Stakeholder Advisory Committee & Behavioral Health Stakeholder Advisory Committee Hybrid Meeting

Thursday, February 15, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Webinar Tips

- Please use either a computer or phone for audio connection.
- Please mute your line when not speaking.
- For questions or comments, email:

  SACInquiries@dhcs.ca.gov or BehavioralHealthSAC@dhcs.ca.gov.

Welcome, Director's Opening Comments, Introduction of New Members, Roll Call, and Today's Agenda

Michelle Baass, Director

DHCS

Director's Update

Michelle Baass, Director, and Sarah Brooks, Chief Deputy Director for Health Care Programs

DHCS

Governor Newsom's 2024-2025 Proposed Budget

Governor's Proposed Budget

- The Governor's proposed fiscal year 2024-25 budget includes $253.4 billion total funds for all health and human services programs.
- The Governor's proposed budget includes **$161.1 billion total funds for DHCS** and 4,649.5 positions to support DHCS programs and services. Of this amount, $1.3 billion funds state operations (DHCS operations), while $159.8 billion supports local assistance (funding for program costs, partners, and administration).
- DHCS budget proposals continue to build on the Administration's previous investments and enables DHCS to continue to transform Medi-Cal and behavioral health services.

DHCS Budget Proposals

- Full scope coverage to Californians ages 26-49
- Asset Test Elimination
- Managed Care Organization (MCO) Tax
- Targeted Provider Rate Increases
- Children and Youth Behavioral Health Initiative – Wellness Coach Benefit (CYBHI)
- Assisted Living Waiver (ALW) slot increase
- Home and Community Based Alternatives (HCBA) Waiver slot increase
- Respiratory Syncytial Virus vaccines and injectable drugs

DHCS Budget Proposals (Continued)

Considering the state's overall General Fund condition, several budget solutions were included in the DHCS budget.

- New MCO Tax revenue
- Increased use of the Medi-Cal Provider Payment Reserve Fund
- Delay Round 6 of the Behavioral Health Continuum Infrastructure Program
- Delay Behavioral Health Bridge Housing Program

Managed Care Plans (MCP) 2024 Transition Update

2024 MCP Transition Context

Scale and Complexity

- **Scale**: Approximately 1.2 million members were identified to transition to a new MCP on January 1, 2024; in addition, Kaiser became the prime* MCP for approximately 800K members
- **Complexity**: These transitions took place across 21 counties and 14 unique MCPs
  - 250K members received an enrollment packet to choose an MCP because of the county plan model changes in a county where there is more than one plan in the county. (5 counties impacted)
  - 400K members transitioned because of the county plan model change and were enrolled in COHS or Single Plan County (15 counties impacted)
  - 500K members transitioned from Health Net to Molina in Los Angeles County (1 county impacted)
  - 800K members transitioned to Kaiser as their Prime MCP* in 27 counties

A **Prime MCP is an MCP that directly contracts with DHCS to provide Covered Services to members within the county or counties specified in their contract.*

Preparation for the 2024 MCP Transition

Operational Readiness Assessment

- DHCS required MCPs to submit approximately 250 Operational Readiness deliverables corresponding to the MCP contract
- For example, Operational Readiness deliverables focused on:
  - Quality Improvement
  - Utilization Management
  - Network Adequacy
  - Delegation Oversight
  - Continuity Of Care
  - Population Health Management
  - Enhanced Care Management
  - Community Supports
- DHCS conducted deep dive assessments for five MCPs identified as high-priority due to the size and complexity of their expansion to additional counties or the number of members they will serve, as well as being new to providing Medi-Cal managed care services

Member Engagement

- **Pre-Transition:** DHCS utilized various strategies for engaging members, raising awareness about the 2024 transition and their rights, and providing contact information
  - Letters
  - Call campaigns
  - Text campaigns
  - Member-focused web resources
  - DHCS' Friday newsletter
- **Post-Transition**: DHCS is analyzing member call data, grievances, appeals, and stakeholder survey feedback to identify and address member challenges
- ***Ongoing:*** DHCS is collaborating with MCP partners and advocates to ensure effective communication and resolution of identified transition issues

MCP Transition Monitoring Approach

Due to the scale and complexity of the 2024 MCP Transition, DHCS is utilizing a multi-pronged approach to enable oversight and ensure compliance with MCP Transition policies.

	Activities	Cadence
MCP Survey Responses	Previous and Receiving MCPs are required to submit Continuity of Care (CoC) performance data via survey across 4 domains: • CoC for all transitioning members and Special Populations members (note: Special Populations members are especially vulnerable members as defined in the MCP Transition Policy Guide) • CoC for Enhanced Care Management (ECM) and Community Supports • Member Issues	***Biweekly*** *November through February;* ***Monthly*** *through March; and* ***quarterly*** *through December 2024*
Stakeholder Survey	DHCS is soliciting and tracking stakeholder feedback through a survey; MCPs are also expected to track stakeholder input and ensure appropriate feedback loops exist with MCP leadership	***Monthly*** *November 2023 through March 2024*
Other Activities	DHCS is also monitoring plan-to-plan data sharing to confirm CoC protections are honored. • **Plan to Plan Data Sharing** (Biweekly): DHCS is reviewing copies of data files shared between Previous and Receiving MCPs for timeliness and completeness.	***Monthly and Biweekly*** *November 2023 through March 2024*

Statewide Metrics: Grievances and Appeals

Grievances and Appeals		
	Number of Grievances	**2,536**
	Percent of members with grievances	**0.123%**
	Baseline percent of members with grievances	**0.145%**
	Number of Appeals	**26**
	Percent of members with appeals	**0.001%**
	Baseline percent of members with appeals	**0.006%**

Top 3 Grievances Types
Case Management/Care Coordination
Plan Customer Service
Enrollment

Top 3 Benefits Appealed
Durable Medical Equipment
Outpatient Physical Health
Pharmacy

Reporting Period: *January 15 – January 28, 2024*

Baseline: *Average bi-weekly number of filings from October 2022 to August 2023*

Statewide Metrics: Call Center Data

Ombudsman (OMB)

- 2.3% of member contacts were flagged as 2024 Transition related (includes MCP Transition, ICF/DD & Subacute Transition, and Adult Expansion Transition calls)

- Between December 2023 to January 2024:
  - Average hold time increased from 3.49 Minutes in December to 6.12 Minutes in January
  - Member calls increased as expected.
  - DHCS is seeing downward trends in February

Member Calls*	Top 3 Topics
	Access to Care
	Continuity of Care/treatment plan
	Enrollment

**MCP Call Centers, DMHC, and Ombudsman*

January OMB Call Volume

- Self Service Option increased 33% from December
- Ombudsman Calls increased 54% from December

Reporting Period: January 2024

Continuity of Care Policies (1/2)

DHCS developed a robust Policy Guide for the MCP Transition detailing policies that aim to minimize member disruption.

Domain		Policy
Continuity of Care (CoC)	**Primary Care Provider (PCP) Retention**	Receiving MCPs must retain at least 90% of transitioning members' PCPs either as network providers or through CoC for Providers Agreements.
	All Members	Receiving MCPs must approve requests from members (or their provider or authorized representative) to stay with their out-of-network (OON) provider through at least December 31, 2024, if certain conditions are met. Receiving MCPs must continue member services by honoring active courses of treatment and all unexpired authorizations from the Previous MCP.
	Special Populations	Receiving MCPs must proactively outreach to OON providers on behalf of vulnerable transitioning members ("Special Populations"[1]) to establish Agreements.[2] MCPs must continue member services by honoring active courses of treatment and all unexpired authorizations from the Previous MCP.

[1] See Section V of the Policy Guide for a more detailed definition of Special Populations: Resources | Stakeholders | Managed Care Plan Transition | DHCS
[2] Agreements refers to both Network Contracts and CoC for Providers Agreements.

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Continuity of Care Policies (2/2)

DHCS developed a robust Policy Guide for the MCP Transition detailing policies that aim to minimize member disruption.

Domain		Policy
Continuity of Care (CoC)	**Enhanced Care Management**	DHCS strongly encourages 100% ECM provider overlap between Receiving and Previous MCPs. Receiving MCPs must honor all ECM authorizations from the Previous MCP.
	Community Supports	DHCS strongly encourages 100% Community Supports provider overlap between Receiving and Previous MCPs. MCPs must honor all Community Supports authorizations from the Previous MCP where Community Supports overlap.
Data Sharing		Receiving MCPs must ingest 14 data files from Previous MCPs, refreshed on a weekly basis, as well as monthly data from DHCS, including the Data Feed and data specific to Special Populations.

Statewide Metrics: Continuity of Care

Key Takeaways:

- Continuity of Care (CoC) allows members to continue seeing their provider even if that provider is not in the Receiving MCP's network yet.
- Pending CoC agreements does not disrupt the member from continuing to see their provider.
- The pending CoC requests were made in January and MCPs have 30 days to process most requests.

Total Number of CoC for Provider Requests **9,458**	Number of Agreements	**1,212**
	Number Pending	**2,941**
	Number Approved Because Provider is Already in Network	**3,876**
	Number Denied for Other Acceptable Reasons*	**1,389**
	Number Cancelled by Requestor	**40**

Reporting Period: *January 15 – January 28, 2024*

Statewide Metrics: Continuity of Care Special Populations

MCPs are required to outreach to Special Populations members' OON Providers.

Key Takeaways :

- If a member's existing provider was not in the Receiving MCP's network, the MCP was required to proactively contact all eligible providers that members had a pre-existing relationship with.
- DHCS and the Previous MCP shared data for Special Populations with the Receiving MCP to then proactively begin the CoC process.
- If the MCP and provider do not come to an agreement, the MCP must find the member an in-network provider so that the member can have continued access to services.

Total Number of OON Special Population Providers **21,483**	Number (%) Outreach	**18,542 (86%)**
	Number (%) Agreements	**8,090 (38%)**

Reporting Period: *January 15 – January 28, 2024*

Special Populations include:

- Members authorized to receive ECM or Community Supports
- Members residing in Skilled Nursing or Intermediate Care Facilities
- Current / former Foster Youth
- Members enrolled in California Children's Services
- And other groups outlined in the MCP Transition Policy Guide.

Statewide Metrics: ECM & Community Supports

DHCS strongly encourages 100% ECM and Community Supports provider overlap between Receiving and Previous MCPs.

Key Takeaways

- While agreements with Out-of-Network providers are pending, transitioning members will continue to be able to access ECM and CS services either with their previous provider or through in-network provider with the choice to be reassigned to their previous provider once the agreement is executed.
- MCPs were required to provide written justifications for all Out-of-Network providers without an agreement.

ECM	**Total Number of ECM OON Providers**	**142**	
	Percent Agreements	**21%**	**58%**
	Percent Pending	**37%**	

Community Supports	**Total Number of Community Supports OON Providers**	**387**	
	Percent Agreements	**54%**	**64%**
	Percent Pending	**10%**	

Reporting Period: *January 15 – January 28, 2024*

ICF/DD and Subacute Transition

Preparation for ICF/DD & Subacute Transition

Operational Readiness Assessment

- DHCS and DDS convened an ICF/DD Homes Carve-in Workgroup starting in February 2022 to inform policy guidance for the transition.
- DHCS convened a Subacute Care Stakeholder Workgroup between December 2022 - April 2023.
- DHCS required MCPs to collectively submit approximately 231 Operational Readiness deliverables corresponding to the MCP contract

Member and ICF/DD Home Provider Engagement

- **Pre-Transition:** DHCS utilized various strategies for engaging members to raise awareness about the transition and their rights, including 30- and 60-day notices, Notice of Additional Information, and a member call campaign. DHCS convened 9 ICF/DD webinars and office hours, and 5 subacute care webinars open to the public.
- **Post-Transition**: DHCS is conducting post-transitional monitoring of MCPs and continuing to hold office hours through April to identify and address operational challenges.
- **Ongoing:** DHCS is collaborating with MCP partners and advocates to ensure effective communication and resolution of identified transition issues.

ICF/DD & Subacute Transition Context

Scale and Complexity

- **Scale**: Approximately 4,700 members were identified to transition from Fee-for-Service to an MCP on January 1, 2024; about 4,000 ICF/DD and 700 Subacute
  - Approximately 95% of these members transitioned on January 1, 2024
- **Complexity**: These transitions took place by county to make the LTC benefit statewide:
  - ICF/DD, ICF/DD-Habilitative, ICF/DD-Nursing Homes – 31 non-County Organized Health System (COHS) counties
  - Subacute Care Facilities – 31 non-COHS counties (adult); 36 counties (pediatric)

ICF/DD & Subacute Care Strike Team

- Process:
  - DHCS has developed a Strike Team including DDS to track, triage, and resolve inquiries expeditiously.
  - Stakeholders submitted inquiries to LTCTransition@dhcs.ca.gov.
- Summary:
  - In 2024, DHCS has responded to a total of 46 stakeholder inquiries.
  - Of these 46 inquiries received in 2024:
    - 54% were resolved in less than 3 calendar days
    - 76% were resolved in less than 5 calendar days
    - 82% were resolved in less than 7 calendar days
    - 100% were resolved in less than 10 calendar days

Topics	Totals	Percentages
Authorizations	10	22%
Benefits/Services	3	7%
Billing/Claims	5	11%
Care Coordination	0	0%
Continuity of Care	5	11%
Contracting	5	11%
Credentialing	3	7%
LOA/Bed Holds	0	0%
Member Eligibility	4	9%
Member Enrollment	2	4%
Payment (Rates)	2	4%
Regional Center/MCP Coordination	0	0%
Other	20	43%

ICF/DD Homes Transition Early Implementation Concerns

- **Eligibility/Enrollment issues caused confusion for providers who did not know who to bill.**
  - County/address mismatch in MEDS eligibility system prevented the member from being enrolled in a plan.
  - Plan enrollment for members who made a choice after the deadline in their *My Medi-Cal* choice packet was effective February 1, 2024.
- **Reluctance among providers to sign provider agreements.**
  - Provisions in the MCP/Provider contract irrelevant to the ICF/DD Home care model caused ICF/DD Home providers to be reluctant to sign contracts.
  - Some MCPs requested credentialing documents beyond the streamlined process outlined in the APL 23-023.
- **Additional MCP training for providers needed.**
  - ICF/DD Home providers are requesting additional training or feel that the training offered is insufficient.
- **Operational details for specific MCPs were not made clear to providers.**
  - MCPs are handling expiring FFS treatment authorization requests (TARs) in different ways which is not clear to providers (e.g., extending the TAR date or creating a new authorization).
  - MCPs have unique provider portals and systems, hence there are specific processes for granting access.
  - MCPs contract with specific clearinghouses to processes claims payments, which may vary from MCP to MCP.

Monitoring Approach

DHCS is monitoring the ICF/DD Homes and Subacute Care Facilities carve-in to ensure MCPs are taking appropriate actions to carry out their contract obligations pertaining to timely claims payments, member grievances, and access for potential oversight actions.

Dates	Frequency
Post-Transition Monitoring (2024)	
January 1 – February 29	Bi-Weekly
March 1 – June 30	Monthly
Regular Quarterly Monitoring (2024)	
July 1 – December 31	Quarterly

Oversight/Technical Assistance Activities

- In addition to analyzing Post-Transition monitoring data, DHCS is conducting the following oversight activities to identify and resolve provider concerns:
  - Extended Office Hours to April 2024 for MCPs, ICF/DD Home providers, and other stakeholders/advocates to discuss operational issues and share promising practices
  - Established weekly meetings with key ICF/DD Home providers and provider associations to troubleshoot and escalate concerns
  - Performing targeted MCP outreach to conduct further deep dives into the MCP's processes and identify where any corrective action is necessary
- Evolving MCP and ICF/DD Home Provider needs will help drive priority technical assistance areas.
  - DHCS will continue to develop additional resources to provide continued post-transition support.

Update on Adult Expansion Enrollment

Age 26-49 Adult Expansion

The Adult Expansion was implemented on **January 1, 2024**, and provides full scope Medi-Cal to Californians 26-49 years of age, regardless of immigration status, if they meet all Medi-Cal eligibility criteria.

- With this expansion, full scope Medi-Cal coverage is now available to all otherwise eligible Californians, regardless of immigration status.
- **The Governor's 2022-2023 Budget estimates the Adult Expansion population to be 707,000 individuals.**
- Policy guidance is posted in ACWDL 23-08.
- Additional information and resources available on the DHCS Age 26-49 Adult Expansion webpage

Age 26-49 Adult Expansion Outreach

- DHCS developed a Global Outreach Toolkit translated into all 19 threshold languages.
- DHCS highly recommends that counties and partners utilize the messaging and integrate it into their outreach and social media campaigns.
- DHCS is broadly sharing the global outreach language for use by Medi-Cal MCPs, other state departments, Medi-Cal providers, and other community partners for use in their outreach activities.

Age 26-49 Adult Expansion Outreach

- DHCS worked closely with foundations and CBOs to have materials tested by community members.
- DHCS developed a Get Your Community Covered Resource Hub of materials translated into all 19 Medi-Cal threshold languages.
  - DHCS recommends that counties and partners utilize the messaging and integrate it into their outreach and social media campaigns.
  - DHCS is sharing the global outreach language to be used by Medi-Cal MCPs, other state departments, Medi-Cal providers, and other community partners for use in their outreach activities.
- Statewide paid media campaign to run from November 2023 through May 2024.
  - Includes a new Medi-Cal.dhcs.ca.gov page in English and Spanish.

Resources

- The DHCS Adult Expansion webpage provides Age 26- 49 Adult Expansion publications and information
- ACWDL 23-08
- To learn about public charge: California Health & Human Services Agency Public Charge Guide

Contact Information

- For more information, visit the DHCS Adult Expansion webpage
- Questions? AdultExpansion@dhcs.ca.gov

DHCS Response to California State Auditor Report on Barriers to Timely Access to Behavioral Health Services for Children

Status of Medi-Cal Redeterminations

René Mollow, Deputy Director, and Yingjia Huang, Assistant Deputy Director,
Health Care Benefits and Eligibility

DHCS

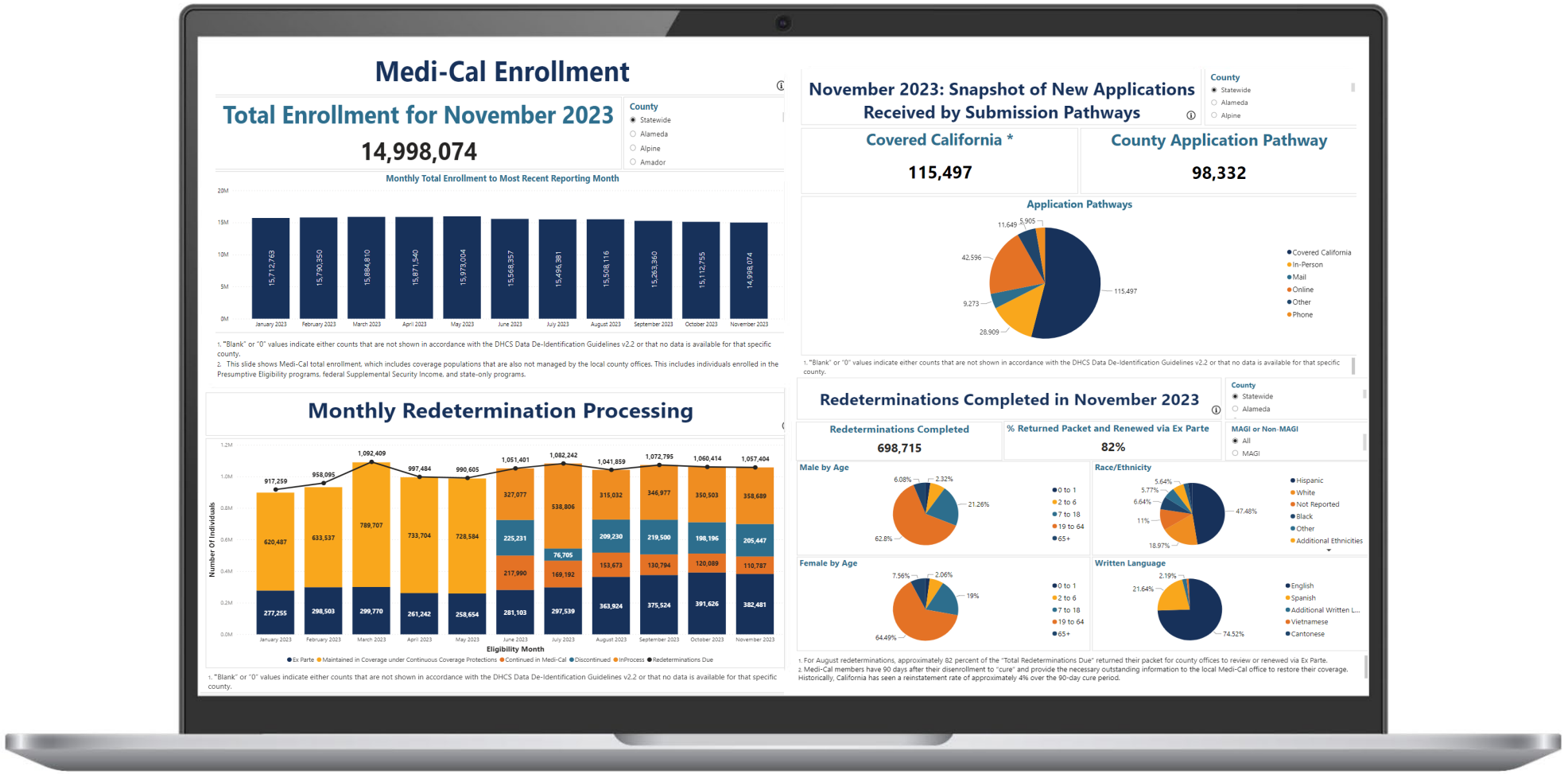
Continuous Coverage Unwinding Updates

- Federal guidance received provides an extension of continuous coverage unwinding waivers through December 31, 2024.
- DHCS posted 90-day data refreshes for June, July, and August 2023 on our DHCS unwinding webpage.
- DHCS, in partnership with the California Health Care Foundation, is conducting a survey with individuals procedurally disenrolled from Medi-Cal to gather insights on renewal barriers and reasons for disenrollments. Month 1 Survey results are now posted on the DHCS unwinding webpage.

Redetermination Outcomes

	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Enrollment							
Monthly Enrollment	15.6 million	15.5 million	15.5 million	15.3 million	15.1 million	14.9 million	14.9 million
Number of New Applications Received	143,069	142,052	171,798	160,682	181,721	213,829	204,313
Newly Enrolled in Medi-Cal for the First Time	53,836	63,443	72,569	62,576	57,772	68,453	77,505

Medi-Cal Continuous Coverage Unwinding Dashboard



Continued Redetermination Outcomes

	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Redeterminations							
Number redeterminations due	1.05 million	1.08 million	1.04 million	1.07 million	1.06 million	1.05 million	1.25 million
Percentage returned renewal packets for review or complete through ex parte	81%	80%	82%	81%	83%	82%	93%
Number of disenrollments as a result of renewals	225,231	76,705[1]	209,320	219,500	198,196	205,447	108,350
Percentage disenrolled (of total redeterminations due)	21%	7%	20%	20%	19%	19%	8.7%
Ex parte percentage	30%	27%	35%	35%	37%	36%	66.1%

Contact Information

- For more information, visit www.KeepMediCalCoverage.org.
- Questions? Ambassadors@dhcs.ca.gov

CalAIM Behavioral Health: Key Findings from Preliminary Implementation Feedback Report

Tyler Sadwith, Deputy Director for Behavioral Health, and Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health Policy Division

DHCS

Goal

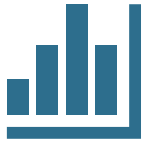
Assess preliminary implementation of several CalAIM behavioral health initiatives, including:

- Access Criteria for Specialty Mental Health Services (SMHS)
- No Wrong Door policy for Mental Health Services
- Screening and Transition of Care Tools for Mental Health Services
- Medi-Cal Peer Support Services

Data Collection

Statewide surveys on initiative implementation

Targeted stakeholder interviews



Quantitative, official, and additional data sources

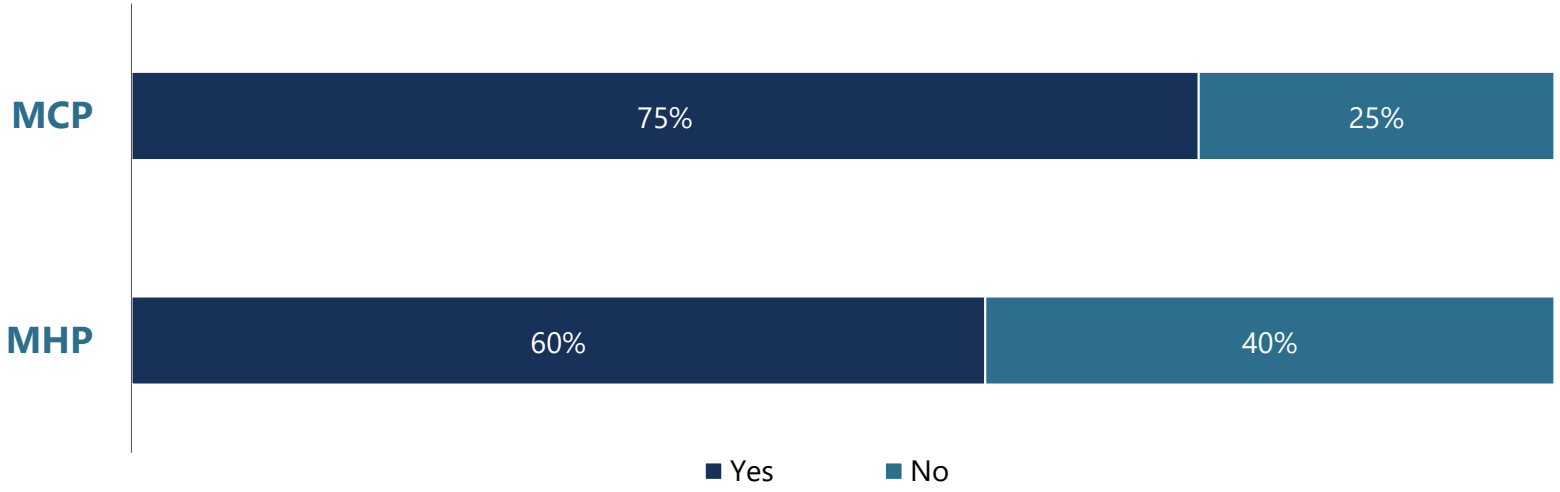
Overall Findings: Access Criteria, No Wrong Door, and Screening and Transition of Care Tools

Key Themes


Reduced barriers to care
Improved coordination
Implementation challenges

Improved Coordination

Figure 2: Are Policies Fostering Improved Cross-System Coordination?
Q3 2023 Access Criteria, No Wrong Door, and Screening and Transition of Care Tools

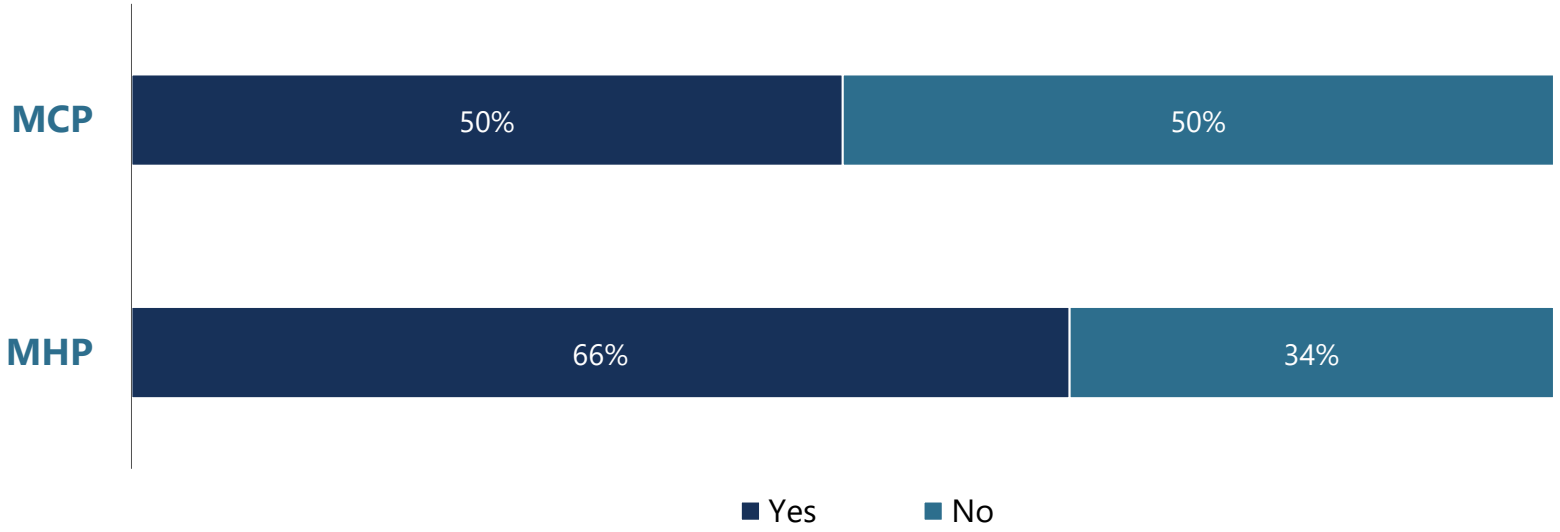


Source: *Year 1 MHP & MCP Surveys (n=65), August-September 2023.*
Note: Graphic represents responses to question; "Is implementation of Access Criteria, No Wrong Door, and Screening and Transition Tools fostering improved coordination with the MCP(s)/MHP(s) in the other delivery system?". Seven MHP responses were recorded as N/A and omitted from analysis. N/A Responses reflected instances where the plans had unique contracting arrangements, insufficient data to provide a yes or no response, or determined that the questions did not apply to their situation given existing positive relationships with MCPs.

- Improvements attributed to:
  - Increased information sharing and referral tracking workflows
  - Coordination between the No Wrong Door policy and the Screening and Transition of Care Tools
- Workflow development remains the biggest ongoing challenge for coordination

Reducing Barriers to Care

Figure 1: Are Policies Resulting in Fewer Barriers to Care for Medi-Cal Members?
Q3 2023 Access Criteria, No Wrong Door, and Screening and Transition of Care Tools



Source: *Year 1 MHP & MCP Surveys (n=69), August-September 2023.*
Note: Graphic represents responses to question; "Is implementation of No Wrong Door and Access Criteria and use of the Screening and Transition of Care Tools resulting in fewer barriers to care for Medi-Cal members?". Three MHP responses were recorded as N/A and omitted from analysis. N/A Responses reflected instances where MHPs had unique contracting arrangements or insufficient data to provide a yes or no response.

» Initiatives reduce barriers by:

- Increasing access to care for youth
- Increasing speed of member engagement in services and treatment
- Facilitating smoother transitions and connections to services for members in crisis

Access Criteria and No Wrong Door: Reported Successes

- Initiatives led to increased member access to services and faster service provision
- Some uncertainty interpreting access criteria for children and youth

"The impact of No Wrong Door has been entirely positive…It's really improved access and made it significantly easier for members to get services."
-MCP

Access Criteria and No Wrong Door: Reported Challenges

- Lack of clarity around how the No Wrong Door and Access Criteria policies intersected with other DHCS guidance.
- Challenges interpreting the access criteria for children and youth.
- Children and youth in SMHS need additional nuance in access criteria.

"It seemed like the policy is open to interpretation around Child Protective Services (CPS) involvement – what it means and how we differentiate levels of involvement. We've taken it as broad thing – if CPS is mentioned in any way, we count that."
-MHP

Screening and Transition of Care Tools: Development Process

The multi-year development process for the Screening and Transition of Care Tools involved robust testing and stakeholder input, including:

- National research to identify existing and validated tools
- Working groups to inform tool development and process
- Beta testing to refine tools before piloting on a larger scale
- Pilot testing to ensure statewide applicability
- Field testing to identify critical issues following updates
- Multiple public comment periods to solicit additional feedback

Screening and Transition of Care Tools: Reported Successes

- Increased clinical efficiency and reliability
- Supports information exchange across delivery systems
- Transition of Care Tool provides insight into service delivery and supports care coordination and non-duplication of services

"Having standard forms cuts down on confusion and ensures the type of information exchanged is consistent."
-MCP

Screening and Transition of Care Tools: Reported Challenges

- Concerns that screening tool scores do not **always** match the members to the appropriate delivery system
  - 91% percent or more of MCPs and MHPs surveyed reported they believe members are being directed to the appropriate delivery system for clinical assessment most of the time or always for the Youth and Adult Screening Tools, similar to pilot and field testing results.
- Transition of Care Tool is too long or requires double documentation
- Difficult to track referrals and develop closed-loop workflows
- Administering screening tools is time consuming for clinical staff delivering care
  - Note: Non-clinician administrative staff may administer the screening tools

Medi-Cal Peer Support Services Workforce

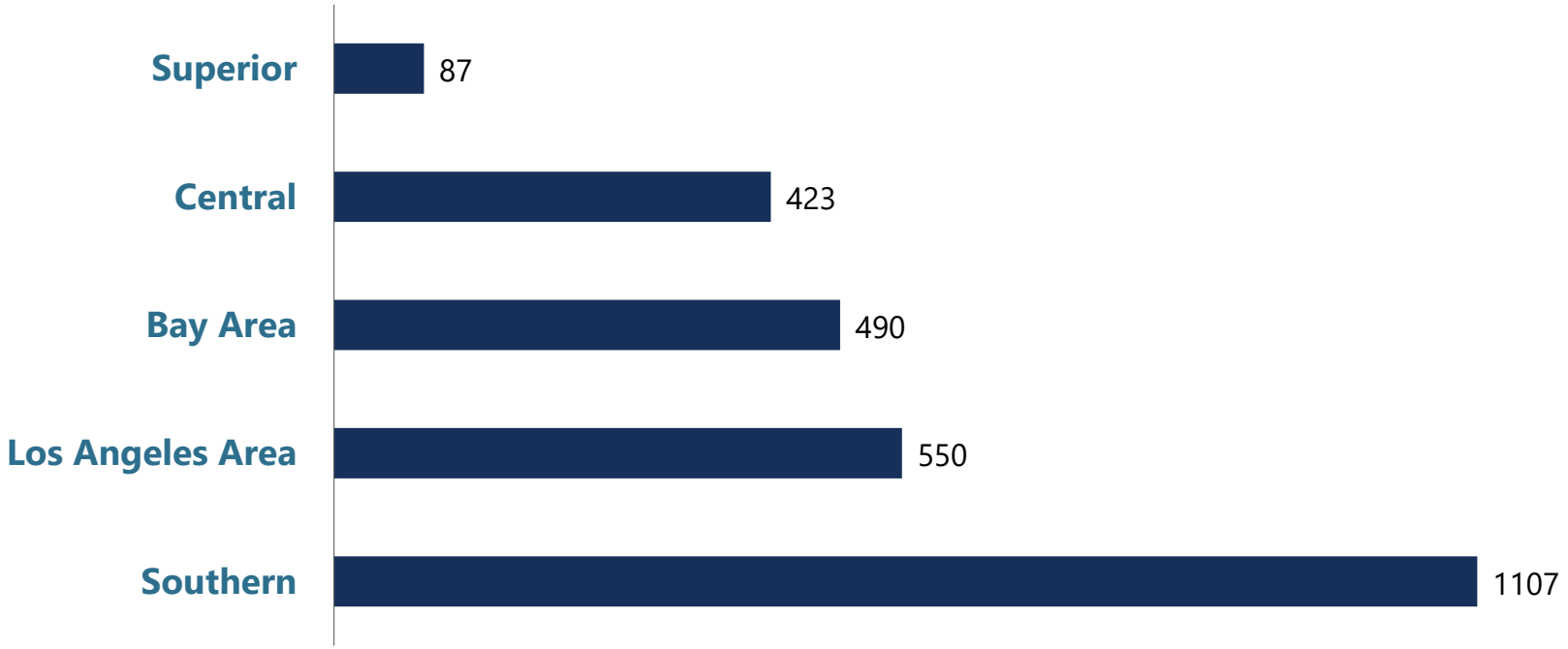
- County peer workforce development practices included:
  - Recruiting through member pipeline, in partnership with community organizations, and supporting interested individuals in obtaining certification
  - Improving workflows to accommodate new role and creating peer specializations

2,541 individuals have been certified as Medi-Cal Peer Support Specialists since 2022

DHCS' Behavioral Health Workforce Development (BHWD) initiative aims to diversify and enhance the BH workforce to improve access to BH services through grant-funded projects, including supporting peer-run organizations' capacity to bill for Medi-Cal Peer Support Services.

Medi-Cal Peer Support Specialist Certification

Figure 5: Number of Peer Certifications by Region
Fiscal Year 2022-2023 and 2023-January 2024

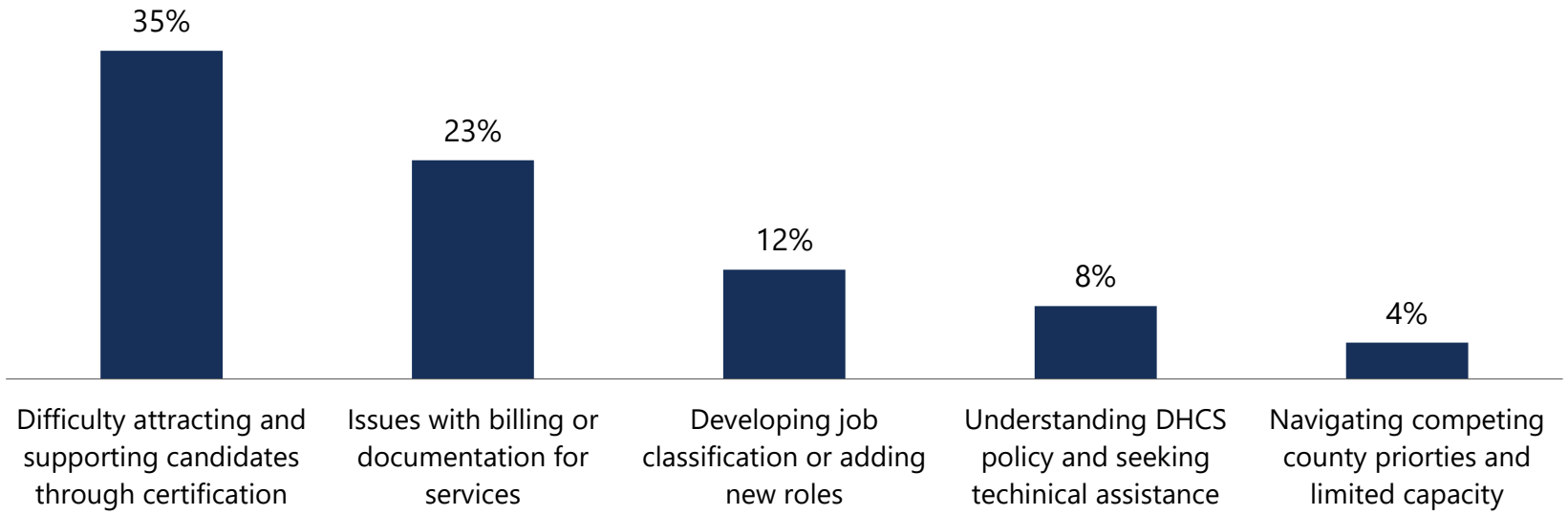


- Certifications continue to increase at a steady pace
- **1,368** individuals were certified in FY 2022-23, and an additional **1,173** have been certified in FY 2023-24

Source: *CalMHSA Peer Certification Program Dashboard | https://www.capeercertification.org/certification-program-data-dashboard/. Data Represented: Fiscal Year 2022-2023 and 2023-January 2024 | Data Downloaded: January 31, 2024.*
Note: Counts represent total number of Medi-Cal Peer Support Services Peers certified in each region. Region categories provided by CalMHSA.

Peer Support Services Reported Challenges

Figure 6: Challenges to County Peer Support Services Implementation
Percent of Counties Experiencing Challenge, Q4 2023



Source: *Medi-Cal Peer Support Services Survey (n=40), October-November 2023*.
Note: Graphic represents responses to question "Have you experienced challenges in implementing the Medi-Cal Peer Support Services benefit since Peer Support Specialist certification became available in fall 2022? If yes, what challenges have you experienced?". Figure shown by percent of opt-in counties reporting.

- **85 percent of counties** reported challenges implementing Peer Support Service benefit
- Challenges included:
  - Difficulty attracting and supporting candidates through certification
  - Navigating billing and documentation
  - Developing job classifications
- Peer-run organizations reported challenges contracting to provide Peer Support Services

Medi-Cal Peer Support Services Reported Successes

- Partnered with community organizations, vendors, and the California Mental Health Services Authority (CalMHSA) to implement the benefit.
- Supported prospective peer workers through training and certification.
- Received positive feedback from members.

"My experience with peer support was very positive. They accommodated our language. We had access to information and a network of resources."
-MHP member

Discussion: Opportunities for Improvement

How should DHCS best approach technical assistance, resource development, and policy improvement in the key areas identified?

- Screening & Transition of Care Tools
- SMHS & NSMHS Referrals, including Closed Loop Referrals
- SMHS Access Criteria – Trauma Screening

Resources

» Access Criteria
- BHIN 21-073

» Peer Support Services
- BHIN 21-041
- BHIN 22-026
- Website

» No Wrong Door
- BHIN 22-011
- APL 22-005

» Screening and Transition of Care Tools
- APL 22-028
- BHIN 22-065
- Website

» For more information: BHCalAIM@dhcs.ca.gov

Next Steps

- The CalAIM Behavioral Health Preliminary Implementation Feedback Report will be published in early 2024.
- DHCS will continue to monitor implementation and leverage findings to support ongoing technical assistance and policy planning.

Contact Information

- For more information, visit CalAIM Behavioral Health Initiative webpage
- Questions? BHCalAIM@dhcs.ca.gov

Equity and Practice Transformation (EPT) Provider Directed Payment Program

Palav Babaria, MD, Chief Quality and Medical Officer and Deputy Director, Quality and Population Health Management (QPHM)

DHCS

Equity and Practice Transformation (EPT) Overview

EPT is a five-year, $700 million program to support primary care practices to address population health, health equity, and implement evidenced-based practices.

- Participating practices will:
  - Work on specific activities and milestones, receiving payments for progress made.
  - Work with one focus population (pregnant individual, children, adult with chronic conditions, adults with preventive health needs, or individuals with behavioral health conditions).

Accepted Practices

211 practices
representing
a maximum of
$387M
in potential
payments to
practices over
five years.

83%
of practices
are from
HPI Quartiles
1 or 2

Types of practices represented:

Small
Independent Practices

Federally Qualified
Health Centers (FQHC)
or FQHC look-alikes

Large Health Systems

Next Steps

- DHCS is currently implementing the first cohort of 211 practices.
  - Launch webinars are being held this month.
  - The Population Health Learning Center will service as the program office for EPT.
- A second cohort will likely occur in the future, but no details are available at this time.

Contact Information

- For more information, visit Equity & Practice Transformation Payments Program
- Questions? ept@dhcs.ca.gov

Public Comment

Next Steps and Adjourn

Michelle Baass, Director

DHCS

2024 Meeting Dates

- Wednesday, May 29, 2024
- Wednesday, July 24, 2024
- Wednesday, October 16, 2024

LUNCH BREAK

12:30 – 1:00 p.m.

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Behavioral Health-Stakeholder Advisory Committee Hybrid Meeting

Thursday, February 15, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Webinar Tips

- Please use either a computer or phone for audio connection.
- Please mute your line when not speaking.
- For questions or comments, email:

  SACInquiries@dhcs.ca.gov or BehavioralHealthSAC@dhcs.ca.gov.

Welcome, Roll Call, and Today's Agenda

Michelle Baass, Director

DHCS

Behavioral Health Payment Reform Update

Tyler Sadwith, Deputy Director for Behavioral Health, and
Brian Fitzgerald, Chief of the Local Governmental Financing Division

DHCS

Goal

- Behavioral Health Payment Reform updates
- Prioritizing access to care
- Key principles for implementation
- Statewide and targeted technical assistance opportunities
- Implementer panel discussion

State Plan Amendment (SPA) 23-045

- SPA 23-045 submitted to CMS on December 11, 2023
- Proposes two changes in financing of psychiatric inpatient services:
  - Removes the state maximum allowable (SMA) as a limit to "fee-for-service (FFS)" psychiatric hospitals.
  - Removes language for "Short-Doyle Medi-Cal" psychiatric hospitals that limits DHCS ability to update acute psychiatric inpatient reimbursements based on more recent cost information

Prioritizing Access to Care

- Early and Periodic Screening, Diagnostic, and Treatment Mandate (EPSDT) mandate obligations
- Network adequacy and timely access requirements
- Significant change in provider network reporting
- Oversight and compliance enforcement

DHCS Letter to County Behavioral Health Directors (December 2024)

EPSDT Mandate Obligations

- Medi-Cal Behavioral Health Delivery Systems must provide medically necessary services to members under age 21, who are **coverable** under the Medicaid State Plan*, that are needed to correct or ameliorate discovered health condition, regardless of whether those services are covered in the Medicaid State Plan.
- Per CMS, services need not be curative or restorative. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and covered as EPSDT services.

**(described at 42 U.S.C. § 1396d(a))*

Network Adequacy & Timely Access Requirements

- MHPs and DMC-ODS plans are required to:
  - Maintain adequate networks of BH providers.
  - Ensure timely access to covered services (including EPSDT)
  - BHIN 23-041: 2023 Federal Network Certification Requirements for MHPs and DMC-ODS plans
- DMC-counties do not maintain closed provider networks, but are obligated to monitor and ensure timely access.
  - BHIN 22-070: Parity requirements for DMC State Plan Counties

Significant Change in Provider Network

- MHPs and DMC-ODS plans are required to report significant network changes to DHCS within 10 days of the change.

- DHCS will follow-up to assess potential impacts to access and initiate corrective action when notified of a significant change.

Enforcement and Monitoring of Network Adequacy & Timely Access Requirements

- Medi-Cal BH Delivery Systems must monitor the adequacy of their own networks.
- DHCS may impose administrative or financial sanctions per BHIN 22-045
- DHCS expects Medi-Cal BH Delivery Systems to proactively communicate and collaborate in real time with providers to mitigate impact to network adequacy and member access.
- DHCS encourages Medi-Cal BH Delivery Systems and providers to apprise us of anticipated or actual provider closures at NAOS@dhcs.ca.gov

Key Principles for Implementation

- Tailored and targeted provider rate design
  - Differentials for field-based care models, key services, and access gaps
- Provider efficiency
  - Clinic-based productivity and indirect costs
- Flexible provider contracting approaches
  - Rate renegotiations, term renegotiations, and flexibilities
- Close collaboration and constant communication

Provider and County Technical Assistance

- CBHDA and CalMHSA, in collaboration with DHCS and provider associations, will host a TA webinar in February 2024.

- DHCS will provide additional ongoing direct TA directly with provider associations and direct service providers.

Rate Comparisons

Rate comparison: Proc. Code 90837 'Psychotherapy, 60 Minutes with Patient			
Fair Health Uninsured Cost	DHCS Behavioral Health Average Rate*	Medicare**	Medi-Cal FFS Base Rate***
$155	$726	$189	$98

* Lowest rate by practitioner type is $393 in Sacramento county.
All practitioner statewide average is $825
** Highest rate by facility type
*** Base rate is $98 with a maximum of $124

While not all delivery systems or payer provide reimbursement in the exact way that DHCS reimburses for county behavioral health services, a general comparison can be made which demonstrates the adequacy of the Payment Reform Fee Schedule

County and Provider Experience

- Sherri Terao, County of Santa Clara Behavioral Health Director
- Amy Ellis, County of Placer Health & Human Services Deputy Director
- Katy Eckert, County of Monterey Behavioral Health Bureau Chief/Behavioral Health Director
- Dawan Utecht, Telecare Senior Vice President, Chief Development Officer

Contact Information

- Questions? bhpaymentreform@dhcs.ca.gov

QPHM: Overview and Stakeholder Engagement for Behavioral Health Components

Palav Babaria, MD, Chief Quality and Medical Officer and Deputy Director, QPHM

DHCS

CalAIM PHM Program: A powerful tool to achieve the vision

	PHM Program	PHM Service
	A core part of the CalAIM initiative requires Medi-Cal delivery systems to develop and maintain a whole system, person-centered PHM program.	A technological service that supports DHCS' PHM vision by integrating data from disparate sources, performing population health functions, and allowing for multi-party data access and sharing.
SCOPE	The initial PHM program design targets MCPs	The PHM Service includes programs and infrastructure that extend beyond MCPs
TIMELINE	1/1/23 launch	Select components of the service for 1/1/23 launch

PHM Service: Overview of Capabilities

The PHM Service will aggregate, link, and provide access to a variety of data types and support key population health functions.

Integrate Data from DHCS and Other Sources

Enable Key PHM Functions and Services

Provide Access to PHM Data

Integrate physical and behavioral health data, social services, dental, developmental, home and community-based services, In-Home Supportive Services (IHSS), 1915c waiver, and other program and administration data from providers, MCPs, counties, CBOs, DHCS, and other government departments and agencies.

PHM Service: Overview of Capabilities

The PHM Service will aggregate, link, and provide access to a variety of data types and support key population health functions.

Integrate Data from DHCS and Other Sources

Enable Key PHM Functions and Services

Provide Access to PHM Data

Facilitate and support key population health functions, such as individual screening and assessment; risk stratification, segmentation, and tiering; and gap reporting.

PHM Service: Overview of Capabilities

The PHM Service will aggregate, link, and provide access to a variety of data types and support key population health functions.

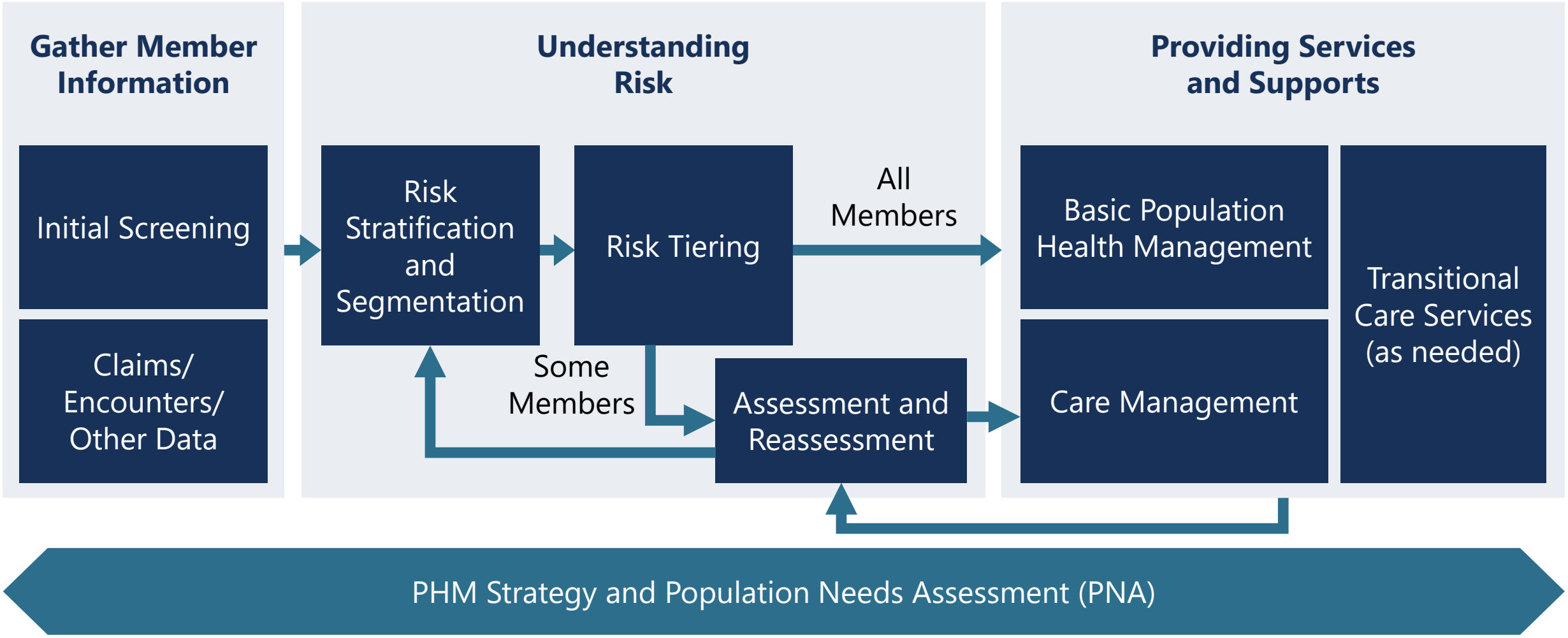
Integrate Data from DHCS and Other Sources

Enable Key PHM Functions and Services

Provide Access to PHM Data

Provide users access to integrated data to support PHM use cases and streamline care delivery. Intended users include DHCS as well as MCPs, counties, providers, members, human services programs, and other partners.

PHM Framework Overview



Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT): Evidence-Based Practices and Child and Adolescent Needs and Strengths Alignment

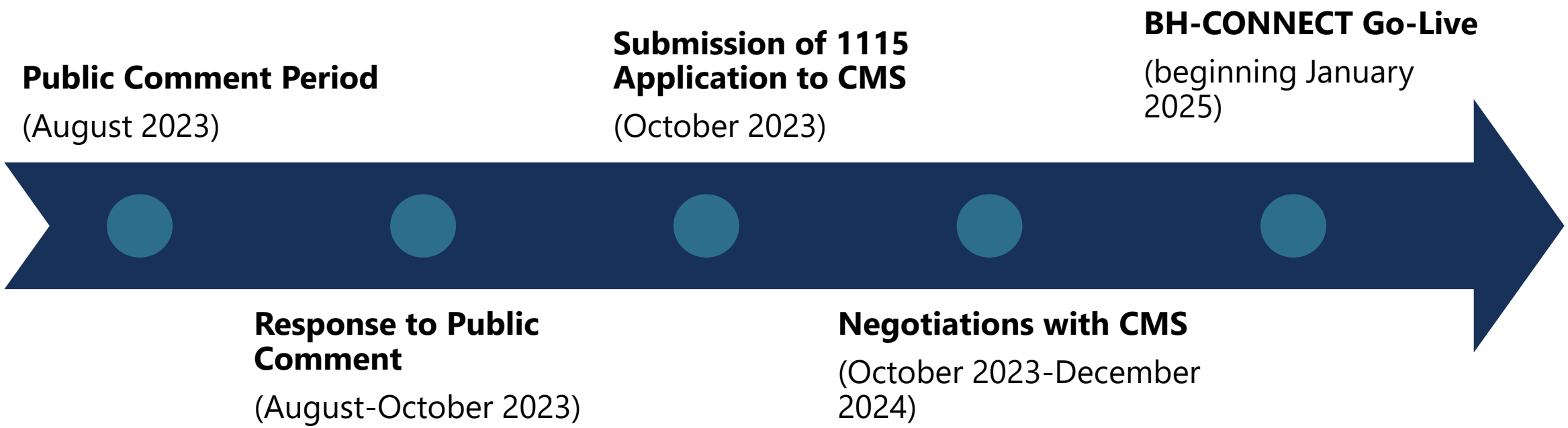
Paula Wilhelm, Assistant Deputy Director for Behavioral Health
Ivan Bhardwaj, Chief of the Medi-Cal Behavioral Health Policy Division

DHCS

Agenda: BH-CONNECT

- BH-CONNECT Demonstration Timeline & Components
- Updates for Discussion:
  - Assertive Community Treatment (ACT)
  - Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
  - Child and Adolescent Needs and Strengths (CANS) Alignment
- Upcoming Milestones and Stakeholder Engagement
- Discussion

BH-CONNECT Section 1115 Demonstration Submission Updates



DHCS is committed to engaging with stakeholders throughout the design and implementation of BH-CONNECT

Key Demonstration Components

DHCS is requesting Section 1115 demonstration authorities for specific features of the BH-CONNECT proposal. Other features will require a State Plan Amendment or administrative expenditures, and others can be implemented using existing federal Medicaid authorities *(*denotes February BH-SAC discussion topics).*

Section 1115 Authorities

Expenditure Authority Requests

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

Waiver Authority Requests

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

Forthcoming State Plan Amendment

- ✓ **ACT***
- ✓ **Forensic ACT***
- ✓ **Coordinated Specialty Care for First Episode Psychosis***
- ✓ Individual Placement and Support (IPS) Model of Supported Employment
- ✓ Community Health Worker Services
- ✓ Clubhouse Services

Existing Federal Medicaid Authorities

- ✓ **Centers of Excellence***
- ✓ Clarification of Coverage of Evidence-Based Child and Family Therapies
- ✓ Initial Child Welfare/Specialty Mental Health Assessment
- ✓ Foster Care Liaison Role
- ✓ **CANS Alignment***
- ✓ Requirements for Counties that Opt-In to Receive FFP for IMDs
- ✓ Implementation of Other CMS Milestones

Assertive Community Treatment

Overview: Assertive Community Treatment (ACT)

- As part of BH-CONNECT, DHCS intends to cover ACT as a Medi-Cal service. All counties will have the option to implement ACT.

  Counties that opt-in to receive federal financial participation (FFP) for care provided during short-term stays in Institutions for Mental Disease (IMDs) will be required to provide ACT to members for whom it is clinically appropriate.

- Person-centered, comprehensive approach to care
- Robust evidence base for ACT
- California is in the minority of states that do not fully cover and reimburse ACT through Medicaid
- DHCS does not have comprehensive data on how or where full-fidelity ACT programs may be operating in California today
- DHCS intends to optimize FFP for ACT services

Overview: ACT Workgroup

Between April and November 2023, DHCS convened a small workgroup of subject matter experts to discuss key considerations for implementing ACT in Medi-Cal. The workgroup shared their experience and expertise with ACT to support DHCS' goal of designing a service that meets the needs of Medi-Cal members while retaining fidelity to the evidence-based model.

Members

- Workgroup members brought perspectives on ACT implementation statewide and in other states, and included representatives from:
  - County Behavioral Health Agencies: Nevada County, Solano County, Alameda County, San Diego Counties
  - Experts at Academic Institutions: UCLA, UCSF
  - Advocacy Groups: County Behavioral Health Directors Association (CBHDA), National Health Law Program (NHeLP)

Discussion Topics

Overview: ACT Workgroup

Between April and November 2023, DHCS convened a small workgroup of subject matter experts to discuss key considerations for implementing ACT in Medi-Cal. The workgroup shared their experience and expertise with ACT to support DHCS' goal of designing a service that meets the needs of Medi-Cal members while retaining fidelity to the evidence-based model.

Members

Discussion Topics

» Over the course of ten meetings, workgroup members met to discuss key issues related to ACT service design and implementation, including:

- Service components
- Fidelity models and team structure
- Eligibility criteria
- Reimbursement strategies
- Training and technical assistance
- Accountability, oversight, and monitoring

Key Considerations: ACT Service Design

- Service Components
- Fidelity Model and Team Structure
- Flexibility in Rural Areas
- Eligibility Criteria
- Reimbursement Model
- Certification and Implementation Planning

Key Considerations: Role of a Center of Excellence in ACT Implementation

- As part of BH-CONNECT, DHCS plans to establish one or more Centers of Excellence (COEs) to support high-fidelity implementation of evidence-based practices across the state, including COEs for ACT, Coordinated Specialty Care for First Episode Psychosis, Supported Employment for children and youth.
- Core responsibilities may include:
  - Training
  - Ongoing technical assistance
  - Conducting fidelity reviews and certification
  - Data collection
  - Learning communities
  - Support ramp-up and scaling

Coordinated Specialty Care for First Episode Psychosis

Overview: Coordinated Specialty Care (CSC)

Every year, approximately 100,000 adolescents and young adults in the U.S. experience their first episode of psychosis (FEP).

Role of Coordinated Specialty Care

Evidence Base for CSC

SAMHSA Community Mental Health Services Block Grant (MHBG) Funding

National Landscape

CSC is the leading, team-based approach for serving young adults following a FEP. Like ACT, it is a team-based, multidisciplinary behavioral health practice.

Overview: Coordinated Specialty Care (CSC)

Every year, approximately 100,000 adolescents and young adults in the U.S. experience their first episode of psychosis (FEP).

Role of Coordinated Specialty Care

Evidence Base for CSC

SAMHSA Community Mental Health Services Block Grant (MHBG) Funding

National Landscape

Previous research on CSC for FEP found that individuals who received CSC were much less likely to develop a SMI later in life compared to those who received typical care. Other benefits include improved psychopathology and overall quality of life.

Overview: Coordinated Specialty Care (CSC)

Every year, approximately 100,000 adolescents and young adults in the U.S. experience their first episode of psychosis (FEP).

Role of Coordinated Specialty Care

Evidence Base for CSC

SAMHSA Community Mental Health Services Block Grant (MHBG) Funding

National Landscape

Federal law requires SAMHSA to set aside 10 percent of the MHBG allocation for each state to support evidence-based programs for FEP. California allocates 11 percent of its MHBG allocation to support FEP.

Overview: Coordinated Specialty Care (CSC)

Every year, approximately 100,000 adolescents and young adults in the U.S. experience their first episode of psychosis (FEP).

Role of Coordinated Specialty Care

Evidence Base for CSC

SAMHSA Community Mental Health Services Block Grant (MHBG) Funding

National Landscape

Almost every state has a CSC program and many use Medicaid – in addition to SAMHSA block grant funding – to finance components of the service. However, no state currently has a State Plan Amendment (SPA) to cover CSC for FEP as a bundled service; only New York has indicated it plans to submit a SPA for its bundled case rate.

State Landscape: CSC for First Episode of Psychosis (FEP) in California

Many counties in California already implement programs to support members experiencing their FEP. BH-CONNECT intends to build upon work already underway in California to expand access to evidence-based treatment.

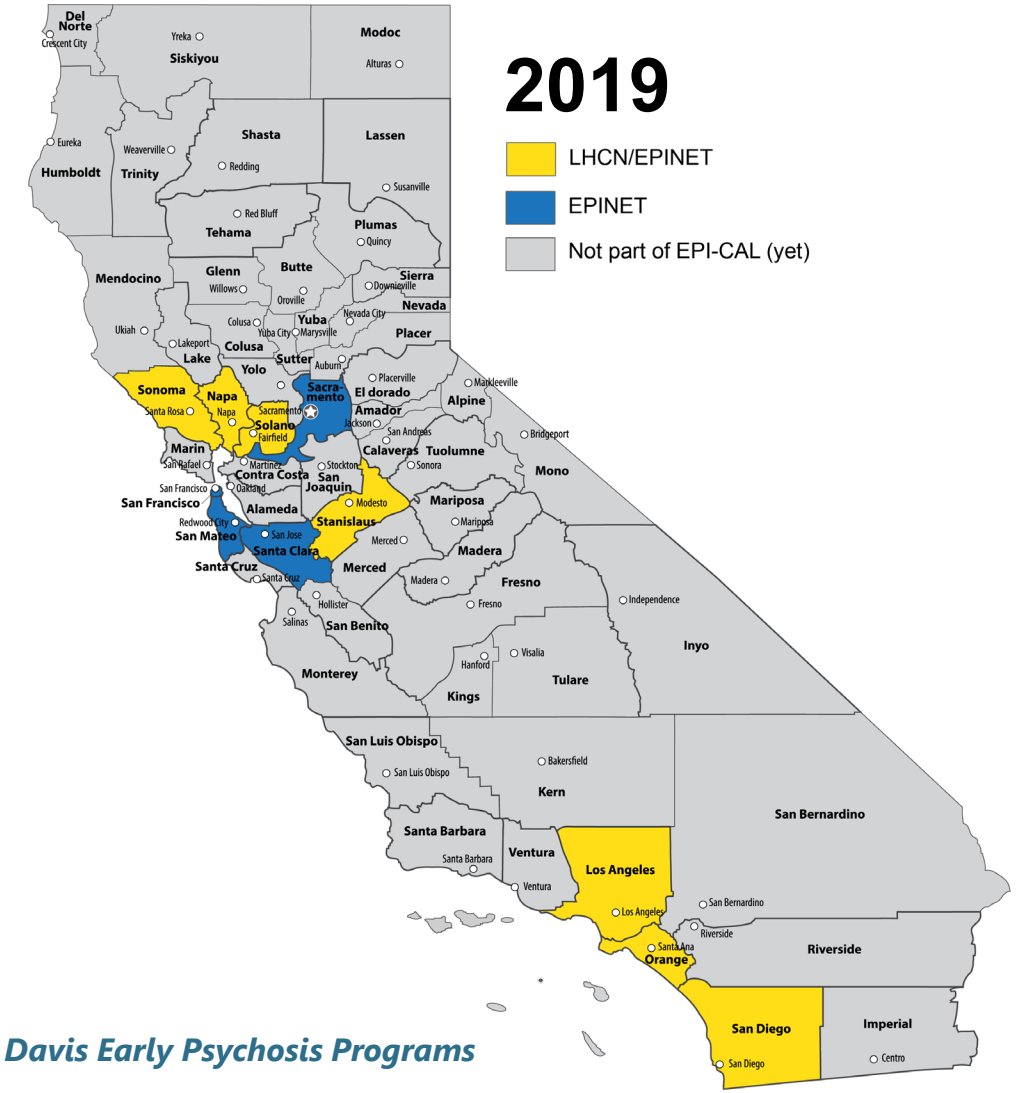
- **Mental Health Services Oversight & Accountability Commission (MHSOAC).** In addition to MHSOAC INN, AB 1315 established the Early Psychosis Intervention Plus (EPI Plus) Program. This consisted of a competitive selection process to expand the provision of high-quality, evidence-based early psychosis and mood disorder services. UC Davis was selected as a lead TA provider to support grantees in reaching full fidelity to the CSC model over four years. In 2020, MHSOAC awarded five EPI Plus Program grants totaling $10 million. In 2021, two additional grants were awarded.
  - In FY 2022-23, DHCS allocated $24 million directly to counties for FEP set-aside. DHCS is committing $25 million for a contract expansion to further support and expand EPI-CAL from April 1, 2022, through June 30, 2025.
- **Role of UC Davis.** UC Davis currently supports implementation of CSC for FEP programs across California and nationwide, spearheading several initiatives to provide training and technical assistance to county behavioral health departments. The California Early Psychosis Intervention Program (EPI-CAL) is a learning health care network and training and TA center for California's early psychosis programs. DHCS is actively participating in convenings hosted by UC Davis to discuss the California landscape for CSC for FEP and key barriers and opportunities in implementation.

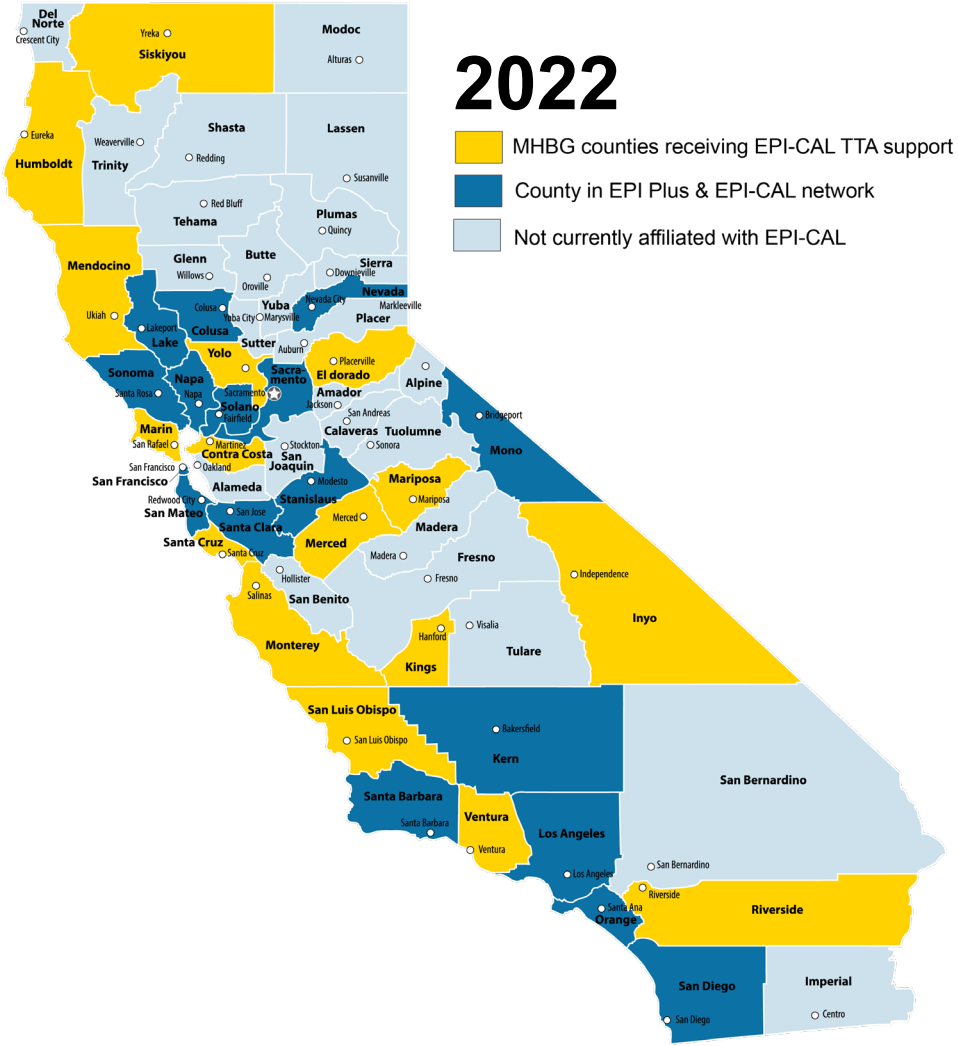
State Landscape: CSC for FEP in California (continued)

- **CYBHI** includes $429 million in grants to organizations seeking to scale evidence-based and/or community-defined evidence practices (EBPs/CDEPs) that improve youth behavioral based on robust evidence for effectiveness, impact on racial equity, and sustainability.
  - Through extensive community engagement and close collaboration with MHSOAC, DHCS selected EBPs and CDEPs to consider for scaling throughout the state. The initiative includes 100+ practices and programs across the continuum of care that are applicable in a variety of clinical, home, and community-based settings.
  - Six rounds of CYBHI EBP/CDEP grants were released.
  - Fifth round ($80 million) focused on early intervention programs and practices – RFA submission was November 17, 2023
    - CSC for FEP was explicitly called out.
    - Commitment to follow CSC model to fidelity.

SPA coverage of a bundled CSC for FEP service could strengthen counties' existing programs and encourage other counties to offer CSC for FEP, while freeing up other funding sources for training, TA, and outreach.

State Landscape: Growing EPI-CAL Programs*





Source: UC Davis Early Psychosis Programs

Preliminary Approach for BH-CONNECT: Coordinated Specialty Care

Like with ACT, DHCS intends to cover all Medicaid-coverable components of Coordinated Specialty Care for FEP. It will be designed to build upon and complement work already underway in California to establish robust CSC programs.

Specific CSC service components *may* include:

- Assessment
- Medication management
- Individual, group, and family therapy
- Vocational/educational support services
- Peer and family peer support services
- Person-centered planning

CSC team members *may* include:

Preliminary Approach for BH-CONNECT: Coordinated Specialty Care

Like with ACT, DHCS intends to cover all Medicaid-coverable components of Coordinated Specialty Care for FEP. It will be designed to build upon and complement work already underway in California to establish robust CSC programs.

Specific CSC service components *may* include:

CSC team members *may* include:

- CSC for FEP team leader
- Psychiatrist or other prescriber
- Vocational specialist
- A team member who can work with clients on goals that require social or coping skills training and attention to substance use
- A team member dedicated to establishing and maintaining a referral network and evaluating potential members

Child and Adolescent Needs and Strengths Tool

Overview: Aligned Use of the Child and Adolescent Needs and Strengths (CANS) Tool

Child welfare and specialty mental health use different variations of the CANS tool and have different requirements. As part of BH-CONNECT, DHCS proposes to develop an aligned CANS tool to be used across the child welfare and specialty mental health systems.

The CANS tool is used to:

- **Support decision making**, including level of care and service planning.
- Allow for the **monitoring of outcomes** of services.
- **Guide conversations** about the well-being of children and youth.

Alignment of the CANS tool across the two systems is intended to:

- Ensure that both child welfare and behavioral health providers are **using the same CANS tool** with the same modules.
- Ensure that the CANS tool is **administered in the same way**, whether done by a specialty mental health provider or by a child welfare worker, so that outcomes are being measured consistently and can be tracked over time.
- Support a **cohesive approach to decision making and service planning across systems**, with the goal of improving outcomes and wellbeing for children and youth.

CANS Tool Elements for Alignment

Element	DHCS Tool: CANS-50	CDSS Tool: CANS-IP
Ages	6 to 20 years old	5 to 21 years old
Cadence	• At the beginning of treatment • Every 6 months • At end of treatment	• At intake (within 60 days of opening a case) • Every 6 months
Who Administers	Only professionals certified as CANS Providers: Social Worker (SW), Child and Family Team (CFT) Facilitator, MHP	Those actively CANS-certified through the Center for Innovation in Population Health (IPH-C, formerly Praed) and recertified on an annual basis
Sharing CANS	Placing agency and MHP must share CANS and upload to their respective agency data system	
MH Screening	For children/youth who are already in foster care and not currently receiving SMHS, the CANS tool may function as the required MH Screening	
Redaction	CANS Questions #8 (Substance Use) and #48A (Caregiver Substance Use)	

Provisional Alignment Decisions

DHCS and CDSS have had monthly workgroup meetings to discuss alignment of the CANS tool. The provisional alignment decisions below are examples of the types of changes that would need to be made for alignment.

Current CDSS Guidance	» CANS must be administered during the first 60 days after a case plan opens, and every 6 months until closure of the case plan (i.e., permanency or reunification) (ACL No. 18-81).
Current DHCS Guidance	» CANS assessments are to be administered on new clients entering treatment, every 6 months thereafter, and at the end of treatment (BHIN 17-052).
Provisional Alignment Decision	» To align with DHCS' requirement, CDSS proposes to update its policy to explicitly state that the **CANS must be administered at closure** of the case plan.

Provisional Alignment Decisions

DHCS and CDSS have had monthly workgroup meetings to discuss alignment of the CANS tool. The provisional alignment decisions below are examples of the types of changes that would need to be made for alignment.

Current CDSS Guidance

Current DHCS Guidance

Provisional Alignment Decision

CDSS requires that the individual responsible for completing the CANS assessment tool be trained, actively CANS-certified and maintain annual certification through IPH (formerly Praed) (ACL No. 18-81)

- DHCS expects MHPs to provide/arrange for training to all clinicians who administer CANS and references Praed as an optimal resource for MHPs to leverage for formal training (BHIN 17-052).
- To align with CDSS' policy, DHCS proposes to require CANS administrators to be **certified through IPH.**

Upcoming Milestones and Stakeholder Engagement Opportunities

Key Milestones: Implementation of BH-CONNECT Evidence-Based Practices

Release of Request for Information (RFI) for COEs
(January 2024)

Development of SPAs for BH-CONNECT EBPs, Including Public Comment Periods
(January-June 2024)

Submission of SPAs to CMS
(Q2 2024)

Development of Implementation Guidance for BH-CONNECT EBPs
(June-December 2024)

Implementation of BH-CONNECT EBPs
(beginning January 2025)

DHCS will continue to engage stakeholders on the design and implementation of BH-CONNECT EBPs, including in future BH-SAC meetings.

BH-CONNECT Stakeholder Engagement Opportunities

Previous Stakeholder Engagement

- Public comment process for BH-CONNECT concept paper and Section 1115 waiver application (multiple stakeholder forums)
- 10 ACT workgroup meetings including members representing county behavioral health agencies, academic institutions, and advocacy groups
- Targeted interviews with provider organizations and other states on the design and implementation of EBPs
- Presentations to DHCS' Youth Advisory Group on components of the demonstration, which are specific to children and youth (e.g., CANS alignment)

Ongoing & Upcoming Engagements

BH-CONNECT Stakeholder Engagement Opportunities

Previous Stakeholder Engagement

- Continued stakeholder engagement during policy design and guidance development (including applicable public comment periods)
- At least quarterly convenings of the CalAIM BH Workgroup and BH-SAC
- Additional stakeholder meetings to review specific components of BH-CONNECT

Ongoing & Upcoming Engagements

Contact Information

- Additional feedback is always welcome at BH-CONNECT@dhcs.ca.gov

Public Comment

Next Steps and Adjourn

Michelle Baass, Director

DHCS

2024 Meeting Dates

- Wednesday, May 29, 2024
- Wednesday, July 24, 2024
- Wednesday, October 16, 2024

Thank You

DHCS