
Step 2: Hypothesize

- Use the Theory of Change to hypothesize why you may see the results you see and what could be done differently from a program/planning perspective. Use "I wonder…" statements.



Step 3: PHM

- Identify ways to reach specific people identified by the data to improve outcomes.



Step 4: Improvement Cycles

- Track changes over time and repeat steps 1-3.

Example: Performance Measures for the Improving Access and Reducing Untreated Behavioral Health Conditions

Measures	Statewide Rate FY 24-25
Goal Measures	
One or More Behavioral Health Services for People with Mental Health Needs (*DHCS*)	65.93%
One or More Behavioral Health Services for People with Significant Mental Health Needs (*DHCS*)	50.20%
Initiation of SUD Treatment (*HEDIS*)	*Coming soon*
Three or More Behavioral Health Services for People with Mental Health Needs (*DHCS*)	71.43%
Three or More Behavioral Health Services for People with Significant Mental Health Needs (*DHCS*)	50.20%
Engagement in SUD Treatment (*HEDIS*)	*Coming soon*
Intervention Measures	
Depression Screening and Follow-Up for Adolescents and Adults (*HEDIS*)	75.80%
Follow-Up After Emergency Department Visit for Substance Use -- 7 Days (*HEDIS*)	26.91%
Follow-Up After Emergency Department Visit for Mental Illness -- 7 Days (*HEDIS*)	37.07%
Evidence-Based Practices for People with Significant Mental Health Needs	*Coming 2029*

Analyzing Performance Measure Rates: Goals Measures (1/2)

Statewide Rates FY 24-25

Measure	One or More Services	Three or More Services
Behavioral Health Services for People with Mental Health Needs	65.93% BHSRV1-WMH	36.19% BHSRV3-WMH
Behavioral Health Services for People with **Significant** Mental Health Needs	71.43% BHSRV1-WSMH	50.20% BHSRV3-WSMH



Analyzing Performance Measure Rates: Goals Measures (2/2)

BHP and MCP Rates

You can review each MCP and BHP FY 2024-25 rates here.

Consider the following:

- How do you compare with the statewide rate?
- How do you compare with regional peers and/or counties with similar populations?
- What disparities do you see by race/ethnicity, sex, age, and language? (Demographic stratifications at the BHP/MCP level are not yet publicly available.)
- What is your relative performance across all the measures for this goal, and what does that tell you about opportunities for improvement?
  - What is the "drop-off" you see from one to three services?
  - What is the difference between the full population with behavioral health needs compared with significant behavioral health needs?

Illustrative Example: Using Performance Measures for Untreated Behavioral Health Conditions Goal (1/3)

Reporting Years:
(When rate is released)
2026 and 2027

Measurement Years:
FY 2024-25 and
FY 2025-26 Rates

Rates will reflect performance prior to the launch of BHSA.

1. Analyze performance on the goal and establish a strategy to improve performance in BHP's **BHSA Annual Updates** and MCP's **Population Health Strategy Deliverable.**
2. Use data to inform and implement **population health strategies.**

Illustrative Example: Using Performance Measures for Untreated Behavioral Health Conditions Goal (2/3)

Reporting Years:
(When rate is released)
2028

Measurement Years:
FY 2026-27 Rates
(First Year of BHSA)

Rates released in 2028 will show performance for Year 1 of the BHSA.

1. Evaluate the **impact of the IP** in improving performance across the 14 statewide behavioral health goals in Year 1 (including in the Year 1 Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) due in 2029).
2. Leverage BHT measures to inform **collaborative planning** for the second IP (due in 2029).
3. Use data to inform and implement **population health strategies.**

Illustrative Example: Using Performance Measures for Untreated Behavioral Health Conditions Goal (3/3)

Reporting Years:
(When rate is released)
2029

Measurement Years:
FY 2027-28 Rates (Second Year of BHSA)

Rates released in 2029 will show Year 2 of BHSA performance and will include BHSA services data for the first time.

1. Evaluate the **impact of the IP** in improving performance across the 14 statewide goals in Year 2 (including in the Year 2 BHOATR due in 2030).
2. Analyze progress on the goal and refine the strategy to improve performance in BHPs' **BHSA Annual Updates** and MCPs' **Population Health Strategy Deliverable.**
3. Use insights from measures for **population health**, including using newly available measures assessing the delivery of BHSA services.

BHT Performance Measures Resources

DHCS released performance measure materials to explain how the measures were developed and validated and provide strategies to advance each of the statewide goals.

Performance Measures Materials
Policy Manual *(Module 5):* Includes final BHT Performance Measures list
Policy Manual: Phase 2 Measure Supplement: Provides lay description of measures, important context for interpretation, and measure responsibility
Technical Specifications Manual: Provides detailed technical specifications for all measures going live in July 2026
Theories of Change: Summarizes the Theory of Change for county behavioral health and MCPs to advance each statewide BH goal
FY 2024-25 Rate Report: Provides final FY 2025 rates (statewide, statewide stratifications, BHP, and MCP rates) for all 2026 measures
Coming Soon: Performance Measures FAQ



Questions?

Public Comment

Public Comment Guidelines

- During the public comment period, we do not answer questions, but simply listen to public comments.
- All public comments are recorded in the meeting minutes.
- Public comments are from members of the public present in the room and those attending virtually.
- Please state your name and organization.
- Please keep your comments concise and limited to 1 minute.

Final Comments and Adjourn

2027 Meeting Dates



- March 25, 2027
- May 20, 2027
- June 3, 2027
- August 26, 2027
- October 21, 2027

Thank you.



DHCS

Appendix

CCS Eligibility Changes

CMS Interim Final Rule – Key Guidance

- **Qualifying activities:** more detailed definitions (community service, in-kind and unpaid work, half-time education)
- **Exceptions first:** states must screen for exceptions before applying work requirements
- **Medical frailty:** narrowed to conditions that "significantly impair" the ability to work
- **Short-term hardship:** one-month lookback in California
- **Self-attestation:** allowed in 2027; limited in 2028 and beyond
- **Good-faith waivers:** up to six months at a time

Finding Mental Health Providers in FFS

- Non-SMHS (e.g., anxiety, depression, stress) are available in Medi-Cal FFS
- Medi-Cal Hotline 1-800-541-5555
- Find Care | DHCS
- DHCS Provider Finder Hub
- CCS Provider Lists | DHCS

CCS Funding Changes

Population	Current Funding	Updated Category	Updated Funding
UIS: moves from managed care to FFS	Medi-Cal CCS: 100% State	Medi-Cal CCS	100% State
UIS: loses Medi-Cal for an eligibility reason, or undocumented with restricted-scope; meets CCS-Only rules	Medi-Cal CCS: 100% State	CCS-Only	50% State | 50% County
Lawfully present immigrants who lose federal Medicaid eligibility, but keep Medi-Cal and CCS	Medi-Cal CCS: 50% Federal | 50% State	Medi-Cal CCS	100% State
SIS: loses Medi-Cal for an eligibility reason; meets CCS-Only rules	Medi-Cal CCS: 50% Federal | 50% State	CCS-Only	50% State | 50% County

Members who lose Medi-Cal for a procedural reason are not eligible for CCS-Only.