



Medical Necessity Criteria CaAIM Behavioral Health Workgroup

December 20, 2019



Agenda

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| 10:00 – 10:15 | Welcome and Introductions |
| 10:15 – 10:30 | Goals of the Medical Necessity Proposal |
| 10:30 – 12:00 | Overview of Proposed Changes to Medical Necessity Criteria for Outpatient Specialty Mental Health and Substance Use Disorder Services |
| 12:00 – 12:45 | Break for Lunch |
| 12:45 – 1:45 | Overview of Level of Care Assessment Tools and Case Study Examples |
| 1:45 – 2:45 | Overview of Proposed Changes to Medical Necessity Criteria for Inpatient Specialty Mental Health Services |
| 2:45 – 3:00 | Discuss Future Meeting Approach And Workgroup Deliverables |
| 3:00 – 3:15 | Public Comment |
| 3:15 – 3:30 | Closing and Next Steps |



Welcome and Introductions





Meeting Objectives

The objective this Behavioral Health workgroup meeting is to:

- Discuss opportunities and challenges around revising medical necessity criteria for specialty mental health services and substance use disorder services
- Provide feedback and recommendations on proposed changes to medical necessity criteria for outpatient specialty mental health services and substance use disorder services
- Provide feedback and recommendations on proposed changes to medical necessity criteria for inpatient specialty mental health services
- Provide feedback and recommendations on standardizing level of care assessment tools for specialty mental health services and substance use disorder services
- Provide recommendations for communicating new medical necessity requirements to stakeholders



Overview and Goals of the Medical Necessity Proposal



Framing the Issue

- The medical necessity criteria for specialty mental health and substance use disorder services, as currently defined, is outdated, lacks clarity, and should be re-evaluated.
- Existing medical necessity determinations are driven by diagnostic determinations and documentation of functional impairments.
- Responsibility for mental health services is shared between counties and Medi-Cal managed care plans.
- This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services.





Medical Necessity Proposal Goals

To ensure beneficiary behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties for providing behavioral health services, DHCS is proposing to:

- Separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services.
- Allow counties to provide and be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the mental health or substance use disorder provider determining whether the beneficiary has a covered diagnosis.



Medical Necessity Proposal Goals

- Identify an existing or develop a statewide, standardized level of care assessment tool, one for beneficiaries 21 and under and one for beneficiaries over 21, that would be used to by counties, Medi-Cal managed care plans, and providers to determine a beneficiary's need for mental health services (i.e., level of care needed), if any, and which delivery system is most appropriate to cover and provide treatment.
- Revise the existing intervention criteria to clarify that specialty mental health services are to be provided to beneficiaries who meet the eligibility criteria for specialty mental health and that services are reimbursable when they are medically necessary and provided in accordance with the Medi-Cal State Plan instead of the existing state service criteria.
- Align with federal requirements; allowing a physician's certification/recertification to document a beneficiary's need for acute psychiatric hospital services.



Medical Necessity Proposal Goals

- DHCS is proposing that eligibility criteria, being largely driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, should be the driving factor for determining the delivery system in which someone should receive services.
- Each delivery system should then provide services in accordance with an individualized beneficiary plan, as recommended by a physician or other licensed mental health professional.



Medi-Cal Medical Necessity

- For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. (W & I Code §14059.5(a).)
- For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service is necessary to correct or ameliorate mental illnesses and conditions (42 U.S.C. Section 1396d(r)(5); W & I Code § 14059.5(b)(1).)



Workgroup Discussion

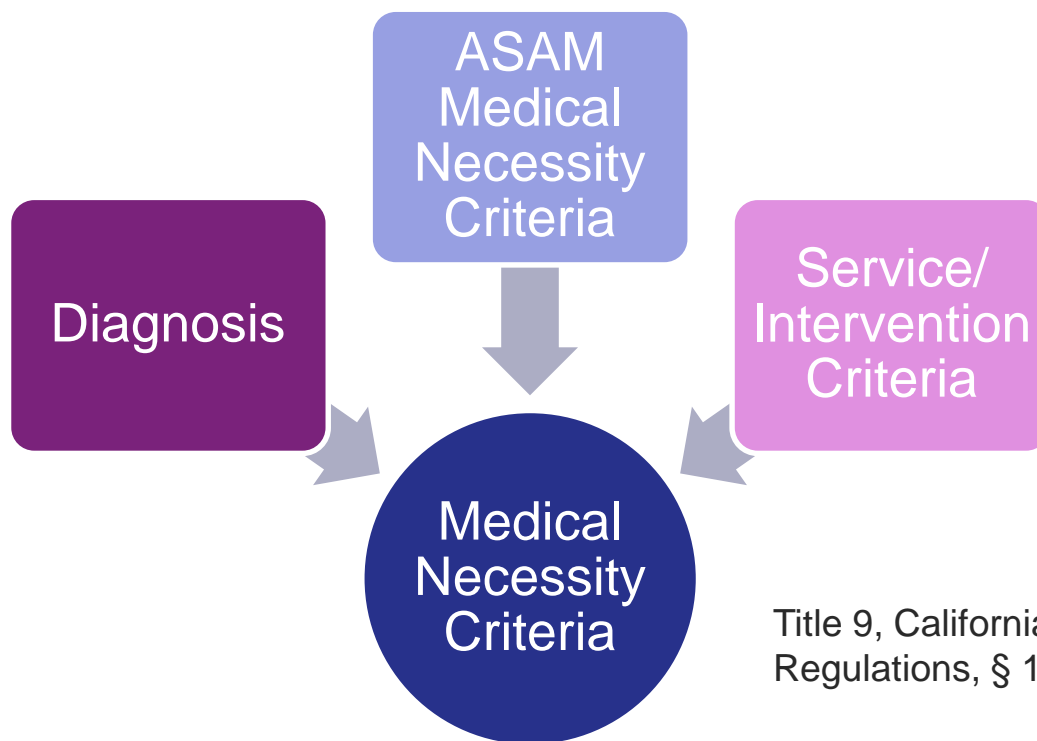




Overview of Proposed Changes to Medical Necessity Criteria for Outpatient Specialty Mental Health and Substance Use Disorder Services



Existing SUDS Medical Necessity (DMC-ODS)



Title 9, California Code of Regulations, § 1820.205

Diagnosis + ASAM Criteria => What is the appropriate level of care (DMC-ODS only)?

Service/Intervention Criteria => Is the service itself medically necessary?



Existing SUD Medical Necessity Requirements

- The current Section 1115 waiver and regulations for substance use disorder services require a beneficiary to be diagnosed with a substance use disorder to meet criteria for reimbursement.
- The existing rules are vague and limit the counties' ability to be reimbursed for services that are provided prior to the completion of an assessment, which is necessary for a physician to diagnose a beneficiary, or if an SUD diagnosis is not reached within 30-days of the beneficiary's "admission to treatment date."
- The basis for the SUD diagnosis is required to be documented in the beneficiary's medical records by the physician; the physician's signature on a treatment plan that includes a DSM code does not currently fulfill this requirement. (22 CCR § 51341.1(h)(1)(A)(v)(a).)
- For DMC-ODS, the beneficiary must also meet the ASAM medical necessity definition:
 - **Medical Necessity.** Pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk (as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 (psychiatric issues (such as imminent suicidality)). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "clinical necessity" "necessity of care" or "clinical appropriateness." (The ASAM Criteria, 3rd Edition, page 422)



Proposed Changes to SUDS Medical Necessity

Is the beneficiary eligible for the service?

SUD Diagnosis

- Yes, Beneficiary is eligible for SUD services

**No SUD Diagnosis
Determined Prior to
or Upon Completion
of an Assessment**

- Yes, Beneficiary is eligible for SUD services while the diagnosis (or lack thereof) is established



Proposed Changes to SUDS Medical Necessity

Is the service itself medically necessary?

- Is the service necessary to correct or ameliorate a child/youth's SUD condition? **YES, the service is medically necessary.**
- Are the SUD treatment services provided to stabilize and rehabilitate Medi-Cal beneficiaries who have been recommended to receive treatment for an SUD? **YES, the service is medically necessary.**
- Are the services reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury are covered by the Medi-Cal program? **YES, the service is medically necessary.**



Existing Medical Necessity (Children/Youth)

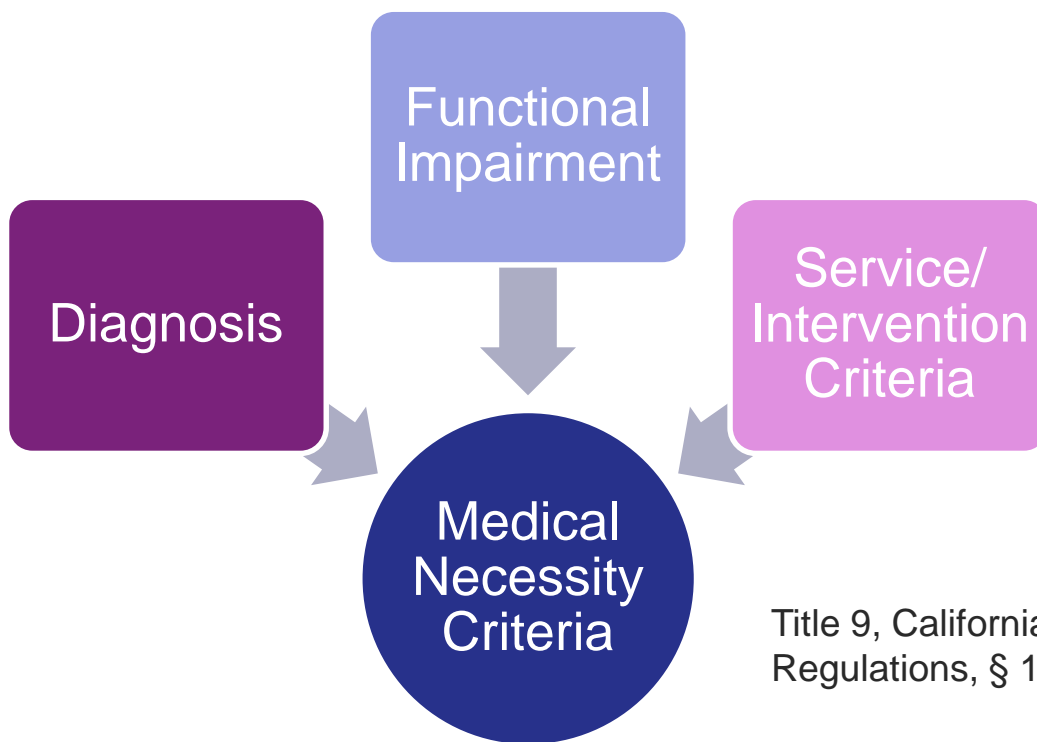


Clarifications to Medical Necessity Criteria in Federal and State Law:

- Federal EPSDT Requirements – Title 42, U.S.C. §1396(r)(5)
- Senate Bill 1287 – Welfare & Institutions Code § 14059.5



Existing Outpatient SMHS Medical Necessity (Adults)



Title 9, California Code of Regulations, § 1820.205

Diagnosis + Impairment => Does the beneficiary need the specialty mental health level of care?

Service/Intervention Criteria => Is the service itself medically necessary?



SMHS Diagnosis Requirements

- Under the existing requirements, Medi-Cal beneficiaries are eligible to receive outpatient specialty mental health services if the beneficiary has been diagnosed with a covered mental health condition and, as a result of that condition, meets specified impairment criteria.
- DHCS requires counties use the criteria sets in the DSM-5, as the clinical tool to make diagnostic determinations.
- Not all diagnoses are covered under the mental health managed care plans, as other delivery systems are better suited to provide treatment for the certain conditions.
- When a new beneficiary presents for an assessment, a diagnosis is not immediately known.
- Today, mental health managed care plans are reluctant to provide treatment services to someone without a defined diagnosis due to existing criteria or the county is providing such services using other county funds when the services should be eligible for Medi-Cal funding.
- **DHCS' Proposal –**
 - A county should be able to provide and be paid for treatment services to meet a beneficiary's mental health needs prior to the mental health provider determining whether the beneficiary has a covered diagnosis.
 - Once a diagnosis is determined, and level of impairment has been determined, the beneficiary would be referred to the appropriate delivery system.



Service/Intervention Criteria

Current regulatory language specifies that interventions (i.e., services) must meet the following criteria:

- The focus of the proposed intervention is to address the beneficiary's covered mental health condition; and
- The expectation that the proposed intervention will: 1) significantly diminish the impairment, 2) prevent significant deterioration in an important area of life functioning, 3) allow a child to progress developmentally as individually appropriate, or 4) for a child, meet the requirements laid out in state regulations; and,
- The condition would not be responsive to physical health care-based treatment.



State Plan – Rehabilitative Mental Health Services

- DHCS is proposing to revise the existing intervention criteria to clarify that specialty mental health services should be provided to beneficiaries who meet the eligibility criteria for specialty mental health and that services are reimbursable when they are provided in accordance with the Medi-Cal State Plan.
- Rehabilitative mental health services (i.e., specialty mental health services) are services recommended by a physician or other licensed mental health professional, within the scope of his or her practice, under State law for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a beneficiary's functional level.



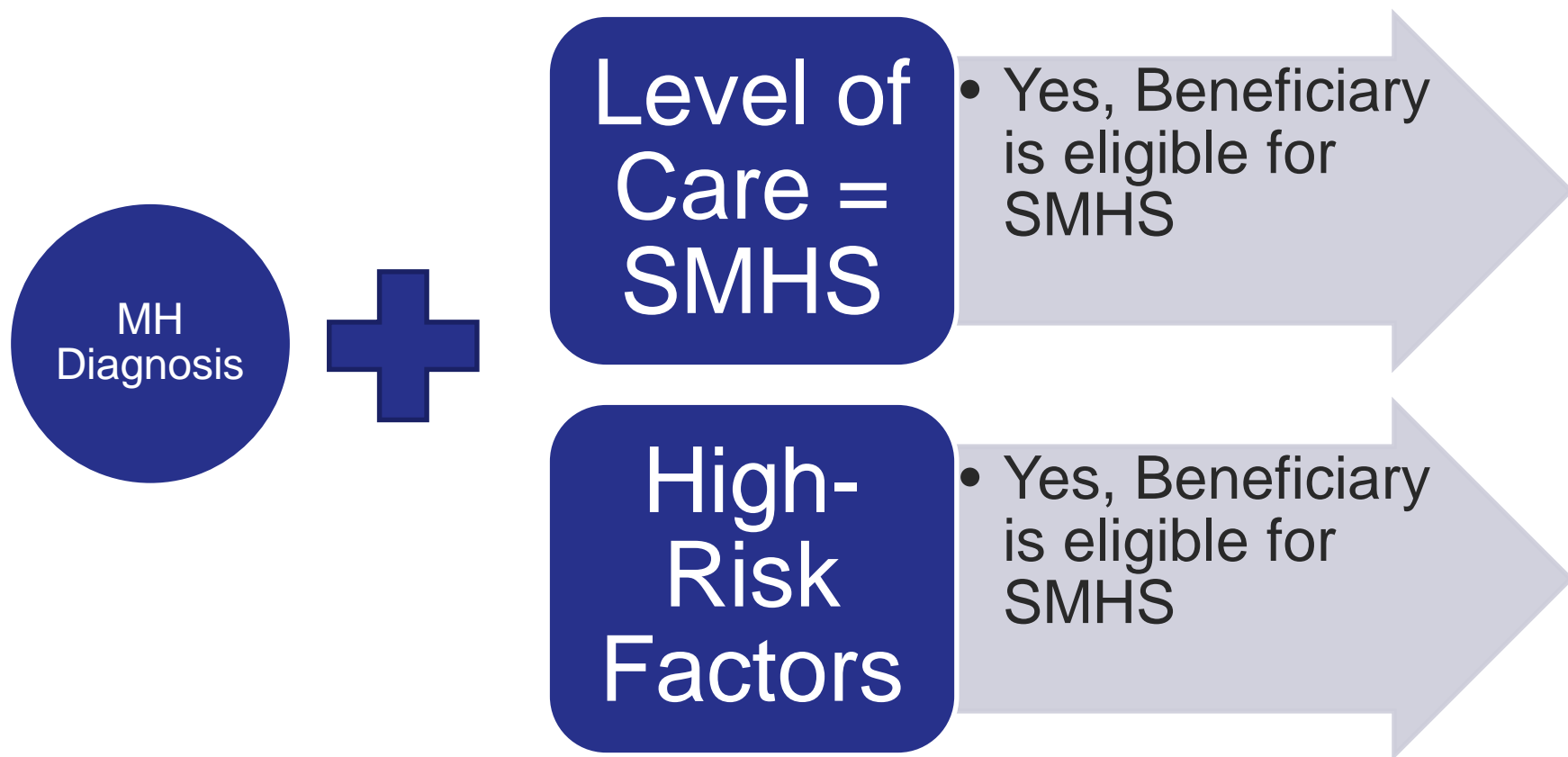
State Plan – Rehabilitative Mental Health Services

- Specialty mental health services must also meet the following criteria:
 - Allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention;
 - Provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency; and
 - Provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to State requirements.



Proposed Changes to SMHS Medical Necessity

Is the beneficiary eligible for SMHS?





Proposed Changes to SMHS Medical Necessity

Is the service itself medically necessary?

- Is the service necessary to correct or ameliorate a child/youth's mental health condition? **YES, the service is medically necessary.**
- Are the services recommended for the maximum reduction of mental or emotional disability, and restoration, improvement and/or preservation of an adult beneficiary's functional level? **YES, the service is medically necessary.**
- Will the service allow a beneficiary to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, or prevent the need for institutionalization of a higher level of medical intervention? **YES, the service is medically necessary.**
- Is the service provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency? **YES, the service is medically necessary.**



No Wrong Door (Children/Youth)



- DHCS is proposing a no wrong door approach with children under the age of 21.
- Essentially, whether the child presents first in the Medi-Cal managed care plan or the mental health managed care plan, each system is responsible for providing services to the child, assessing the child and either providing ongoing treatment, as necessary, or referring the child to the appropriate delivery system.
- Both the Medi-Cal managed care plan and mental health managed care plan would be reimbursed for all medically appropriate services provided to a child, even if the child ultimately moves to the other delivery system.



EPSDT Guidelines

- In accordance with federal law, beneficiaries under the age of 21 are allowed EPSDT service protections, which must also “...correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”
- Therefore, for beneficiaries under the age of 21, each delivery system should provide mental health services according to the broader EPSDT guidelines.



CA Medi-Cal Mental Health Service Array

Non-Specialty Mental Health Services (MCP)	Specialty Mental Health Services – Outpatient (MHP)	Specialty Mental Health Services - Inpatient (MHP)
<ul style="list-style-type: none"> • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation 	<ul style="list-style-type: none"> • Mental Health Services <ul style="list-style-type: none"> • Assessment • Plan development • Therapy • Rehabilitation • Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential • Adult Crisis Residential • Crisis Intervention • Crisis Stabilization • Targeted Case Management • Intensive Care Coordination • Intensive Home Based Services • Therapeutic Foster Care • Therapeutic Behavioral Services 	<ul style="list-style-type: none"> • Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services (if the beneficiary is in fee-for-service hospital)



Memorandum of Understanding (MOU) Requirements

Objectives:

- Ensure coordination between the managed care plans and specialty mental health plans
- Promote local flexibility that exist at the county level

Core elements:

- Basic Requirements
- Covered Services and Populations
- Oversight Responsibilities of the MCP and MHP
- Screening, Assessment, and Referral
- Care Coordination
- Information Exchange
- Reporting and Quality Improvement Requirements
- Dispute Resolution
- After-Hours Policies and Procedures
- Member and Provider Education



Workgroup Discussion





Level of Care Assessment Tools and Case Study Examples



Level of Care Assessment Tools

- DHCS is seeking input regarding the implementation of a statewide, standardized level of care assessment tool that could be used across delivery systems to determine level of impairment for beneficiaries with mental health conditions.
- DHCS is proposing the identification of an existing, or development of a new, statewide, standardized level of care assessment tool, one for beneficiaries 21 and under and one for beneficiaries over 21, that would be used by counties, Medi-Cal managed care plans, and providers to determine a beneficiary's need for specialty mental health services, if any, and/or which delivery system is most appropriate to cover and provide treatment.
- DHCS would like to engage with stakeholders on any special considerations DHCS should make concerning foster children with such assessment.



UCLA Study

- In 2016, DHCS commissioned UCLA to conduct a survey of standardized assessment tools ([published August 2017](#)) for the performance outcomes system.
- UCLA conducted an environmental scan of the tools used to measure functional status by other states or nations, a survey of county mental health plans (MHPs) and their contracted providers on tools currently in use, and an in-depth literature review of the most frequently used tools identified in the environmental scan and survey to assess their psychometric properties and use as an outcome measure.
- Through the environmental scan and surveys, UCLA found that the Child and Adolescent Needs and Strengths (CANS) was the most frequently used standardized assessment tool for children/youth, both nationally and in California.



CANS-50 and PSC-35

- DHCS adopted the Pediatric Symptom Checklist (PSC-35 caregiver completed version) and the Child and Adolescent Needs and Strengths (California CANS 50) Core Item set for its Performance Outcomes System functional outcome reporting.
- **PSC-35**
 - The PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.
 - Parents/caregivers will complete the [PSC-35 \(parent-completed version\)](#) for their children ages 3 and youth up to age 18.
 - The PSC-35 is completed at the beginning of treatment, every six months following the first administration, and at the end of treatment.
- **CANS**
 - The CANS is a structured assessment for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes.
 - Providers complete the CANS ([California CANS](#)) form (dated October 24, 2017) through a collaborative process which includes children ages 6 and youth up to age 17, and their caregivers (at a minimum).
 - The CANS version being used is the CANS Core Item set.
 - The CANS is completed at the beginning of treatment, updated every six months following the first administration, and at the end of treatment.



Beacon Health Options Screening for Mental Health Services



Factors to Consider

- Shared responsibilities for the delivery of mental health services (county mental health managed care and Medical managed care plans)
- Current SMHS landscape
 - Existing requirements regarding CANS-50 for children/youth
 - Lack of existing standardized assessment tool for adults
- High-risk characteristics, service considerations, and other factors (in addition to functional impairment)
 - Adverse Childhood Experiences
 - EPSDT requirements
 - Service array variability between plans (specialty vs. non-specialty)
- Other factors



Case Study Examples

Beneficiary Age	Diagnosis	Functional Impairment(s)	High-Risk Characteristic/ Factors	Meets SMHS Medical Necessity Criteria?
62	Major depressive disorder	<ul style="list-style-type: none"> Loss of appetite Excessive fatigue Withdrawn from social groups/activities 	Co-occurring SUD	Yes
34	Bipolar I disorder, in full remission (no significant signs/symptoms during past 2 months) *Medication compliant	<ul style="list-style-type: none"> Intensity of symptoms is moderate. (between mild and severe) 	Chronic diabetes Inpatient hospitalization within last 6 months Unstable housing (living with friends temporarily)	Yes
34	Bipolar I disorder, in full remission (no significant signs/symptoms during past 2 months) *Medication compliant	<ul style="list-style-type: none"> Intensity of symptoms is mild 	Chronic diabetes	No



Case Study Examples

Beneficiary Age	Diagnosis	Functional Impairment(s)	High-Risk Characteristic/ Factors	Meets SMHS Medical Necessity Criteria?
15	Generalized Anxiety Disorder	<ul style="list-style-type: none"> • Impaired school performance • Excessive fatigue • Difficulty sleeping • Excessive worry about school and social relationships 	Child welfare involvement	Yes
10	No diagnosis determined ACEs score of ≥ 3	<ul style="list-style-type: none"> • Worry about school and home 	<ul style="list-style-type: none"> • Parent with SUD and SMI • Psychological abuse • Child-welfare involvement and/or juvenile-justice involvement 	Yes
10	No diagnosis determined ACEs score of 1	<ul style="list-style-type: none"> • Worry about school and home 	<ul style="list-style-type: none"> • Parent with SMI • Child-welfare involvement 	No



American Society of Addiction Medicine Criteria

- The ASAM Criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement.
- ASAM Criteria uses six unique dimensions, which represent different life areas that together impact any and all assessment, service planning, and level of care placement decisions.
- The ASAM Criteria structures multidimensional assessment around six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health and mental health services.



ASAM Criteria

- The ASAM Criteria provides a consensus based model of placement criteria and matches a patient's severity of SUD illness with treatment levels that run a continuum marked by five basic levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services).
- At a minimum, providers and staff conducting assessments are required to complete the two e-Training modules.
- There is no standardized ASAM Criteria assessment tool
- Many counties utilize ASAM-like tools



Workgroup Discussion





Overview of Proposed Changes to Medical Necessity Criteria for Inpatient Specialty Mental Health



Existing Inpatient Criteria

- Included Diagnosis
- Admission Criteria:
 - Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; **and,**
- Requires psychiatric inpatient hospital services for **one of the reasons (1 or 2)** below:
 - 1. Has symptoms or behaviors due to a mental disorder that (one of the following):**
 - a. Represent a current danger to self or others, or significant property destruction.
 - b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
 - c. Present a severe risk to the beneficiary's physical health.
 - d. Represent a recent, significant deterioration in ability to function.
 - 2. Require admission for one of the following:**
 - a. Further psychiatric evaluation.
 - b. Medication treatment.
 - c. Other treatment that can reasonably be provided only if the patient is hospitalized.



Federal Requirements

- Federal regulations require the completion of a certification by a physician (and recertification by a physician or nurse practitioner or physician assistant under the supervision of a physician) to authorize inpatient care.
- § 456.160: certification and recertification of need for inpatient care
- Current State and federal regulations further require the completion of medical, psychiatric and social evaluations, as well as a written plan of care, before admission to a mental hospital or before authorization for payment.



Proposal

- DHCS is proposing that a physician's certification/recertification be required to document a beneficiary's need for acute psychiatric hospital services and that services are provided at the appropriate level of care. Specifically:
 - A physician must certify that, at the time of admission to an acute psychiatric inpatient hospital, the beneficiary, as the result of a mental disorder, meets the admission requirements.
 - For the second and each subsequent day a beneficiary receives acute psychiatric inpatient hospital services, a physician, or a physician assistant or nurse practitioner acting within their scope of practice, as defined by State law, and under the supervision of a physician, must certify that the beneficiary continues to meet the criteria.
 - If an individual enrolls in Medi-Cal while receiving inpatient psychiatric hospital services, a physician must certify that the individual met the criteria at the time the individual was admitted and for each day the beneficiary received acute psychiatric inpatient hospital services. The certification must be completed before the Mental Health Plan authorizes payment.



Concurrent Review Requirements

- [Information Notice 19-026](#)
- Counties are required to conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services, following the first day of admission.
- DHCS is working with counties and hospitals to develop concurrent review/authorization guidelines to operationalize the procedures consistently statewide.
- Counties must maintain responsibility to ensure that services furnished to beneficiaries are medically necessary and must ensure compliance with all requirements necessary for Medi-Cal reimbursement.



Workgroup Discussion





Workgroup Focus Questions and Deliverables





Future Meeting Planning

Future Medical Necessity Focused Workgroup Meeting Dates:

- **January 30, 2019**

Meeting Deliverables

- Level of care assessment tools
- Proposal medical necessity language

Workgroup Feedback

- Hear from workgroup members what they would like to discuss at future meetings.
- What additional information is needed to inform policy recommendations?



Workgroup Focus Questions

- Does DHCS' proposal to amend medical necessity criteria for outpatient and inpatient specialty mental health services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of CalAIM? If not, what changes are needed to address identified gaps? What else should DHCS consider?
- What are your recommendations regarding the specific amendments DHCS should make to the medical necessity criteria for outpatient SMHS?
- What are your recommendations regarding the specific amendments DHCS should make to the medical necessity criteria for inpatient SMHS?
- Does DHCS' proposal to amend medical necessity criteria for substance use disorder services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of CalAIM? If not, what changes are needed to address identified gaps? What else should DHCS consider?
- What are your recommendations regarding the specific amendments DHCS should make to the medical necessity criteria for substance use disorder services?
- How should DHCS operationalize the “no wrong door” approach for children/youth for accessing mental health services?
- What are your recommendations to strengthen care coordination between the counties and Medi-Cal managed care plans?



Workgroup Focus Questions

- What factors should DHCS consider when selecting a level of care assessment tool for SMHS for children/youth? Do you have a recommendation regarding a specific tool(s)?
- What factors should DHCS consider when selecting a level of care assessment tool for adults? Do you have a recommendation regarding a specific tool(s)?
- What are your recommendations about how to standardize, across delivery systems, screening and/or assessment procedures for mental health services? Should Medi-Cal managed care plans utilize the same standardized assessment tool selected for the SMHS delivery system?
- What are your recommendations regarding the identification of high-risk characteristics that would act as assessment “over-rides”? How should DHCS incorporate a consideration of ACES for determining medical necessity for SMHS?
- Should a beneficiary’s need for a specific service or services, which are not covered by both the MCP and SMHS delivery systems (e.g., Intensive Care Coordination, Day Treatment Intensive), drive delivery system determinations?
- What factors should DHCS consider when standardizing an ASAM Criteria tool for DMC-ODS?
- What research and/or deliverables should DHCS prepare for the next meeting?



Workgroup Expected Deliverables

- Policy recommendations based on workgroup focus questions
- Provide feedback and recommendations on proposed changes to medical necessity criteria for outpatient specialty mental health services and substance use disorder services
- Provide feedback and recommendations on proposed changes to medical necessity criteria for inpatient specialty mental health services
- Provide feedback and recommendations on standardizing level of care assessment tools for specialty mental health services and substance use disorder services
- Provide recommendations for communicating new medical necessity requirements to stakeholders

Workgroup Meeting Schedule

<i>Date</i>	<i>Time</i>	<i>Topic(s) / Agenda Items</i>
Friday, December 20 th	10:00 am to 3:30 pm	Medical Necessity
Friday, January 10 th	10:00 am to 3:00 pm	Payment Reform
Thursday, January 23 rd	10:00 am to 3:00 pm	BH Integration
Friday, January 24 th	10:00 am to 3:00 pm	BH Integration
Wednesday, January 29 th	10:00 am to 3:30 pm	IMD
Thursday, January 30 th	10:00 am to 3:00 pm	Medical Necessity
Tuesday, February 4 th	10:00 am to 3:00 pm	Payment Reform
Wednesday, February 26 th	10:00 am to 3:00 pm	Medical Necessity/ BH Integration
Thursday, February 27 th	10:00 am to 3:00 pm	Wildcard (tie up loose ends)



Public Comment

Please limit comments to 2 minutes





Closing and Next Steps



Next Behavioral Health Workgroup Meeting: **January 10, 2020** (Payment Reform)

Questions? CaAIM@dhcs.ca.gov